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State of New Hampshire

DEPARTMENT OF ADMINISTRATIVE SERVICES
25 Capitol Street - Room 120
Concord, New Hampshire 03301
Office@das.nh.gov

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Deputy Commissioner
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July 22, 2020

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, New Hampshire 03301

REQUESTED ACTION

Authorize the Department of Administrative Services (DAS), Division of Risk and Benefits to enter into a fully-insured Medicare Advantage Plan agreement with Aetna Life Insurance Company (VC#288785), which includes a guaranteed premium rate of $0 per retiree or spouse and a contingency fund in an amount not to exceed $378,338 to be used in the event plan administrative costs arise. Effective upon Governor and Council approval for the period of January 1, 2021 through December 31, 2023. **Approximately 42% General Funds, 17% Federal Funds, 4% Enterprise Funds, 14% Highway Funds, 1% Turnpike Funds and 22% Other Funds.**

Funding is available in the Employee Benefit Risk Management Fund contingent upon availability and continued appropriations for all fiscal years with the authority to adjust encumbrances in each of the State fiscal years through the Budget Office if needed and justified:

MEDICARE ADVANTAGE – Fully-Insured

Administrative Costs – Contingency Only	SFY2021	SFY2022	SFY2023	SFY2024
01-14-14-140560-66500000 102-500653	$60,600	$123,624	$128,569	$65,545
GRAND TOTAL				$378,338

EXPLANATION

The purpose of this item is to obtain authority for DAS to enter into an agreement with Aetna Life Insurance Company to provide a fully-insured group Medicare Advantage Plan for over 10,000 State Medicare-eligible retirees and spouses. The monthly premium rate is $0.00 per retiree or spouse per month (PMPM), guaranteed for the three-year term with minimal exceptions such as changes in specific Centers for Medicare and Medicaid Services (CMS) regulations, reintroduction of the federal premium tax or material changes in enrollment or plan design.

DAS is requesting approval of $378,338 as a contingency fund in the event plan administrative costs arise such as implementation or data transfer fees, design and distribution of customized retiree communications, or ad hoc reporting requests. The contingency amount was calculated using $1.00 PMPM over the life of the contract, adjusted to reflect increased enrollment.

Aetna has agreed to the existing plan design and coverage and can provide retirees with the same network access to the providers who accept Medicare that they use today. Therefore, retirees should not have to change doctors and will not experience any increase in out of pocket costs. Retirees are still subject to the Medicare Part B deductible established by CMS on an annual basis just as they are today. The only notable change retirees should expect is to change the Medicare Advantage member ID cards in their wallets.

Medicare Advantage Strategic Procurement Methodology

In December 2017, DAS learned that Anthem achieved the network presence and "Star-Rating" score from CMS to warrant consideration to transition to a fully-insured Medicare Advantage plan. CMS uses a Star-Rating system to measure how well Medicare Advantage plans perform in several categories, including quality of care, chronic disease management and customer service. On June 20, 2018, the Executive Council approved DAS' request (tabled item #156) to amend the existing Anthem contract for Medicare Retiree Health Benefits (RHB) converting it from a self-funded Medicare supplemental plan, commonly referred to as Medicomp to a fully-insured group Medicare Advantage Plan.

In subsequent years, through continued work with Segal, the health care consultant to the Employee and Retiree Health Benefit Plan, DAS learned that the NH Medicare Advantage marketplace had become more competitive. In addition to Anthem, three other major carriers, Aetna, United Healthcare, and Humana, also met CMS' passive Preferred Provider Organization (PPO) requirements and achieved high star ratings. A carrier can achieve designation as a passive PPO in the group insurance marketplace if 51% of a group's membership lives in the Medicare Advantage plan's network service area. The significance of being a passive PPO is that members can seek

care from any provider, in-network or out-of-network, as long as the provider accepts Medicare.

In consideration of the competitive marketplace, DAS decided to go out to bid for the Medicare Advantage plan separate from the medical plan for active employees and non-Medicare retirees. On May 20, 2020, the Executive Council approved DAS' request (Item #76) to extend the State's contract with Anthem to administer only the self-funded medical plan covering approximately 27,000 active employees and non-Medicare eligible retirees and their families.

Medicare Advantage Plan Procurement Results

As referenced in the attached Executive Summary of Overall Results, all four major carriers provided responses to the State's Request for Proposal (RFP). The financial score encompassed fifty percent (50%) of the total proposal score. In accordance with the RFP, the financial proposals were scored on the projected costs as determined by the State for the three-year period from January 1, 2021 to December 31, 2023. The lowest cost proposal received 100% of the 50 points allocated for the Financial Section of the RFP. All other financial proposals were scored on a sliding scale, with proposals losing 2 points for every percentage point higher than the lowest cost proposal. Proposals with costs twenty-five percent (25%) higher than the lowest cost proposal receive a Financial Score of zero (0). Because Aetna's projected costs were $0, all other financial proposals received zero (0) points for the Financial Section. The second lowest cost bidder was $13.45m higher than Aetna over the three-year term (see attached Proposal Analysis – Financial, Total Projected Costs).

The remaining fifty percent (50%) of the allocated points were distributed amongst the non-financial scoring criteria. Bidder responses were evaluated based on the extent to which the bidder documents conformance with specifications, as well as the completeness, soundness, and creativity of the response. In accordance with the State's procurement rules, non-financial section scoring was based on the quality of each bidder's response and not based on any outside knowledge of the programs and/or services offered by each bidder. All four proposals were competitive, making the financial section of the RFP the determining factor.

Savings Achieved by Maximizing Federal Subsidy Dollars

Aetna is able to offer the same level of benefits and coverage that our retirees are accustomed to today at zero ($0) premium cost to the State because they are able to leverage their nationwide enrollment and CMS quality ratings to maximize their federal subsidies. Like the group Medicare Advantage plan administered by Anthem since 2019, the Aetna group Medicare Advantage plan will continue to enhance the focus on our Medicare eligible retirees' health and well-being. Aetna will work with retirees to coordinate care among their various health care providers to ensure the member receives appropriate care. CMS financially incentivizes care coordination and

care management by carriers to optimize patient outcomes. Other than the increased attention to the care retirees are already receiving, members should experience minimal disruption while continuing with the same level of medical coverage with the flexibility to see the same Medicare participating providers they see today.

Maximizing federal subsidy dollars has been a successful cost containment strategy for DAS. In 2015, DAS, working with its Pharmacy Benefits Manager Express Scripts, transitioned the Medicare-eligible Retiree Health Benefit Plan's prescription drug benefit from a Retiree Drug Subsidy (RDS) plan to a self-funded Employer Group Waiver Program (EGWP) with a wrap for Medicare Part D resulting in increased federal subsidy dollars while maintaining a consistent level of prescription drug coverage. Similarly, in 2019, DAS transitioned our Medicare retirees from a Medicare supplemental plan to a Group Medicare Advantage Plan maximizing federal funds to support our Medicare retirees' medical care needs and saving the state a total of $11.8 million over calendar years 2019 and 2020.

Explanation of Medicare Advantage (Medicare Part C)

Medicare Advantage plans (Medicare Part C) were created as part of the Medicare Modernization Act enacted in 2003 and replace coverage offered through Medicare Parts A and B. Under a Medicare Advantage plan, Insurance companies receive a per-person payment from the Centers for Medicare and Medicaid Services (CMS) to subsidize the cost of coverage. This capitated payment varies by county, the health of the members covered by the insurance company within that county, and the overall quality of care provided by the insurance company. While being at risk for all claims costs, CMS' Medicare Advantage funding formulas incentivize the insurance company to manage that risk and maximize CMS funding through risk adjustment strategies including minimizing claims costs through medical management strategies. The insurance company is also incentivized to maintain a high level of member satisfaction as measured through CMS survey of Medicare Advantage plan members. The insurance company's success with all of these factors helps contain premium costs.

Medicare Retiree Health Benefits and Funding Challenges

Under State law, DAS must manage the RHB Plan within the limits of the funds appropriated at each biennial session. As the retiree population continues to grow and healthcare costs continue to rise, the State has faced and will continue to face significant financial challenges to maintain current benefit coverage for retirees. In fact, in 2015 the Joint Legislative Fiscal Committee worked extensively to close a $10.6 million funding gap between budget appropriations and projected RHB expenses for the FY 16/17 biennium. In addition, the FY 18/19 budget included an additional $25.4 million in funding to meet projected RHB expenses. While most of this budget increase was funded by the State, non-Medicare retirees experienced an increase in the percentage of premium contribution they pay from 17.5% to 20% and Medicare retirees born on or after January 1, 1949 began paying a first-ever 10% premium contribution.

At the request of the Fiscal Committee, in February 2017, DAS submitted a draft report prepared by Segal titled the Retiree Health Benefits Long-Term Study. The Study provided an overview of potential Retiree Health Benefit Plan long-term options; one of the options was a group Medicare Advantage plan. The Study is available on the DAS Risk Management Unit webpage under the Resources section.

Unfortunately, in 2017 when the State first reviewed the feasibility of group Medicare Advantage plans, there were no plans in the state that met the passive PPO requirements that also had a high enough star-rating with CMS to provide savings to the State's Health Benefit Plan. This changed within a little more than one year and effective January 1, 2019, the state transitioned its Medicare retirees to the group Medicare Advantage plan through Anthem.

Proposed Aetna Contract and Savings to the Retiree Health Benefits Plan

The approval of this contract will continue to support DAS' work to contain healthcare costs. Cost containment is particularly important to the Retiree Health Benefits Plan given its challenging fiscal history. Compared to the current $109.11 monthly premium that we pay to the incumbent, Anthem, the approval of this contract will save the state a total of $45.2 million, or $20.8 million General Funds, over three years. Containing health care costs is important not just to the state but to our retirees who pay a percentage of the monthly premium cost as well as copays and other out of pocket costs. In short, when the state saves money, our retirees save money.

DAS in confident that Aetna's group Medicare Advantage plan will provide State of New Hampshire retirees and spouses the same level of coverage and service they have become accustomed to over the years. In addition to the quality and performance measures that CMS requires and monitors, DAS negotiated contractual performance guarantees and quality indicators to manage vendor performance. DAS looks forward to developing a new partnership with Aetna over the next three years. Based on the foregoing, I am respectfully recommending approval of the agreement with Aetna Life Insurance Company.

Respectfully submitted,

Charles M. Arlinghaus
Commissioner

Executive Summary – Overall Results

Category	Allocated Points	Aetna		Anthem		Humana		UHC	
		Percent	Points	Percent	Points	Percent	Points	Percent	Points
Financial - Projected Costs	50	100%	50.0	0%	0.0	0%	0.0	0%	0.0
Network Match & Access	15	94%	14.0	95%	14.2	91%	13.7	97%	14.5
Performance Guarantees	5	88%	4.4	93%	4.7	100%	5.0	97%	4.9
Experience & Stability Data Reporting Revenue Maximization & Medical Management	10	79%	7.9	86%	8.6	95%	9.5	96%	9.6
Administrative, Member & Claim Paying Services	10	89%	8.9	93%	9.3	93%	9.3	92%	9.2
Enrollment, Implementation, & Communication	10	89%	8.9	99%	9.9	97%	9.7	100%	10.0
Total Score*	100	**94.0**		**46.7**		**47.2**		**48.1**	
Total Rank		[1]		[4]		[3]		[2]	

* The sum of category scores may not tie back to total score due to rounding.

Proposal Analysis – Financial
Total Projected Cost

	Current CY 2020 Adjusted Premium*	Proposals			
		Aetna	Anthem	Humana	UHC
Year 1 - Calendar Year 2021					
Fully Insured Premium	**$10,299,000**	**$0**	**$8,494,000**	**$3,518,000**	**$4,979,000**
Change from Current Contract - $		**($10,299,000)**	**($1,805,000)**	**($6,781,000)**	**($5,320,000)**
Change from Current Contract - %		-100.0%	-17.5%	-65.8%	-51.7%
Year 2 - Calendar Year 2022					
Fully Insured Premium		**$0**	**$8,494,000**	**$4,476,000**	**$4,979,000**
Year 3 - Calendar Year 2023					
Fully Insured Premium		**$0**	**$8,494,000**	**$5,454,000**	**$4,979,000**
Total Projected 3-Year Costs		**$0**	**$25,482,000**	**$13,448,000**	**$14,937,000**
Difference from Lowest Cost Proposal - $		$0	$25,482,000	$13,448,000	$14,937,000
Difference from Lowest Cost Proposal - %		0%	> 25%	> 25%	> 25%
Financial Score,**		**50.0**	**0.0**	**0.0**	**0.0**
Financial Rank		**1**	**4**	**2**	**3**

*** This information is being provided for comparative purposes only. This reflects the estimated costs for Year 1 under the current rates adjusted for the discontinuation of the ACA Health Insurer Fee for CY 2021.**

**** The most competitive proposal's Financial Score equals 50 points. All other financial proposals will be scored on a sliding scale where the vendor's score will be reduced by 2 point for every percentage point it is higher than the lowest cost proposal. Proposals with costs 25% higher than the lowest cost proposal receive a Financial Score of zero (0).**

Notes:

1. Projections assume February 2020 enrollment of 10,075 Medicare participants.
2. UHC's proposed Year 3 (CY 2023) premium rate is contingent on the CY 2021 actual Benefit Cost Ratio (BCR) being less than 100%. If the BCR for CY 2021 is greater than 100%, the rate would increase from $41.18 to $56.18 for CY 2023. This calculation assumes a CY 2023 rate of $41.18.

Subject: Fully Insured Group Medicare Advantage Agreement

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

General Provisions

1. **IDENTIFICATION.**

1.1 State Agency Name Department of Administrative Services		1.2 State Agency Address State House Annex Building, Room 412 25 Capitol Street Concord, NH 03301	
1.3 Contractor Name Aetna Life Insurance Company		1.4 Contractor Address 151 Farmington Avenue Hartford, CT 06156	
1.5 Contractor Phone Number (800)872-3862	1.6 Account Number 01-14-14-140560-66000000 01-14-14-140560-66600000 01-14-14-140560-66500000	1.7 Completion Date December 31, 2023	1.8 Price Limitation $378,338
1.9 Contracting Officer for State Agency Joyce I. Pitman, Director Risk and Benefits		1.10 State Agency Telephone Number (603) 271-3080	
1.11 Contractor Signature Richard A. Frommeyer Date: 7/6/20		1.12 Name and Title of Contractor Signatory RICHARD A. FROMMEYER SENIOR VICE PRESIDENT - GROUP RETIREE	
1.13 State Agency Signature Date: 7/19/20		1.14 Name and Title of State Agency Signatory Charles Arlinghaus Commissioner	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By: Director, On:			
16.1 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: /s/ Christen Lavers On: 7/22/20			
17. Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

Contractor Initials: RAF
Date: 7/6/20

FULLY INSURED MEDICARE ADVANTAGE GROUP AGREEMENT
BETWEEN THE STATE OF NEW HAMPSHIRE AND
AETNA LIFE INSURANCE COMPANY

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Date: 7/6/20

2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations

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and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters,

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memoranda, papers, and documents, all whether finished or unfinished.
10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.
10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.
12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.
12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omission of the Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.
14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:
14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and
14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.
14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.
14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.
15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.
15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the

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Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

Contractor Initials: [initials]
Date: 7/6/20

Exhibit A: Special Provisions

The State and Contractor agree to the following modifications, deletions and additions to the general provisions (Form P-37) in this Agreement between the State and Contractor for the group Medicare Advantage PPO plan:

1. Section 4 is hereby deleted in its entirety and replaced with the following:

> **4. CONDITIONAL NATURE OF AGREEMENT.** Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provide in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. Such notice shall be provided to Contractor as soon as practicable after DAS becomes aware of such reduction or termination of appropriated funds. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

2. Section 6.3 is hereby deleted in its entirety and replaced with the following:

> 6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts relating to the Services provided under this Agreement for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

3. Section 7.2 is hereby deleted in its entirety and replaced with the following:

> 7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement. Subcontractors, persons, firms or corporations engaged in a combined effort to perform the Services herein include those on the Tier 1 Subcontractor List incorporated herein as Appendix E. In order to effect the terms of this Section the State will provide Contractor with a list of State employees or officials "materially involved in the procurement" and Contractor will provide such list to subcontractors described herein and to those new subcontractors who become engaged in a combined effort to perform the Services described herein.

4. Section 8.2.1 is hereby deleted in its entirety and replaced with the following:

> 8.2.1. give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective thirty (30) days after giving the Contractor notice of termination;

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5. Section 9.1 is hereby deleted in its entirety and replaced with the following:

9.1. Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by sixty (60) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

6. Sections 10.2 and 10.3 are hereby deleted in their entirety and replaced with the following:

10.2 Data is owned by the State to the extent that data is customized for the State and: (i) was created based on the State's written specifications, (ii) paid for separately by the State, and (iii) pursuant to a written statement of work signed by both parties (hereinafter referred to as "Customized Data"). All other data shall be owned by Contractor and retained and maintained consistent with all applicable laws, rules and regulations, including Centers for Medicare and Medicaid Services requirements.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State except as authorized by this Agreement.

7. Section 12.2 is hereby deleted in its entirety and replaced with the following:

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice to and consent of the State. By execution of this Agreement the State has received written notice and given consent to the list of current Tier 1 subcontractors attached to this Exhibit A and made a part hereof. Tier 1 subcontractors are defined as a subset of Contractor suppliers for whom a portion of the Services provided may include direct contact with the State's retirees who are enrolled in the Medicare Advantage plan offered by Contractor under this Agreement ("Members") and/or significant access to Member-identifiable data. Should the State have any issues with any of Tier 1 subcontractors, Contractors agrees to work in good faith to promptly resolve those concerns. In the event the Parties are unable to resolve such concerns, the State shall have the right to terminate this Agreement as provided herein. Contractor shall give similar written notice and seek the consent of the State with regard to new Tier 1 subcontractors engaged during the course of this Agreement. Such consent shall not be unreasonably withheld. Additionally, the State is entitled to copies of all subcontracts and assignment agreements, to the extent that Contractor is permitted to do so under such agreements, and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

8. Section 13 is amended to add the following sentence at the end:

Notwithstanding the foregoing, network providers/health care professionals are not Contractor's agents; therefore, Contractor will not indemnify the State for any acts,or omissions of network providers/health care professionals.

9. Section 14.3 is hereby deleted in its entirety and replaced with the following:

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance requiredunder this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than five (5) days prior the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

10. Section 18 is hereby deleted in its entirety and replaced with the following:

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18. **CHOICE OF LAW AND FORUM.** This Agreement shall be governed, interpreted and construed in accordance with federal laws and the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

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Contractor Initials: [initials]
Date: 7/6/20

Exhibit B: Services to be Performed

This Group Agreement is by and between Contractor and the State and provides a description of the scope of services and work to be completed and the conditions of these services to be provided by Contractor to the State under the State Agreement. This Group Agreement takes effect on January 1, 2021 (the "Effective Date") and remains in force until terminated.

This Agreement consists of General Provisions Form P-37, Exhibits A, B and C and the following documents that are attached and/or incorporated by reference:

- Aetna's response to the Request for Proposal (RFP) is incorporated here by reference as noted in Exhibit D.
- The State's Group Application (the "Group Application"), attached hereto and made a part hereof as Appendix A.
- Plan Sponsor Letter Agreement (PSLA) (to be finalized during implementation) Appendix B
- Summary of Benefits (to be finalized during implementation) Appendix C
- The Evidence of Coverage (EOC) is incorporated here by reference.
- Universal Medical File Format Appendix D
- Tier 1 Subcontractor List Appendix E
- Any riders, amendments, inserts or attachments issued pursuant to any of the foregoing documents.

Contractor and State agree as follows:

Section 1. Covered Benefits

This Agreement identifies the fully-insured Medicare Plan(s) (the "Plan(s)") offered to the State under this Group Agreement for the corresponding time periods and the service area(s) (the "Service Area(s)") where the Plans are offered. Contractor shall provide coverage to Members for all of the health care services and supplies that are covered by the Plan(s) (the "Covered Benefits").

Section 2. Term

2.1. **Initial Term.** The initial term of this Group Agreement (the "Initial Term") will be 12 months beginning at 12:00 a.m. on January 1, 2021.

2.2. **Subsequent Terms.** Each Subsequent Term shall commence at 12:00 a.m. on January 1st and end at 11:59 p.m. on December 31st of the applicable calendar year, pursuant to the General Provisions Form P-37 and Section 5 of this Agreement.

Section 3. Premiums

3.1 **Premiums.** Contractor will charge the State a monthly premium ("Premium") as agreed upon in Exhibit C. Membership as of each Premium Due Date as defined in Exhibit C will be determined by Contractor in accordance with Contractor's Member records.

3.2 **Membership Adjustments.** Contractor may make retroactive additions of Members at its discretion based upon Contractor's eligibility and enrollment guidelines consistent with all Mandates. Such additions are subject to the payment of all applicable Premiums.
Contractor may also make retroactive adjustments to the State's billings for the termination of Members, but only for a maximum of 1 billing period.

Contractor Initials: RAF
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Section 4. Enrollment/Disenrollment

4.1 **Enrollment.** The State shall offer enrollment in the Plan(s) in compliance with all applicable Mandates as follows:

- The State shall enable all eligible individuals to enroll in the Plan(s) within 31 days of becoming eligible to receive coverage under the Plan(s).
- If an eligible member does not elect to enroll upon initial eligibility, they retain the right to participate at any time during the year upon completion of enrollment process.

All eligible individuals and dependents not enrolled in the Plan(s) within 31 days of becoming eligible may be enrolled at any time during the year upon completion of appropriate enrollment forms and proof of Medicare Part A and B enrollment. Coverage under the Plan(s) will not become effective until confirmed by Contractor.

4.2 **Eligibility.** Contractor will abide by specified eligibility rules established by the State.

4.3 **Enrollment/Disenrollment Processing.** The Parties shall agree in advance who shall bear responsibility for enrollment and disenrollment transactions. The Party bearing responsibility for enrollment/disenrollment transactions shall perform the function in accordance with all applicable Mandates, including Mandates relating to timeframes for processing and submission of such transactions. All of the enrollment and disenrollment requirements described in this Group Agreement also apply to any third party administrator retained by the State to accept enrollment/disenrollment requests on its behalf.

The State must notify Contractor of the date in which a Member's eligibility ceases for the purpose of termination of coverage under this Group Agreement.

4.4 **Eligibility Data.** Contractor agrees to work with the State and/or the State's designated data management team for EDI 834 data interface file production and/or other data transfer matters. Any changes to the standard file format will be as specified by the State.

Contractor agrees to accept and process an Interface file from the State twice per week, on dates agreed upon by the State and Contractor, to ensure timely subscriber eligibility and enrollments. Upon acceptance of the file by the Contractor, the Contractor agrees to process each file within 24 hours of receipt of file.

The State's standard is to exchange data with its contractors using the State of New Hampshire's Secure File Exchange Server. This Secure File Exchange Server is password protected and accessible by designated, State-approved Contractor staff via Internet access. All data files on this server are encrypted while at rest. The data stays protected until downloaded by the receiver. Unless otherwise mutually agreed upon, contractors are required to retrieve eligibility and enrollment data, from this server. In addition, contractors and/or subcontractors will be required to use this method for sending/receiving any other agreed upon data files to the State.

Section 5. Termination

5.1 **Termination by Contractor.**

This Group Agreement may be terminated by Contractor as follows:

- Effective upon any anniversary of the Effective Date if CMS terminates or otherwise non-renews the Contractor's CMS Contract. In the event of such CMS termination on non-renewal Contractor shall inform State as soon as possible in advance of, or as soon as possible upon

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termination or non-renewal, whichever is earlier.

- Immediately upon notice to the State if the State no longer has any Member under the Plan(s) who resides in the Service Area;
- Upon 30 days' written notice to the State if the State (i) fails to meet Contractor's contribution or participation requirements applicable to this Group Agreement as set forth in Exhibit C; (ii) provides 30 days' written notice to Members stating that coverage under this Group Agreement will no longer be provided to Members; or (iv) ceases to meet any Mandates applicable to offering the Plan(s), including the Service Area Extension Mandates described in the CMS/Regulatory Compliance Addendum, if applicable; Upon 60 days' written notice to the State (or such shorter notice as may be permitted by Mandates, but in no event less than 30 days) if Contractor ceases to offer a product or coverage in any market in which Members covered under this Group Agreement reside.

5.2 **Effect of Termination.** Subject to General Provisions Form P-37, no termination of this Group Agreement will relieve Contractor or the State from any obligation incurred under this Group Agreement before the date of termination. When terminated, this Group Agreement and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. In the event of termination for any reason, Members must continue to pay all Member Premiums due and unpaid before the effective date of the termination and the State must continue to pay all State Premiums due and unpaid before the termination, including Member Premiums and State Premiums due during the applicable Member or State Grace Period. Members also remain responsible for Member cost sharing and other required contributions during the Member Grace Period.

Should a subsequent contract for Group Medicare Advantage be awarded to a contractor other than the Contractor, the Contractor shall, to the greatest extent possible and reasonable, cooperate with the State in executing those actions necessary to facilitate a smooth and orderly transition to the next service provider. If deemed necessary by the State, upon approval from the Governor and Executive Council, the parties may execute any contract extension necessary to ensure there is no lapse or decline of service at the start of the subsequent contract.

5.3 Upon termination of this Agreement for any reason, Contractor confirms they will provide historical data to State (or to a third party, as directed by State) at no additional charge. This will include up to five files of historical data (to include without limitation MOR and MMR reports and transition of care records) for the three immediately preceding contract years. Transition of data will begin immediately following notification of termination and must be complete within ninety days of notification. Contractor shall provide all data on a rolling basis at least once every thirty days thereafter until all data has been provided to State (or third party, as directed).

Section 6. Privacy and Security of Information

6.1. **Compliance with Privacy and Security Laws.** Contractor and the State shall each abide by all Mandates regarding the confidentiality and the safeguarding of individually identifiable health and other personal information, including the privacy and security requirements of HIPAA.

6.2. **Disclosure of Protected Health Information.** The State has determined that it needs protected health plan information ("PHI"), as defined in HIPAA, in connection with administration of the Plan. To ensure compliance with 45 C.F.R. § 164.504(f) and other applicable Mandates, the Parties executed the Plan Sponsor Letter Agreement (PSLA) attached hereto as Appendix B

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Section 7. Independent Contractor Relationships

7.1. **Relationship Between Contractor and Network Providers.** The relationship between Contractor and providers contracted with Contractor to participate in the Plan(s)' provider network ("Network Providers") is a contractual relationship among independent contractors. Network Providers are not agents or employees of Contractor nor is Contractor an agent or employee of any Network Provider.

Network Providers are solely responsible for any health services rendered to their patients. Contractor makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any Network Provider. A Network Provider's participation in the provider network for the Plan(s) may be terminated at any time without advance notice to the State or Members, subject to Mandates. Network Providers provide health care diagnosis, treatment and services for Members. Contractor administers and determines Plan benefits.

Section 8. Definitions

8.1. "CMS" means the Centers for Medicare and Medicaid Services.

8.2. "CMS Contract" means the contract between Contractor and CMS under which Contractor offers the Plan(s) in the applicable time period.

8.3. "EOC" means the Evidence of Coverage, which is a document issued pursuant to this Group Agreement that outlines coverage for Members under the Plan(s). The EOC includes the Schedule of Copayments/Coinsurance and any riders or amendments.

8.4. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

8.5. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder.

8.6. "Mandates" means applicable laws, regulations and government requirements in effect during the Term of this Group Agreement including, without limitation, applicable Medicare laws, regulations and CMS requirements (including CMS manuals, memo guidance and other directives).

8.7. "Member" is a Medicare beneficiary who: (1) has enrolled in the Plan(s) and whose enrollment in the Plan(s) has been confirmed by CMS, and (2) is eligible to receive coverage under the State's Retiree Health Benefit Plan(s), subject to the terms and conditions of this Agreement and the EOC.

8.8. "Party, Parties" means Contractor and the State.

8.9. "Retiree" is someone determined by the State to be eligible to participate in the State's Retiree Health Benefit Program.

8.10. "Term" means the Initial Term or any Subsequent Term.

Section 9. Miscellaneous

9.1. **Disease Management and Care Management Programs.** From time to time, Contractor may offer programs that are designed to improve quality of care, ensure access to Covered Benefits or coordinate care delivered to Members under the Plan(s) ("Disease and Care Management Programs"). Contractor will administer Disease and Care Management Programs consistent with

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any applicable Mandates. The State acknowledges that Contractor may alter or discontinue the Disease and Care Management Program offered to Members at any time, consistent with all Mandates. Contractor will provide the State timely notice of any addition or deletions to the Disease and Care Management Program.

9.2. **Claim Determinations and Administration of Covered Benefits.** Contractor is a fiduciary for the purpose of Section 503 of Title 1 of ERISA. Contractor has complete authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this Group Agreement. Contractor shall be deemed to have properly exercised such authority unless it abuses its discretion by acting arbitrarily and capriciously. Contractor's review of claims may include the use of commercial software and other tools to take into account factors such as an individual's claims history, a provider's billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.

9.3. **Incontestability.** Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the State or any Member shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.

9.4. **Waiver.** A Party's failure to implement, or insist upon compliance with, any provision of this Group Agreement or the terms of the EOC incorporated hereunder, at any given time or times, shall not constitute a waiver of Party's right to implement or insist upon compliance with that provision at any other time or times.

9.5. **Non-Discrimination.** The State shall not encourage or discourage enrollment in the Plan(s) based on health status or health risk and shall follow all applicable Mandates on non-discrimination.

9.6. **Compliance with Mandates.** The State and Contractor shall comply with all Mandates applicable to the performance of their obligations under this Group Agreement. The Parties shall comply with the applicable provisions of the CMS/Regulatory Addendum, which is designed to ensure State's and Contractor's compliance with specific Mandates.

9.7. **Force Majeure.** Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation, acts of God, epidemic acts of any public enemy, acts of terrorists, acts of war, riot, civil insurrection, floods, statutory or other laws, regulations, rules, or orders of the federal, state, or local government or any agency thereof.

9.8. **Use of the Contractor Name and all Symbols, Trademarks, and Service Marks.** Contractor controls the use of its name and all symbols, trademarks, and service marks presently existing or subsequently established. The State shall not use any of them in advertising or promotional materials without Contractor's prior written consent. The State shall stop any and all use immediately upon Contractor's request or upon termination of this Group Agreement.

9.9. **Clerical Errors.** Clerical errors or delays by either Party in keeping or reporting data relative to coverage will not reduce or invalidate a Member's coverage. Upon discovery of an error or delay, an adjustment of Premiums shall be made. Contractor may also modify or replace an EOC or other

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document issued to a Member in error.

9.10. **Plan Audit.** Contractor agrees to be audited by the State or entity chosen by the State, and reserves the right to review and audit the Contractor's Medicare Advantage operations performance as it pertains to the State. The State reserves the right to audit for the term of the contract and up to three years after the termination of the Agreement.

9.11. **Confidential Information**. The term "Confidential Information" includes information subject to state or federal privacy laws (including but not limited to HIPAA), and information exempt from disclosure under RSA 91-A.

- **Confidentiality Obligations.** Subject to RSA 91-A, Contractor and State shall not disclose or make use of any Confidential Information except as permitted under this Group Agreement without the prior written consent of the non-disclosing party, which consent may be conditioned upon the execution of a confidentiality agreement. Each Party may disclose Confidential Information of the other Party only to its employees, agents, consultants, or authorized representatives who have a need to know the Confidential Information in order to accomplish the purpose of this Group Agreement and who (A) have been informed of the confidential and proprietary nature of the Confidential Information, and (B) with respect to agents, consultants or authorized representatives, have agreed in writing not to disclose it to others and to treat it in accordance with the requirements of this Section subject to 91-A.
- **Permitted Disclosure of Confidential Information**. Except to the extent that continued use or disclosure is impermissible under state or federal law, the foregoing shall not apply to such Confidential Information to the extent: (A) the information is or becomes generally available or known to the public through no fault of the receiving party; (B) the information was already known by or available to the receiving party prior to the disclosure by the other party on a non-confidential basis; (C) the information is subsequently disclosed to the receiving party by a third party who is not under any obligation of confidentiality to the disclosing party; (D) the information has already been or is hereafter independently acquired or developed by the receiving party without violating any confidentiality agreement or other similar obligation; or (E) the information is required to be disclosed pursuant to a non-appealable court order or (F) the Information is required under any federal, state, or local law, statute, rule or regulation, subpoena or legal process. If either Party, or any of its respective employees, agents, consultants, or authorized representatives, is requested to disclose the Confidential Information of the other Party such Party shall give prompt prior written notice to the other Party to allow the other Party to seek an appropriate protective order or modification of any requested disclosure. If the receiving party is ultimately legally compelled to disclose such Confidential Information, the receiving party shall disclose the minimum required pursuant to the court order or other legal compulsion.

Section 10. CMS/Regulatory Requirements

The following provisions describe critical regulatory requirements that apply to all plan sponsors offering Contractor group Medicare plans, and they are included in this Group Agreement to ensure Contractor and State's compliance with Mandates.

1.0 CMS Uniform Premium Requirements

1.1 **Medicare Advantage – Premium Requirements**. This Section 1.1 applies only if Contractor is offering a Medicare Advantage PPO Plan to Members, and the State and Members are paying any portion of the Premium for the Medicare Advantage benefit ("MA Premium").

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State will comply with the following conditions with respect to any subsidization of MA Premium and any required MA Premium contribution by the Member:

- State may subsidize different amounts of MA Premium for different classes of Members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly).
- MA Premium contribution levels cannot vary for Members within a given class.
- Direct subsidy payments from CMS to Contractor must be passed through to reduce the amount of any required MA Premium payment by the Member.

2.0 Records

2.1 **Maintenance of Information & Records**. State agrees to maintain Information and Records (as those terms are defined in Section 2.2 below) in a current, detailed, organized and comprehensive manner and in accordance with Mandates, and to maintain such Information and Records for the longer of: (i) a period of ten (10) years from the end of the final contract period for the Plan(s), (ii) the date the U.S. Department of Health and Human Services, the Comptroller General or their designees complete an audit, or (iii) the period required by Mandates.

2.2 **Access to Information and Records**. State will provide Contractor and federal, state and local governmental authorities having jurisdiction, directly or through their designated agents (collectively "Government Officials"), upon request, access to all books, records and other papers, documents, materials and other information (including, but not limited to, contracts and financial records), whether in paper or electronic format, relating to the arrangement described in this Group Agreement ("Information and Records"). State agrees to provide Contractor and Government Officials with access to Information and Records for as long as it is maintained as provided in Section 2.1 above. Access to Information and Records will be provided within 14 calendar days of receipt of an applicable request, where practicable, and in no event later than the date required by an applicable law or regulatory authority.

2.3 **Survival**. The preceding provisions of this Section 2.0 shall survive termination of this Group Agreement regardless of the cause of termination.

3.0 Medicare Secondary Payer Requirements

3.1 Contractor and State agree to comply with all Medicare Secondary Payer ("MSP") Mandates that apply to State, the Plan and Contractor ("MSP Requirements").

3.2 **MSP Requirements Applicable to Medicare Beneficiaries Diagnosed with End Stage Renal Disease ("ESRD")**. Contractor and State agree to comply with all MSP Requirements applicable to State's active employees and retirees and their dependents who are Medicare beneficiaries diagnosed with ESRD ("ESRD Beneficiaries" or "ESRD Beneficiary"), including, without limitation, those MSP Requirements set forth in 42 U.S.C. § 1395y (b)(1)(C), 42 C.F.R. §§ 411.102(a), 411.161, and 411.162 and 42 C.F.R. §§ 422.106 and 422.108 ("ESRD MSP Requirements").

3.3 State acknowledges and agrees that if an ESRD Beneficiary is eligible for or entitled to Medicare based on ESRD, the MSP Requirements require the commercial group health plan offered by State ("GHP") to be the primary payer for the first 30 months of the ESRD Beneficiary's Medicare eligibility or entitlement ("30-month coordination period"), regardless of the number of employees employed by State and regardless of whether the ESRD Beneficiary is a current employee or retiree.

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To ensure Contractor's and State's compliance with ESRD MSP Requirements, State agrees to confirm to Contractor whether ESRD Beneficiaries are in their 30-month coordination period, and not seek to enroll ESRD Beneficiaries in the Plan(s) during their 30-month coordination period unless coverage under the GHP is maintained for such ESRD Beneficiaries for that period. If State seeks to enroll an ESRD Beneficiary in a Plan, State agrees to provide Contractor, upon request, with information or documentation to verify compliance with ESRD MSP Requirements, including any MSP reporting or other requirements established by CMS.

4.0 Office of Foreign Asset Control

If coverage provided by the Group Agreement violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Contractor cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

5.0 CMS Enrollment & Disenrollment Requirements

5.1 To the extent that State directly accepts enrollment and/or disenrollment requests from potential Members or Members that State forwards to Contractor for processing and submission to CMS, State will comply with all Mandates that relate to the handling and processing of enrollment and disenrollment requests that apply to the Plan(s). A Member's signature on an enrollment/disenrollment form must be dated prior to the requested enrollment/disenrollment effective date.

If requesting retroactive enrollment or disenrollment, State will forward enrollment and disenrollment forms completed by potential Members or Members to Contractor no later than 90 days after the Member's enrollment or termination effective date. If there is a delay between the time a Member submits an enrollment/disenrollment request to State and when the enrollment/disenrollment request is received by Contractor, the enrollment/disenrollment transaction may not be processed by CMS, unless Contractor requests and CMS approves a retroactive enrollment/disenrollment transaction for the

Member. Contractor will determine whether to submit retroactive enrollment and disenrollment transaction requests to CMS, and will make such determinations in accordance with Mandates. Contractor confirms the State would be allowed to reinstate (retro-reinstatement) the member once payment is received.

All Members must be notified that they will be enrolled in a Plan. CMS requires that this notice be provided by Contractor or State not less than 21 calendar days prior to the effective date of the Member's enrollment in the Plan to allow Members the opportunity to evaluate other available health plan options.

5.2 All eligible individuals may enroll in the Plan(s) within 31 days of becoming eligible to receive coverage under the Plan(s). Otherwise, the effective date of enrollments and disenrollments in the Plan(s) cannot be earlier than the date the enrollment or disenrollment request was completed by a Member. If approved by CMS, the effective date of an enrollment or disenrollment may be retroactive up to, but may not exceed, 90 days from the date that Contractor received the enrollment or disenrollment request from the State, and the enrollment or disenrollment form must be completed and signed by the Member prior to the requested enrollment or disenrollment effective date.

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5.3 CMS does not permit retroactive termination of a Member's coverage under the Plan(s) if the Member no longer meets State's eligibility criteria to remain enrolled in the Plan(s). To meet this CMS requirement, State will provide Contractor with advanced written notice if State chooses to terminate a Member's coverage under the Plan based on loss of eligibility, and State acknowledges that the Member's prospective coverage termination effective date will be determined in accordance with Mandates.

5.4 If State elects to change Plan coverage offered to Members or to terminate a Member's coverage under the Plan(s), State must provide written notice to such Member(s) at least 21 calendar days prior to the effective date of the change in the Member's coverage or disenrollment from the Plan(s), as applicable. This written notice must include a description of how the Member can contact Medicare to obtain information regarding other Medicare Advantage or Medicare Part D plan options that may be available to the Member. Contractor will assist State with developing appropriate notices.

5.5 Contractor reserves the right to notify Members of the involuntary termination of their coverage under this Group Agreement for any reason.

5.6 If eligible individuals are to be enrolled and/or disenrolled in the Plan(s) electronically, the electronic forms used for this process must be approved by CMS for use by the Plan(s) and conform to all Mandates applicable to format, data fields and other required information. Contractor will work with State to develop appropriate electronic forms.

5.7 Electronic enrollments and disenrollments will be deemed effective on the first day of the month requested, subject to compliance with any applicable Mandates.

5.8 State will produce, at Contractor's request, the original copy of any enrollment or disenrollment form or record received by State.

5.9 State shall limit enrollment in the Plans to retirees who are Medicare eligible individuals and are receiving Retiree Coverage under a Group Health Plan sponsored by State. Retiree Coverage means coverage of health care costs under a Group Health Plan based on an individual's status as a retired participant in the plan, or as the spouse or dependent of a retired participant. A Group Health Plan means a plan defined in Section 607(1) of ERISA or any other plan described in 42 C.F.R. § 422.106(d).

6.0 Notices to Members

6.1 **Notice re Changes**. State will provide Members with written notice describing any changes made to premiums, benefits or other terms of the Plan(s) as required under Mandates. If State does not distribute notices as required under this Section 6.0 Contractor may, at its discretion, distribute such notices to Members upon approval from the State.

6.2 **Notice re Termination of Coverage**. State will notify Members of the termination of the Plan(s) in compliance with Mandates. However, Contractor reserves the right to notify Members of termination or suspension of the Plan(s) for any reason upon approval from the State. State will provide written notice to Members of their rights upon termination of coverage as required under Mandates.

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7.0 Service Area Extension & Network Adequacy for Plan

This Section 7.0 only applies if Contractor is offering a Medicare Advantage PPO Plan to Members who reside in an Extended Service Area (as defined below).

To enable employers/unions to offer group Medicare Advantage ("MA") plans to all of their Medicare-eligible retirees/dependents wherever they reside, CMS has established a waiver of service area requirements ("Waiver") for organizations that are approved by CMS to offer MA plans ("MAOs"). Under this Waiver, MAOs offering a group MA plan in a given Service Area, can extend coverage to an employer/union sponsor's Medicare-eligible retirees/dependents residing outside of that Service Area, even if the MAO does not offer a provider network for the group MA plan ("Provider Network") that meets CMS network adequacy requirements in that Service Area ("Extended Service Area").

Contractor and State agree that Contractor will use this Waiver to offer the Medicare Advantage PPO Plan to Members who reside in an Extended Service Area ("MA PPO Plan"). The Parties acknowledge that Contractor must meet certain CMS requirements to offer the MA PPO Plan in an Extended Service Area, and these requirements include, but are not limited to, the following:

(1) at least 51% of retirees/dependents who are currently enrolled in Contractor MA HMO or PPO plans offered by State must be enrolled in a Contractor MA HMO or PPO plan that offers a Provider Network that meets CMS network adequacy requirements, and
(2) all Members who reside in an Extended Service Area must receive the same Covered Benefits at the preferred in-network cost-sharing for all Covered Benefits.

The Parties agree to comply with all Mandates that apply to use of this Waiver. Further, State acknowledges and agrees that:

(1) Members who reside in an Extended Service Area do not have access to a Provider Network that meets CMS network adequacy requirements, and
(2) health care providers and suppliers that are not contracted with Contractor to participate in the Provider Network are not required to accept the Plan and furnish Covered Benefits to Members who reside inside or outside of an Extended Service Area, except as required under Mandates. Failure to meet CMS requirements of this Waiver may result in termination of the MA PPO Plan in Extended Service Areas.

8.0 Retiree-Only Plan

State represents that actively working employees and their dependents are not permitted to enroll in the Plan(s) and that by offering the Plan(s) it intends to create and maintain a retiree plan that is separate from its active plan.

9.0 Public Records Acts

The Parties acknowledge that State is a public entity and subject to state laws governing disclosure of public records. Prior to disclosing confidential and proprietary information that is in writing and marked as confidential and proprietary by Contractor, State shall notify Contractor as soon as reasonably practicable of any requests for information made by a third party pursuant to applicable state statute or local ordinance and shall further provide Contractor sufficient time to claim applicable exemptions and/or designate those portions of this information that constitute proprietary information exempt from disclosure under applicable state statute or local ordinance. State further acknowledges that it will not release any information identified by Contractor as exempt from disclosure without first providing notice to Contractor of such intent and allowing Contractor to seek judicial relief to prevent such disclosure. If a court thereafter

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determines that State is legally required to disclose such proprietary information, State shall disclose the minimum required pursuant to the court order.

10. Federal Preemption

The Parties acknowledge and agree that § 1856 of the Social Security Act and 42 C.F.R. § 422.402 provide that all State laws (with the exception of State licensing and plan solvency laws) with respect to Medicare Advantage plans that are offered by Medicare Advantage organizations are preempted and do not apply to the Plan.

Section 11. Electronic Data Management

The State and Contractor agree to the following terms:

1. **Part D Data Feeds**. Consistent with CMS guidance, on every other week basis, the State will work with its Part D Carrier to provide Contractor with Part D pharmacy data feed for Members for medical management purposes. The Part D pharmacy feed will include the data outlined in Data Request Form ("DTR Form") and as mutually agreed upon by the Parties.

2. **Universal Medical File**. On a monthly basis, Contractor agrees to provide to the State a Universal Medical File for Members in the format attached to this Agreement Appendix D and made a part hereof as Universal Medical File Sample Record Layout ("Universal Medical File"). Contractor will prepare the Universal Medical File and provide the State with Member PHI (including sensitive diagnosis data) consistent with Mandates and the PSLA.

3. **Member-Level Data Storing & Reporting**. Following execution of the State Agreement, State and Contractor will work together in good faith to confirm what Member-level information (including Social Security Numbers) will be stored by Contractor and provided by Contractor to the State in Member-level reporting. The format and timing of Member-level reports will be mutually agreed upon by the Parties. Contractor will store Member-level information and provide Member-level reporting to the State in a manner consistent with Mandates and the PSLA and at no additional cost to the State.

With regard to SSNs, the State acknowledges that Contractor is working to help reduce identity theft and fraud by limiting the use of SSN, per CMS' recommendation. Contractor's approach to SSN remediation includes removing, replacing and protecting SSN data. Contractor's primary goal is to remove SSNs from systems and processes wherever possible and limit fields that capture SSN and replace it with another unique identifier like Member or employee ID. However, when a legal or regulatory requirement necessitates the continued use of SSN, Contractor will use risk-based layered approach like field level encryption to protect SSNs.

Section 12. Reporting

Contractor is able to customize reports at no cost to the State

Contractor shall provide claim line detail for ALL claims including, but not limited to, financial and diagnoses information.

Contractor shall provide this data in a mutually agreed upon format by the 15th day of the month following the subject month.

Contractor shall submit the Part C Medicare Membership Reports (MMR) monthly, including all fields as received from CMS. The monthly MMR shall be submitted by the end of the corresponding month.

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Contractor shall submit the Part C Model Output Reports (MOR) upon request, no more often than annually, including all fields as received from CMS. The latest MOR shall be submitted within 30 days of request.

Contractor shall provide the State a weekly Transaction Reply Report (TRR) file.

Contractor shall provide monthly, quarterly, and annual appeals reports to the State.

Contractor shall provide and present quarterly reports to the State.

Contractor shall provide sufficient information to the State regarding the previous year's renewals to audit them for accuracy and compare them to actual experience.

Section 13. Member Communications

CMS determines whether material sent to Member relating to the Plan ("Member Materials") may be modified. In some cases, CMS mandates the content of Member Materials and permits no modifications. The State reserves the right to review all CMS mandated member materials prior to distribution.

To the extent permitted by CMS and consistent with Mandates, Contractor's Account Team and professional Marketing Team will work closely with the State to draft, review and finalize Member Materials and obtain the State's approval prior to sending to Members. As of the Effective Date of this Agreement, CMS will allow the State to modify and approve the following Member Materials, whether in written or electronic form, prior to sending to Members:

- Announcement Letter
- Info Packet cover letter
- Enrollment kit brochure (client logo/cobranded)
- Meeting Invite Mailer
- State of New Hampshire-specific Retiree Health Educational PowerPoint Deck (web-based)
- ID Card (client logo/Plan sponsor name/benefit cost shares)
- Health Advocacy Wellness Mailer (client logo/cobranded)
- Evidence of Coverage (EOC)
- And any pre-enrollment documents that relate to Services and/or the Group Plan.

The EOC is issued by Contractor to Members on an annual basis. The Contractor will provide State with the EOC at least 90-days prior to the beginning of each plan year.

Upon the State's request, Contractor will share samples of post-enrollment standard Member correspondence and will work with the State to provide notice of upcoming planned Member mailings. The State acknowledges that operational notices (including, but not limited to, clinical program notifications, preventive reminders, and Explanations of Benefits) mandated by CMS cannot be altered by the State ("Operational Notices"); therefore, Contractor will not obtain the State's approval of such Operational Notices prior to mailing.

Contractor confirms that the State will be provided an opportunity to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and providers. The State has the right to refuse approval of any communications, not mandated by CMS, for any reason.

Contractor will mail, via surface mail, a member ID card to all members at least ten (10) business days before the "go-live" date based on the information confirmation from CMS. Contractor will mail ID cards to newly enrolled members within ten (10) business days of receiving confirmation from CMS. Contractor will re-issue the member ID card within five (5) business days of notice if a member reports a lost card or for any reason

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that results in a change to the information disclosed on the member ID card. Contractor will issue new member ID cards as required by the State, at its expense.

The State and Contractor will work together to develop a Member outreach process through which Contractor attempts to confirm a Member's residential street address. Upon confirming the Member's residential street address, Contractor will update the Member's records and submit the updated address to CMS and provide to the State in a mutually agreed upon format and process.

Contractor will discuss with the State and have them approve any additional Member Materials that may be sent to Members at the option of the State.

For any Member Materials that the State determines may cause Member confusion, Contractor will draft talking points for the State's member services department upon the State's request.

Contractor's member website shall be available to members 24 hours per day, 7 days per week, 365 days per year. In the event of a system downtime, advanced notice shall be provided to members with minimal interruption. The Contractor agrees to no interruptions or blackout periods to the member website, except for scheduled maintenance. Functionalities should include at a minimum:

- Provider directory and provider search (physician, hospital, pharmacy, and ancillary providers) for Providers that accept Medicare assignment)
- Directions to provider's office provided by Map Quest or other mapping/direction applications
- Ability to review claims payment status online
- Ability to review a history of claims payments (medical and pharmacy), including deductible status, and out-of-pocket maximum status
- Ability to see a summary of the State's plan design and review the EOC
- Ability to print ID cards and request replacement cards
- Ability to contact Member Services online
- Star Ratings
- Information about diseases and conditions
- Contact information for the State, its other vendors, and links to their websites
- Online access to forms
- Ability to review/select incentives (i.e., gift cards) when they are available to the member.

Section 14. Member Services

- Contractor shall operate a toll-free dedicated member services telephone line to answer questions from the State's members. Aetna should describe the line, how it will be set up, explain that's its dedicated solely to the State.
- Aetna should describe the member services center servicing SONH, where is it located, hours or operation. Process for member to follow when they call in and go through IVR and process for after-hours support.
- Detail about the pre-enrollment line. How it will be staffed? When the line open and terminate?
- Contractor will have special telephone features for the hearing impaired.
- Contractor will provide resources will be available to assist non-English speaking callers through a translation service.
- Contractor will warm or soft transfer members to other service areas or vendors including the State, if necessary.
- Contractor confirms members will be able to opt out of the Interactive Voice Response (IVR) to speak with a live MSR.
- Contractor confirms all calls will be recorded and kept for 24 months and made available for the State's review upon request.
- Contractor agrees to document 100% of the State's member service calls through call recordings and call notes. Contractor will forward call recordings, written transcripts, and call notes at the State's request within

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two business days of the request being made.

- Contractor will handle all initial internal and external appeals in accordance with CMS requirements and guidelines.
- Contractor will handle any and all grievances in accordance with CMS requirements and guidelines.

Section 15. Account Management

Contractor confirms that all Member Service Representatives (MSR), clinical staff and other applicable team members are appropriately licensed or certified in the state in which they are employed.

If statewide educational sessions are required by the State, the Contractor shall host said sessions for the State's Medicare-eligible retirees and Medicare-eligible dependents of retirees prior to the initial term of the Agreement. Contractor shall conduct these meetings in all regions of the state on mutually agreeable dates as well as prepare and mail the communications announcing the sessions, at no additional cost. If limitations beyond the control of either Party prevent in person sessions, i.e., state of emergency, Contractor shall provide alternative methods of education.

Contractor agrees to, at minimum, quarterly calls to review member service issues. Contractor agrees to allow the State to review member service quality issues to the resolution endpoint.
Contractor agrees to a minimum of one annual meeting with call center executives to discuss services regarding enrollment and member issues.

Contractor shall provide an annual scorecard to the State so that the State can assess the performance of the account team assigned to the State. The State and Contractor will determine a mutually agreed upon scorecard.

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Exhibit C: Price and Method of Payment

Section 1. Medicare Advantage Rate Guarantee

The chart below outlines the Contractor's Medicare Advantage guaranteed rates for 2021, 2022 and 2023 on a per member per month (PMPM) basis.

Plan	2021 Guaranteed Rate ($ PMPM)	2022 Guaranteed Rate ($ PMPM)	2023 Guaranteed Rate ($ PMPM)
MA (C04) ESA PPO Plan	$0.00	$0.00	$0.00

Conditions for the Guarantee (including Gain Share Agreement)

Contractor reserves the right to revise or remove the guarantee if any of the following conditions are not met (subject to Section 5 and Section 17 of the General Provisions Form P-37):

Premium Payment: State of New Hampshire makes the required premium payments in accordance with the contract provisions.

Full Replacement: Contractor group retiree benefits are a full replacement and the only group plan available for all current retirees subject to this Agreement. All current retirees will be defaulted into the Contractor Medicare Advantage plans and must opt out if they want an individual market plan.

Benefit Plan Changes: There are no material changes to the products, programs, current or proposed benefit plans.

Regulatory change: There are no legislative, regulatory or enforcement actions that cause a material change to:

- Benefits offered
- Claim payment requirements or procedures
- Taxes, fees, or assessments
- Any other changes affecting the manner or cost of providing coverage that is required because of legislative or regulatory action

Broker commissions: Rating and guarantee calculations exclude any broker commissions. Any broker commissions would need to be added to these rates.

Pricing and Underwriting Basis: Total enrollment in Medicare Advantage coverage for any given plan year must not vary by more than 25% from the assumed enrollment of 10,056 members.

Out-to-bid provision: Rate guarantees for 2022 and 2023 will be terminated if the Medicare Advantage coverage is put out to bid for the 2022 or 2023 coverage periods.

Additional Rate Terms and Conditions

Employer contribution requirements: This Agreement is based on a minimum employer contribution level of 50 percent of the group premium for the medical plan. If the average employer contribution falls below 50%, the medical plan rates are subject to revision.

Rate and benefit approval: This Agreement is subject to Centers for Medicare and Medicaid Services ("CMS") renewal and approval of the plans' current or pending Medicare Advantage contracts,

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applications and service areas for calendar year 2020. Filed benefits, including cost sharing amounts and premiums, are subject to regulatory approval(s), where applicable, and are effective January 1, 2021 through December 31, 2021 and subsequent term years.

Use of pharmacy data for medical management: The medical rates assume that the Contractor receives pharmacy data feeds every two weeks in a mutually agreed upon format from the State's designated third party. The medical rates are subject to revision if either of these conditions does not occur. Contractor agrees to work directly with the State's prescription drug third party administrator to develop and implement appropriate pharmacy data feeds.

End stage renal disease: The State agrees not to enroll retirees and their dependents who are Medicare beneficiaries diagnosed with End Stage Renal Disease ("ESRD Beneficiaries") in the Contractor Group Medicare Plans during their 30-month coordination period. This same rule does not apply to a post 65 retiree or member who develops ESRD while enrolled in the Medicare Advantage Plan or does not apply to a retiree or member who has met the 30-month coordination period, leaves the plan and subsequently reenrolls.

The State agrees to only offer Group Medicare Plans to ESRD Beneficiaries in a manner that is consistent and complies with applicable laws, rules and regulations, including, but not limited to, 42 C.F.R. § 422.50(a)(2) and other Medicare Advantage and Medicare Secondary Payer ("MSP") laws, rules and regulations and Centers for Medicare and Medicaid Services ("CMS") instructions ("MSP Requirements"). If an ESRD Beneficiary is eligible for or entitled to Medicare based on End Stage Renal Disease, federal law requires the commercial group health plan ("GHP") to be the primary payer for the first thirty (30) months of the ESRD Beneficiary's Medicare eligibility or entitlement ("30-month coordination period"), regardless of the number of employees and regardless of whether the ESRD Beneficiary is a current employee or retiree. Therefore, the State must confirm whether ESRD Beneficiaries are in their 30-month coordination period, and not enroll ESRD Beneficiaries in the Group Medicare Plan during their 30-month coordination period unless coverage under the GHP is maintained for such ESRD Beneficiaries for that period.

Contractor's understanding of the 21st Century Cures Act is that MSP Requirements continue to apply to ESRD Beneficiaries. This means that ESRD Beneficiaries will continue to have the option of enrolling in the Contractor's Group Medicare Plan after they complete their 30-month coordination period, as permitted under MSP requirements. If CMS or any other federal agency with jurisdiction later indicates that MSP Requirements relating to ESRD Beneficiaries have changed as a result of the 21st Century Cures Act or any other applicable law, rule or regulation, Contractor reserves the right to revise or restructure the rates in this Agreement.

Implementation Allowance

The Contractor agrees to provide an allowance of up to $1.00 PMPM that may be used towards transition costs associated with moving to and implementing the new Plan. These funds will be calculated and available after the January 2021 Plan premium has been paid based on that month's enrollment. Any amounts of the allowance remaining 6 months after the initial Plan year begins will be forfeited. This provides the State with a budget or allowance of money from which the State may draw to offset reasonable, identifiable implementation costs incurred during implementation and the first six months of the initial Plan year. The State cannot draw on more than the amount of the allowance provided.

The State may only use the implementation allowance to offset expenses actually incurred as a result of moving to the new Contractor or promoting the new Medicare Plan carrier. Some examples of transition-related expenses it could be applied against are:

- Customized Member I.D. cards (creating, printing & mailing)
- Maintaining Member records due to the transition of business
- Handling Member enrollment

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- Special programming in order to transmit data to Contractor
- The State's third party consulting implementation fees

Reimbursement of implementation-related expenses will be made to the State and/or the State's contracted vendor. Ongoing business expenses and compensation paid to State employees/staff will not be reimbursed using the allowance. Reimbursement will be made once the expenses are incurred and invoice(s) are provided. Invoices must be submitted by December 1, 2021. Should the State terminate this agreement, the allowance cannot be used to fund implementation expenses related to a new group health insurance plan. Reimbursements made by Contractor using the allowance are contingent on Contractor's receipt of a current W9 for any contracted vendor used by the State (if applicable).

Any expenses beyond the implementation allowance are the State's responsibility. Any amounts reimbursed to offset or reimburse the State for expenses incurred as a result of contracting with the Contractor Medicare Plan will be paid in accordance with applicable law. The State must determine appropriate accounting for these payments.

Premium Payments

The Contractor shall provide an invoice in a mutually agreed to format, which includes membership detail. Premium payment is due and payable on the 1st of the month. However, there is a thirty (30) day Grace Period. The payment amount must equal the "TOTAL DUE" amount shown on the billing cover sheet, less any payment previously remitted but not reflected on the current billing statement. Once the State exceeds their Grace Period and enters into a delinquency process the State must pay 100% of the "TOTAL DUE" to avoid termination.

Medicare Advantage – CMS Premium Requirements - CMS requires that Contractor notify the State of premium requirements for Medicare Advantage PPO Plans if the State and Plan members are paying any portion of the premium for the Medicare Advantage benefit ("MA Premium"). The State must comply with the following conditions with respect to any subsidization of MA Premium and any required MA Premium contribution by the member:

1. The State may subsidize different amounts of MA Premium for different classes of members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly).

2. MA Premium contribution levels cannot vary for members within a given class.

3. Direct subsidy payments from CMS to Contractor must be passed through to reduce the amount of any required MA Premium payment by the member.

Prospective rating basis- The rates are prospectively rated. No policy year accounting balance will be calculated for these coverages.

Run-in claim processing- Expenses associated with run-in claims from any prior plan (claims incurred before the effective date of this plan) are excluded from the rates.

Run-off claim processing- Rates reflect an incurred (mature) claim base and take into account the expenses associated with the processing of run-off claims 12-months following cancellation, subject to the conditions of Contractors financial guarantee.

Additional products and services the Contractor reserves the right to bill the State for additional products and services requested by the State and beyond what was in outlined in Exhibit B.

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Section 2. Gain Share Agreement

This Agreement includes a Medicare Advantage Retrospective Gain Share Agreement with the State with separate settlements for:

- The cumulative two-year period January 1, 2021 through December 31, 2022.
- The one-year period January 1, 2023 through December 31, 2023.

Any reconciliation amount determined according to this Gain Share Agreement will be used to reduce the State's supplemental premium in future years. No interest will accrue on any such premium credits. Upon termination or non-renewal of the agreement with the State, Contractor will pay in cash 50% of any remaining unused premium credits. (* see Reconciliation Schedule chart below)
The Gain Share Agreement will be reconciled in aggregate across all retiree sub-groups.

The table below describes how any reconciliation amounts will be calculated:

Calculation of Gain Sharing Amount:

Actual State of New Hampshire Medicare Advantage Incurred Medical Loss Ratio (MLR)	**Reconciliation Period(s)** **Two-Year Cumulative (January 1, 2021 through December 31, 2022)** **One-Year Period (January 1, 2023 through December 21, 2023)**
If the Actual MLR is greater than 85.0%, then:	There is no gain or loss sharing with State of New Hampshire
If the Actual MLR is greater than or equal to 83.0% & less than 85.0%, then:	Contractor provides premium credits to State of New Hampshire: • 50% of the difference between 85.0% & the Actual MLR
If the Actual MLR is less than 83%, then:	Contractor provides premium credits to State of New Hampshire: • 50% of the difference between 85.0% and 83.0% plus • 100% of the difference between 83.0% and the Actual MLR

The incurred **Medical Loss Ratio (MLR)** will be determined as follows and defined below:

[Claims + Quality Improvement Expense + Fraud & Abuse Expense]

Divided by

[CMS Revenue + Supplemental Premium]

Claims are on an incurred basis, including fee-for-service (FFS) and non-FFS claims, as well as a provision for Incurred but Not Reported (IBNR) claims.

Quality Improvement Expense (QIE) and Fraud & Abuse Expense (FAE) include costs as currently defined for federal minimum MLR purposes. If the definition of QIE and FAE under federal minimum MLR rules changes in the future, Contractor reserves the right to review the program parameters.

CMS Revenue includes amounts paid to Contractor by CMS on behalf of State of New Hampshire retirees.

Supplemental Premium includes amounts paid to Contractor by State of New Hampshire, excluding any amounts to recover actual taxes, fees, and assessments.

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The schedule below will apply to these reconciliations, subject to any extenuating or unforeseen circumstances regarding the timing of CMS reimbursement which may materially affect a premium credit due, e.g., CMS Risk Adjustment Data Validation (RADV) Audits.

Reconciliation Schedule:

Two-Year Reconciliation Period	Statement of Reconciliation/ Accounting	*Future Supplemental Premium Impact
January 1, 2021 through December 31, 2022 **Preliminary reconciliation**	March 31, 2023	N/A
January 1, 2021 through December 31, 2022 **Final settlement reconciliation**	July 31, 2023	2024 Premium Levels

One-Year Reconciliation Period	Statement of Reconciliation/ Accounting	*Future Supplemental Premium Impact
January 1, 2023 through December 31, 2023 **Preliminary reconciliation**	March 31, 2024	N/A
January 1, 2023 through December 31, 2023 **Final settlement reconciliation**	July 31, 2024	2025 Premium Levels

If CMS retroactively adjusts revenues paid to Contractor with respect to the State's Medicare Advantage coverage, impacting the total revenue used in any of Contractor's reconciliations (either preliminary or final), Contractor reserves the right to provide a revised reconciliation based on corrected CMS revenue data. Contractor will adjust any premium credits accordingly. If premium credits were already used to decrease premiums paid, the State shall reimburse Contractor in an amount necessary to recover the premium credits. Such amounts shall be paid within 90 days of receipt of the reconciliation. The maximum liability of State is limited to the value of paid premium credits.

This provision survives the termination of this Agreement.

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Gainsharing Illustrative Example:

- Assumes 10,056 average members
- Assumes average CMS revenue of $914 PMPM
- Assumes average customer paid premium of $0.00 PMPM
- Assumes Actual aggregate 2021-2022 MLR of 81.0%
- The aggregate premium credit generated under the Gain Share over the 2-year period is $6.6 million.
- The State of New Hampshire could apply this credit to reduce future supplemental premiums payable to Contractor.
- If the State of New Hampshire were to terminate before applying the premium credits, Contractor will pay 50% of the unused premium credits or $3.3M.

		2021-2022 ($M)	The State of New Hampshire Gain Share (%)	The State of New Hampshire Gain Share ($M)	Portion of Gain Share Retained by Aetna ($M)
Revenue					
CMS Revenue		$ 220.6			
Customer paid premium		$ -			
Net Revenue	(a)	**$ 220.6**			
Incurred Claims*	(b)	$ 178.7			
Actual MLR	(b) / (a)	81.0%			
Amount Below 85.0%	85% * (a) - (b)	$ 8.8			
83% ≤ Amount < 85%	2% * (a)	$ 4.4	50%	$ 2.2	$ 2.2
Amount < 83%	83% * (a) - (b)	$ 4.4	100%	$ 4.4	$ -
Total		**$ 8.8**		**$ 6.6**	**$ 2.2**
Renewing (1/1/24): Gain Share Setttlement (2024 Premium Credit)				$ 6.6	
Terminating (1/1/24): Gain Share Settlement (50% Cash Payment)				$ 3.3	

* Includes Quality Improvement Expense and Fraud & Abuse Expense

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Section 3. Summary of Performance Standards

Performance Category	Minimum Standard	Penalty
Implementation and Go-Live Dates		
All MA services shall take effect/ 'go live' and be fully operational on the initial 'go-live' date as specified in the contract, and all members will have a valid ID card in hand at least ten (10) business days before the beginning of the year based on the information confirmation from CMS.	Report of initial 'go-live' readiness, reported no later than 5 business days prior to the initial 'go-live' date	$100,000 for the first day and $10,000 for each subsequent calendar day the deadline that MA services are not fully operational.
All MA services shall take effect/ go live and be fully operational on the annual 'go-live' date as specified in the Contract, and all members will have a valid ID card in hand at least ten (10) business days before the beginning of each year based on the information confirmation from CMS.	Report of service readiness, reported no later than 5 business days prior to each subsequent annual plan-year effective date	$75,000 for the first day and $5,000 for each subsequent calendar day the deadline that MA services are not fully operational
Plan Design Administration		
MA enrollment for Retiree and Dependent Age-Ins and Working Aged Retiring, as identified on the State enrollment files.	100% of retirees and their dependents who age in to Medicare or become eligible for Medicare due to disability will be eligible for enrollment into the MA plan, effective on their Medicare eligibility date	$5,000 per week for each State retiree or dependent aging into Medicare that experiences a gap in coverage. $5,000 per week for each working aged who retires that experiences a gap in coverage
Reporting of Retiree and Dependents enrolled in MA and Drop Part B	100% of retirees and their dependents enrolled in the MA Plan and are identified as having dropped their Medicare Part B coverage will be reported to the State on the day identified.	$5,000 per week for each MA enrollee who is identified to have dropped their Medicare Part B coverage and is not reported to the State on the day identified resulting in lack of timely reinstatement and therefore experiencing a gap in coverage
Unique member Identifier Administration Requirement		
Contractor must be able to accept, store, and report member-level detail using 3 Identifiers	100% of the Unique member Identifier Administration Requirement is to be administered as described.	$50,000

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Member Services		
Average Speed of Answer	100% of all inbound the State-specific member calls within 30 seconds for member calls selecting a live Member Service Representative (MSR). This excludes calls abandoned before answering	$10,000 for each percentage point below the threshold for a month, measured MSR inbound calls. $100,000 maximum
Abandonment Rate	Average call abandonment rate will be less than 3%	$10,000 for each percentage point above the threshold, measured on a monthly basis. $50,000 maximum
The Contractor's website for the State's members will offer online, real time access, except for scheduled maintenance	Contractor's website for the State's members will be available and fully operational 100% of the time, except for scheduled maintenance	$5,000 for each percentage below the standard. $25,000 maximum
Account Management/Client Services		
Semi-Annual Meetings	At a minimum, an Account Team member closely involved in the daily operations of the State account, a clinician (as appropriate), and an executive-level Team member with oversight responsibility must be in attendance. Reporting and information with the appropriate level of detail will be provided in advance of the call. The meeting must take place between 30 and 45 days after the end of the 6-month period.	$50,000
Tracking Log of Claim Inquiries, member Issues, and/or Complaints and Final Resolutions	100% of claim inquiries, member issues and/or complaints from the State staff, acknowledged (return phone call) within 1 business day, and follow-up of resolution status within 2 business days, if not yet resolved	$25,000 for each percentage below the threshold
Claims Processing		
Accurately Implement Benefits or Program Changes. This includes mandated CMS updates of service codes, fee schedules, etc. that have the potential to create member	100% of benefit or program changes will be accurately and correctly implemented and administered	Contractor will reimburse the State (including the State's retirees) 100% of the value of the error(s) if the Contractor's error

Contractor Initials: MF
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disruption and provider payment issues		results in a loss to the State or its Medicare-eligible retirees and their Medicare-eligible dependents. If the Contractor's error results in a loss to the Contractor, the State will not be responsible for making the Contractor whole for the resulting loss. Additionally, $5,000 per day will be assessed, measured from the date the benefit or program change became effective until the date the error is accurately corrected in the Contractor(s) system(s)
Reporting		
Provide MMR reports monthly	Provide accurate MMR reports monthly by the end of the corresponding month, including all fields as received from CMS	$5,000 per day for each business day that the standard is not met. $100,000 maximum
Provide MOR reports upon request, no more often than annually	Provide accurate MOR reports upon request, no more often than annually, including all fields as received from CMS. The latest MOR will be submitted within 30 days of request	$5,000 per day for each business day that the standard is not met $100,000 maximum.
Provide claims data monthly	Provide claim line detail for ALL claims in a mutually agreed upon format by the 15th calendar day of the month following the subject month, as described in the RFP	$5,000 per day for each business day that the standard is not met. $100,000 maximum
Eligibility		
Eligibility Loads (Initial Enrollment)	Initial enrollment file will be loaded accurately within 24 hours of receipt	$50,000 for each business day that the standard is not met. $250,000 maximum
Eligibility Loads (Initial enrollment and subsequent 2 times weekly files Enrollment)	Daily update eligibility files will be loaded accurately within 24 hours of receipt	$5,000 per day for each business day the standard is not met. $50,000 maximum annually

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Communications		
Approval of Communications	Correspondence and information (whether written, electronic, telephonic, or in any other medium or form) developed by the Contractor and intended for members, (e.g., open enrollment materials, network changes) must be reviewed and approved by the State prior to dissemination. CMS mandated documents do not apply.	$75,000 per occurrence of communication materials being released without the State's review and approval
Account Management Satisfaction		
Annual Score Card	Satisfaction rate will be a minimum of 98%	$25,000 for each percentage below the threshold, $100,000 maximum annually
Network Access		
Provider Recruitment	Guarantee to work with State of New Hampshire to develop a targeted, provider recruitment list that focuses on adding physicians and facilities that are not currently participating in Contractor's network	$50,000

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will initially run from **January 1, 2021 to December 31, 2021 and for each subsequent year of the contract** (hereinafter "guarantee period").

The performance guarantees shown will apply to the fully-insured Medicare Advantage medical plans administered under this Agreement.

For any performance guarantee that is unsatisfactory, Contractor will develop an improvement plan to achieve the stated performance guarantees.

Termination Provisions

Parties shall meet and mutually agree to make changes to or eliminate any of these Performance Standards where:

(i) there is a material change in the plan initiated by State of New Hampshire or by legislative action that impacts the related Minimum Standard;

(ii) State action materially impacts Contractor's ability to meet the Minimum Standard of a particular Performance Category (e.g., a submission of incorrect or incomplete eligibility information may impact enrollment and related reporting Performance Categories).

When this Agreement expires Contractor is obligated to make payment for any Performance Guarantees that apply to the final term of the Agreement within 180 days from the date of termination.

If this Agreement is terminated other than through expiration of the term of the Agreement, Contractor obligated to make payment within 180 days from the date of termination.

If this Agreement is terminated prior to the completion date outlined in Section 1.7 of the General Provisions Form P-37 for any reason, liability for any Performance Category shall be calculated and paid based on the most recent completed measurement period outlined in the Summary of Performance Standards chart above.

Contractor Initials: RAF
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No guarantees shall apply for a guarantee period during which this Agreement is terminated by State of New Hampshire or by Contractor.

Guarantee Payment Process

At the end of each guarantee period, Contractor will compile its Performance Guarantees results. If necessary, Contractor will provide a "lump sum" payment for any penalties incurred by Contractor within 180 days from the end of the guarantee period.
If there is a dispute regarding performance of any of the Performance Category outlined in the Summary of Performance Standards chart above the Parties shall meet in good faith to resolve such dispute and shall mutually agree to the resolution of minimum standard measurement and/or penalty payment under the Performance Category in question.

Measurement Criteria
Contractor's internal quality results for the servicing of the State's group plan will be used to measure guarantee compliance. Final guarantee performance will be based on mutual agreement.
Such internal quality results shall be based on a statistically valid sample size with a 95% confidence level and shall be available to the State upon request.
Unless otherwise specified in the Summary of Performance Standards chart above, the measurement of the Minimum Standard for each Performance Category shall be based on:

(i) The performance of any service team, business unit, or measurement group assigned by Contractor to the activity to which the specific Performance Category being measured relates; and
(ii) Data that is maintained and stored by Contractor or its subcontractors.

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Contractor Initials: RJF
Date: 7/6/20

Exhibit D: Incorporation of RFP Response

The following sections of the Contractor's response to RFP 2295-21 are hereby incorporated by reference:

Non-Financial Sections:

- Section II: Bidding Instructions and Conditions
- Section III: Required Plan Design and Implementation
- Section IV: Network Match and Access
- Section V: Performance Guarantees
- Section VI: Questionnaire

Financial Sections:

- Medicare Advantage Performance Guarantees
- Aetna and Prudential Retiree Medical Solution (not included in Agreement, optional product)
- Implementation Schedule, Key Events, Gant Chart (Sample)
- Satisfaction Survey (Sample)
- Aetna Medicare Advantage HMO Affiliate Addendum
- Aetna Medicare Advantage Subcontractors
- Rate Renewal (Sample)

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Contractor Initials: RAF
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Appendices

Appendix A: Group Application

Appendix B: Plan Sponsor Letter Agreement

Appendix C: Summary of Benefits

Appendix D: Universal Medical File Format

Appendix E: Tier 1 Subcontractor List

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aetna Group Employer Medicare Advantage Plan and Medicare Prescription Drug Plan Application

Company Name: State of New Hampshire

Doing Business As (DBA): State of New Hampshire

Corporate Headquartered Address: 25 Capitol Street, Room 412

City: Concord State: NH Zip Code: 03301

Federal Tax ID Number: 02-6000618 Situs state: New Hampshire

Parent Company name (if Applicable): _____

Employer Sponsor Type:— Employer —(click on "choose an item")

Employer Organization Type:— State Government (click on "choose an item")

The purpose of the application is to request: a. ☒ **Issuance of new coverage**
b. ☐ Change in existing coverage
c. ☐ Extension of existing coverage to additional eligible individuals

Once the Medicare Group contract is drafted, it will be emailed to Customer Email Address: Joyce.Pitman@das.nh.gov

Medicare Coverage: Medical/RX Coverage Selection: Provided or administered by Aetna Life Insurance Company, Aetna Health of California Inc., and/or Aetna Health Inc.

Types of Coverage – Select All that Apply

☐ Medicare Advantage HMO Plan
☐ Medicare Advantage HMO Plan with Medicare prescription drug benefits
☒ **Medicare Advantage PPO Plan and/or Medicare Advantage PPO Plan with Extended Service Area**
☐ Medicare Advantage PPO Plan with Medicare prescription drug benefits and/or Medicare Advantage PPO Plan with Extended Service Area with Medicare prescription drug benefits
☐ Fully-Insured Standalone Medicare prescription drug plan
☐ Self-Insured Standalone Medicare prescription drug plan

Type of Group Health Plan Maintained by Plan Sponsor – Select Type that Applies

☐ *ERISA plan.* An employee welfare benefit plan providing medical care as defined in Section 607(1) of ERISA.
☒ ***Federal or State governmental plan.* A plan providing medical care established or maintained by a federal, state or local government agency for its employees.**
☐ *Collectively bargained plan.* A plan providing medical care established or maintained under or by one or more collective bargaining agreements.
☐ *Church plan.* A plan providing medical care established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches.
☐ *Health Reimbursement Arrangement (HRA).*
☐ *Health Flexible Spending Arrangement (FSA).*
☐ *Health Savings Account (HSA).*
☐ *Archer MSA.* The MSA must be subject to ERISA as an employee welfare benefit plan providing medical care (unless exempt from ERISA because it is a governmental plan or church plan).

Premium Billing – Select All that Apply

Contractor Initials: LAP
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Aetna offers three different methods for billing premiums. A monthly premium can either be billed to individuals enrolled in the Aetna Medicare Plan ("Direct Billing"), to you ("Contract Holder Billing") or to both you and individuals enrolled in the Aetna Medicare Plan ("Split Billing"). **Please note that the Split Billing option is only available if you sign a Service Agreement with Aetna to use bswift as the benefit administrator for your Aetna Medicare Plan.** Please select all of the billing methods that apply to the Medicare coverage you selected in this application:

☒ **Contract Holder / Plan Sponsor Billing**
☐ Direct Billing to members
☐ Split Billing, pursuant to the Service Agreement between you and Aetna.

General Enrollment and Eligibility Section

Requested effective date: 1/1/21 (Actual effective date will be assigned by Aetna if this application is accepted and an agreement between Aetna and Applicant for the coverage specified herein is issued)

Renewal date: 1/1 For Medicare Advantage PPO plans with Medicare prescription drug coverage the renewal date must be January 1st.

Late Enrollment Penalty Attestation (Please review and complete only if applying to obtain coverage under a Medicare Advantage plan with Medicare prescription drug coverage ("MA-PD plans") or Standalone Medicare prescription drug plan ("PDP")

Pursuant to Section 1860D-13(b) of the Social Security Act and 42 C.F.R. §§ 423.46 and 423.56(g), Medicare beneficiaries may incur a late enrollment penalty ("LEP") if there is a continuous period of 63 days or more at any time after the end of the beneficiary's Medicare Part D initial enrollment period during which the beneficiary was eligible to enroll, but was not enrolled in a Medicare Part D plan and was not covered under any creditable prescription drug coverage. "Creditable prescription drug coverage" is prescription drug coverage that is expected to pay at least as much as Medicare's standard prescription drug coverage. To ease the administrative burden associated with implementation of these LEP-related procedures, the Centers for Medicare and Medicaid Services permits Aetna to accept attestations from plan sponsors wherein the plan sponsor attests to the creditable coverage history of eligible individuals submitted for enrollment in the plan sponsor's group MA-PD plan or PDP for purposes of reporting covered months. If an individual was assessed a LEP prior to the effective date of the new coverage, the individual's LEP will carry over even if the employer attests to creditable coverage.

☐ **Yes, Applicant will attest to the creditable prescription drug coverage history of all individuals submitted by Applicant for enrollment in Aetna's MA-PD plans or PDP for purposes of reporting covered months.** By checking this box and signing this application, Applicant attests that all individuals submitted for enrollment in Aetna's MA-PD plans or PDPs were either previously enrolled in another Medicare prescription drug plan or had other creditable prescription drug coverage prior to applying to enroll in an Aetna MA-PD plan or PDP. Applicant understands that by signing this application, Applicant is attesting that it has read and understands the contents of this attestation and that this attestation is truthful, accurate and complete.

☐ **No, Applicant will not attest to the creditable prescription drug coverage history of all individuals submitted for enrollment in Aetna's MA-PD plans or PDPs for purposes of reporting covered months.** Applicant understands that without an attestation from Applicant, all individuals submitted by Applicant for enrollment in Aetna's MA-PD plans or PDPs will be submitted by Aetna through CMS systems to determine if gaps of 63 days or more exist in creditable prescription drug coverage since the close of the individual's initial Medicare Part D enrollment period. Individuals who are identified to have such gaps of creditable prescription drug coverage will receive letters requesting that they attest to any creditable prescription drug coverage during those gaps, and these individuals may contact Applicant for assistance in determining creditable coverage history.

"Age-In" Program

Aetna executes a monthly communications program known as the "Age-in" Program. This Program provides Applicant's retirees who are approaching age 65 with timely information regarding your Aetna Medicare Plan. The "Age-in" Program currently consists of a mailing sent 2 months before the 65th birthday month and the mailing list is determined solely based on age. This means that these mailings may be sent to both Applicant's retirees and active employees who are nearing their 65th birthday. The mailing clearly indicates that only retirees and their eligible dependents (if Applicant permits dependent enrollment) are eligible to enroll in the Aetna Medicare Plan. The scope of this Program is subject to change.

Important Note: Please notify your Account Executive if your organization does not want to participate in the "Age-in" Program. If your organization does not provide this notice to your Account Executive within 30 days of the date you sign this Application, Aetna will proceed with including your organization in the "Age-in" Program.

Enrollment & Optional Mechanism Enrollment

Please check the appropriate box to document if you will use one of the following methods to enroll eligible individuals in the Aetna Medicare Plan(s) selected by you in this application:

Applicant will use optional mechanism enrollment (Excel Spreadsheet) (choose one)? ☐ **Yes** ☐ No

Applicant will use electronic file-based enrollment (choose one)? ☒ **Yes** ☐ **No**

If you selected "yes" with either option, please review the following section titled "Enrollment Requirements". By signing this application, you are agreeing to the requirements in this Section.

Contractor Initials: [initials]
Date: 7/6/20

Enrollment Requirements

The Centers for Medicare and Medicaid Services ("CMS") allows Applicant to enroll eligible individuals in an Aetna Medicare Plan using an electronic group enrollment process ("Electronic Enrollment Process") or a process referred to by CMS as the "Group Enrollment Process – Optional Mechanism" ("Optional Mechanism Enrollment Process"). With both enrollment processes, eligible individuals must be informed prior to enrollment that they can make the initial election of the Aetna Medicare Plan

If Applicant elects to use either the Electronic Enrollment Process or the Optional Mechanism Enrollment Process, Applicant must comply with all applicable laws, regulations and CMS instructions, including the following:

1. For each eligible individual that Applicant submits for enrollment to Aetna through the Electronic Enrollment Process or Optional Mechanism Enrollment Process, Applicant agrees to:
   - Provide a Summary of Benefits and all information necessary for the eligible individual to make an informed choice regarding Aetna Medicare Plan benefits, including, but not limited to, Aetna Medicare Plan rules and requirements and enrollment processes.
   - Provide written notice not less than 21 calendar days prior to the requested effective date of the eligible individual's enrollment in an Aetna Medicare Plan. This notice must advise eligible individuals that they can elect to enroll in the Aetna Medicare Plan by completing the necessary enrollment forms on a timely basis. Failure to complete the necessary forms and/or enroll in Medicare Part A & B when eligible will result in automatic assumption that the individual is opting out of enrollment into the Aetna Medicare Plan. This written notice must describe in detail the opt-out process the eligible individual must follow to decline enrollment in the new Aetna Medicare Plan.
2. Applicant acknowledges that it received from Aetna the data element and format requirements for submission of enrollment transactions to Aetna ("Enrollment Submission Requirements"), and Applicant agrees that all enrollment transactions available to Aetna for processing will comply with these Enrollment Submission Requirements. Applicant acknowledges and agrees that Aetna will not process an enrollment transaction submitted by Applicant that does not comply with Enrollment Submission Requirements. Applicant agrees to exclude all eligible individuals who have elected to opt out of enrollment in an Aetna Medicare Plan from any enrollment transactions submitted to Aetna for processing.

Applicant Acknowledgements and Agreements

It is agreed that no coverage shall become effective as to any person who is not then eligible for coverage under applicable laws, rules, regulations and CMS instructions ("Mandates"). All statements herein shall be deemed representations and not warranties. The Applicant acknowledges that it has selected the coverage specified herein based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. Applicant has selected, in accordance with Mandates, the coverage to be offered to Applicant's retirees and Applicant has solely determined any/all coverage options for the Applicant's retirees and the contribution amounts.

The plan documents (which consist of the Evidence of Coverage and the agreement(s) between Aetna and Applicant relating to the coverage(s) specified herein ("Medicare Agreement") will determine the contractual provisions, including procedures, exclusions and limitations relating to the coverage and will govern in the event they conflict with any benefits comparison, summary or other description of the coverage. Aetna will use the e-mail address provided by Applicant in this application to send Applicant the Medicare Agreement. Applicant will notify Aetna in writing if it prefers that the Medicare Agreement be sent to a different address. Aetna and Applicant agree that the Medicare Agreement will be considered received by Applicant on the date that Aetna sends the Medicare Agreement to the e-mail address provided by Applicant (as described in this application). All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Medicare Agreement is in force, and as required under Mandates and the Medicare Agreement. The availability of a plan or program may vary by geographic service area. "Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

With the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed. With respect to those Aetna group Medicare plans that are network-based, provider network composition is subject to change. Notice of a change in provider network composition shall be provided to individuals enrolled in these Aetna group Medicare plans in accordance with applicable federal law. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome. Some benefits are subject to limitations or maximums.

Important Information

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Alaska, Connecticut, Idaho, Nevada, New Hampshire, North Carolina & South Carolina: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arkansas, District of Columbia, Louisiana, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Contractor Initials: RAE
Date: 7/6/20

Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
Indiana/Illinois: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Kansas/Missouri: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.
Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Maine and Tennessee: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.
Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Minnesota: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
New Jersey: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.
Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon: Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.
Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
Texas: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.
Utah: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading information concerning any fact material thereto may commit a fraudulent insurance act, which is may be a crime and may subjects such person to criminal and civil penalties.
Vermont: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.
Virginia: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.
Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

ORDER OF PRIORITY

Once this application is signed and Aetna accepts it, this application will form part of a Medicare Agreement issued by Aetna. If there is a conflict between anything in this application and any other part of the Medicare Agreement, the other parts of the Medicare Agreement will take priority.

Contractor Initials: RAF
Date: 7/6/20

Signature Section

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete. I understand that this application will form a part of the Medicare Agreement issued by Aetna relating to such coverage and by my signature below I agree to be bound by the terms and conditions of that Medicare Agreement. Aetna will issue a Medicare Agreement to Applicant that will automatically renew for subsequent twelve-month renewal terms, unless sooner terminated in accordance with the Medicare Agreement. I understand that Aetna may choose not to accept this application at its sole discretion, subject to any federal and/or state requirements.

Signed at (location): Concord, NH City, State	State of New Hampshire Applicant (Company Name)
By:  Authorized Applicant Signature	Commissioner, Department of Administrative Services Official Title
Dawn Howe Witness	7/20/2020 Date

Your premium purchases insurance coverage from Aetna, as well as the services of any Aetna-appointed licensed independent agent or broker identified in the member's Application for Group Coverage. Aetna has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which Aetna has made to your producer, or other material relationships your producer may have with Aetna, you may contact your producer or your Aetna account representative. Information regarding Aetna's programs for compensating producers is also available at www.aetna.com. **We appreciate your business and the opportunity to serve you.**

Please keep a copy of this application for your records. If this application is accepted by Aetna, this application will become part of the issued Medicare Agreement.

Contractor Initials: AF
Date: 7/6/20

Appendix B: Plan Sponsor Letter Agreement

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Contractor Initials: RAP
Date: 7/6/20

Plan Sponsor Letter Agreement ("PSLA")

(Release of Confidential Health Data by Aetna)

Dear Valued Customer:

We are pleased to provide insurance benefits or administrative services for the

State of New Hampshire Health Benefit Plan ("you" or "your") health benefits plans (the "Plan(s)"). In the course of this business relationship, you may from time to time request Aetna Life Insurance Company and/or its affiliates (collectively, "Aetna") to release to you, the Plan(s), and/or another third party, certain information (the "Information") concerning the benefits delivered to individuals covered under one or more of the Plan(s). Because the Information may contain confidential member health data, Aetna requires that you agree to the terms of this Appendix to the Agreement before we release the Information to you, the Plan(s), and/or another third party. If you request that Aetna release Information directly to a third party other than the Plan(s) on your behalf, Aetna will require that you sign a letter providing direction to Aetna, which must also be signed by the third party.

In consideration of Aetna's agreement to disclose the Information and any other good and valid consideration, you agree that you (1) hereby attest that the Plan is a Covered Entity, as defined under HIPAA Privacy Rules CFR secs 160 and 164, and that, as required, any third party has signed a HIPAA-compliant Business Associate Agreement with the Plan and (2) will only request the minimum amount of Information necessary to administer the Plan(s), including but not limited to enrollment, audit, wellness programs and benefit, clinical and financial analysis, procurement, and transition to a new carrier. You also represent that you have informed enrollees that Information may be disclosed to third parties in connection with plan administration, through executed enrollment forms, or in another manner which satisfies applicable law. You acknowledge that the Information should be treated as confidential and you agree: (1) except as otherwise permitted by law, the Information will be used solely for the purpose of administering the Plan(s) (including, without limitation, Stop Loss policies purchased by you in connection with the Plan(s)); (2) to comply with all applicable federal and state laws restricting access, use, or disclosure or re-disclosure of the Information, including, without limitation, the "plan sponsor disclosure" rules of the HIPAA Privacy Regulations (45 C.F.R. 164.504(f)), as applicable (effective April 14, 2003); and (3) to ensure that any and all third parties to whom Aetna discloses the Information at your request comply with these obligations. Under no circumstances shall you use the Information for any employment-related actions or decisions, except with the express, written authorization of the relevant employees, consistent with applicable law.

Finally, you agree that this Appendix will apply to any Information disclosed by Aetna to you, or an additional third party at your direction, even after termination of any relationship between you and Aetna. This Appendix may be modified or terminated only if you and Aetna specifically agree to such modification or termination in writing.

Thank you for your cooperation in this matter.

Tracey Scraba

Tracey Scraba
Vice President and Chief Privacy Officer
Aetna Life Insurance Company

Contractor Initials: LHF
Date: 7/6/20

Appendix C: Summary of Benefits

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Contractor Initials: RAE
Date: 7/6/20

Benefits and Premiums are effective January 1, 2021 through December 31, 2021

SUMMARY OF BENEFITS
PROVIDED BY CONTRACTOR LIFE INSURANCE COMPANY

PLAN FEATURES	Network & out-of-network providers
Annual Deductible	$198
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part B services.	
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Services exempt from Deductible: Custom	
Annual Maximum Out-of-Pocket Amount	$198

Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except hearing aid reimbursement, vision reimbursement and Medicare prescription drug coverage that may be available on your plan.

HOSPITAL CARE	This is what you pay for Network & out-of-network providers
Inpatient Hospital Care	$0 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay. Prior authorization or physician's order may be required.	
Outpatient Hospital Care	$0
Prior authorization or physician's order may be required.	
PHYSICIAN SERVICES	**This is what you pay for network & out-of-network providers**
Primary Care Physician Visits	$0

Contractor Initials: RHF
Date: 1/6/20

Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.

Physician Specialist Visits	$0
Primary Care Physician Selection	Optional

There is no requirement for member pre-certification. The Stater provider will do this on your behalf.

Referral Requirement	None
PREVENTIVE CARE	**This is what you pay for network & out-of-network providers**
Annual Wellness Exams One exam every 12 months.	$0
Routine Physical Exams One exam every 12 months.	$0
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	$0
Routine GYN Care (Cervical and Vaginal Cancer Screenings) One routine GYN visit and pap smear every 24 months.	$0
Routine Mammograms (Breast Cancer Screening) One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.	$0
Routine Prostate Cancer Screening Exam For covered males age 50 & over, every 12 months.	$0
Routine Colorectal Cancer Screening For all members age 50 & over.	$0
Routine Bone Mass Measurement	$0
Medicare Diabetes Prevention Program (MDPP) 12 months of core session for program eligible members with an indication of pre-diabetes.	$0

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Additional Medicare Preventive Services	$0

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections

- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening

EMERGENCY AND URGENT MEDICAL CARE	**This is what you pay for network & out-of-network providers**
Emergency Care; Worldwide (waived if admitted)	$0
Urgently Needed Care; Worldwide	$0

DIAGNOSTIC PROCEDURES	**This is what you pay for network & out-of-network providers**
Outpatient Diagnostic Laboratory	$0

Prior authorization or physician's order may be required.

Outpatient Diagnostic X-ray	$0

Prior authorization or physician's order may be required.

Outpatient Diagnostic Testing	$0

Prior authorization or physician's order may be required.

Outpatient Complex Imaging	$0

Prior authorization or physician's order may be required.

HEARING SERVICES	**This is what you pay for network & out-of-network providers**
Routine Hearing Screening	$0

One exam every 12 months.

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DENTAL SERVICES	This is what you pay for network & out-of-network providers
Medicare Covered Dental	$0

Non-routine care covered by Medicare.

Prior authorization or physician's order may be required.

VISION SERVICES	This is what you pay for network & out-of-network providers
Routine Eye Exams	$0

One annual exam every 12 months.

Diabetic Eye Exams	$0

MENTAL HEALTH SERVICES	This is what you pay for network & out-of-network providers
Inpatient Mental Health Care	$0 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Prior authorization or physician's order may be required.

Outpatient Mental Health Care	$0

Prior authorization or physician's order may be required.

Inpatient Substance Abuse	$0 per stay

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Prior authorization or physician's order may be required.

Outpatient Substance Abuse	$0

Prior authorization or physician's order may be required.

SKILLED NURSING SERVICES	This is what you pay for Network & out-of-network providers
Skilled Nursing Facility (SNF) Care	$0

Limited to 100 days per Medicare Benefit Period*.

The member cost sharing applies to covered benefits incurred during a member's inpatient stay.
Prior authorization or physician's order may be required.

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*A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

PHYSICAL THERAPY SERVICES	This is what you pay for network & out-of-network providers
Outpatient Rehabilitation Services	$0

(Speech, Physical, and Occupational therapy)
Prior authorization or physician's order may be required.

AMBULANCE SERVICES	This is what you pay for network & out-of-network providers
Ambulance Services	$0

Prior authorization or physician's order may be required.

MEDICARE PART B DRUGS	This is what you pay for network & out-of-network providers
Medicare Part B Prescription Drugs	$0

ADDITIONAL SERVICES	This is what you pay for network & out-of-network providers
Blood Covered in and out of network	All components of blood are covered beginning with the first pint.
Observation Care Covered in and out of network	The Stater cost share for Observation Care is based upon the services you receive.
Outpatient Surgery	$0
Prior authorization or physician's order may be required.	
Home Health Agency Care	$0
Prior authorization or physician's order may be required.	
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Cardiac Rehabilitation Services	$0
Pulmonary Rehabilitation Services	$0
Radiation Therapy	$0

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Chiropractic Services	$0
Limited to Original Medicare - covered services for manipulation of the spine. Prior authorization or physician's order may be required.	
Durable Medical Equipment/ Prosthetic Devices	$0
Prior authorization or physician's order may be required.	
Podiatry Services	$0
Limited to Original Medicare covered benefits only.	
Diabetic Supplies	$0
Includes supplies to monitor your blood glucose.	
Outpatient Dialysis Treatments	$0
Prior authorization or physician's order may be required.	
ADDITIONAL NON-MEDICARE COVERED SERVICES	**This is what you pay for network & out-of-network providers**
Fitness Benefit	Silver Sneakers
Resources For Living®	Covered
For help locating resources for every day needs.	
Teladoc	Covered
Telemedicine services	
Telehealth	Covered
Telemedicine services	
Wigs	$0; $350 annually

For more information about Aetna plans, go to **www.aetna.com** or call Member Services at toll-free at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

Medical Disclaimers

The provider network may change at any time. The State will receive notice when necessary.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

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The complete list of services can be found in the Evidence of Coverage (EOC). The State can request a copy of the EOC by contacting Member Services at 1-888-267-2637 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

The State may pay more for out-of-network services. Prior approval from Aetna is required for some network services. For services from a non-network provider, prior approval from Aetna is recommended. Providers must be licensed and eligible to receive payment under the federal Medicare program and willing to accept the plan.

Out-of-network/non-contracted providers are under no obligation to treat Aetna members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Aetna will pay any non-contracted provider (that is eligible for Medicare payment and is willing to accept the Aetna Medicare Plan) the same as they would receive under Original Medicare for Medicare covered services under the plan.

Plan Disclaimers

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna).

To join the Aetna Medicare Advantage Plan (ESA), you must meet the requirements of the plan sponsor/your former employer, be entitled to Medicare Part A, enrolled in Medicare Part B, and live in our service area.

The State must be entitled to Medicare Part A and continue to pay your Part B premium and Part A, if applicable.

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If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

The State can read the Medicare & The State 2021 Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

The State can also visit our website at www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

This document is not intended to be member-facing as it does not include the required disclosures.

*****This is the end of this plan benefit summary*****

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Appendix D: Universal Medical File Format

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Universal Medical File 1480-Byte Record Layout

Sensitive Diagnosis Categories will be masked. Current broad categories of Sensitive Diagnosis are: Alcohol and Drug Abuse, Behavioral Health, Domestic Assault/Violence, Gender Reassignment, Genetic Test Information, Hepatitis B/C, HIV/AIDS, Reproductive/Pregnancy/Prenatal Care, and Sexually-Transmitted Disease. In most cases, these apply to assessment, testing, treatment, and medication for these conditions.

Field #	Field Name (Business)	Field Name (Technical)	Start	End	Length	Type	Format/ Comments
1	Hierarchy Level 1 (Most Summarized)	ps_unique_id	1	16	16	string	
2	Hierarchy Level 2	customer_nbr	18	25	8	string	
3	Hierarchy Level 3	group_nbr	27	34	8	string	
4	Filler Space Reserved for Future Use	FILLER	36	38	3	string	Reserved for Future Use
5	Hierarchy Level 5	subgroup_nbr	40	47	8	string	
6	Hierarchy Level 6 (Most Granular)	account_nbr	49	53	5	string	
7	Source System Platform	file_id	55	56	2	string	
8	Adjustment Code	clm_ln_type_cd	58	58	1	string	
9	Preferred vs Non-Preferred Benefit Level	non_prfrrd_srv_cd	60	60	1	string	
10	General Category of Health Plan	plsp_prod_cd	62	63	2	string	
11	Line of Business	product_ln_cd	65	66	2	string	
12	Classification Code	classification_cd	68	68	1	string	
13	Benefit Identification Code (BIC)	bnft_pkg_id	70	74	5	string	
14	Plan Code or Extension of Hierarchy	plan_id	76	80	5	string	
15	Benefit Tier	benefit_tier	82	82	1	string	Primarily for Future Use
16	Funding Arrangement	fund_ctg_cd	84	84	1	string	
17	Subscriber SSN	src_subscriber_id	86	96	11	string	
18	Subscriber Last Name	last_nm	98	127	30	string	
19	Subscriber First Name or Initial	first_nm	129	158	30	string	
20	Subscriber Gender	gender_cd	160	160	1	string	
21	Subscriber Date of Birth	subscriber_brth_dt	162	171	10	date	CCYY-MM-DD
22	Subscriber Zip Code	subs_zip_cd	173	177	5	string	
23	Subscriber State	subs_st_postal_cd	179	180	2	string	
24	Coverage/Enrollment Tier	coverage_type_cd	182	182	1	string	Primarily for Future Use
25	Member SSN	ssn_nbr	184	194	11	string	
26	Member ID (Assigned in Data Warehouse)	member_id	196	215	20	string	
27	Member Number	member_number	217	218	2	string	
28	Member Last Name	last_nm	220	249	30	string	
29	Member First Name	first_nm	251	280	30	string	

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Field #	Field Name (Business)	Field Name (Technical)	Start	End	Length	Type	Format/ Comments
30	Member Gender	mbr_gender_cd	282	282	1	string	
31	Member Relationship to Subscriber	mbr_rtp_type_cd	284	284	1	string	
32	Member Date of Birth	birth_dt	286	295	10	date	CCYY-MM-DD
33	Source-Specific Transaction ID Number	src_clm_id	297	315	19	string	
34	ACAS Generation/Segment Number	acas_gen_seq_nbr	317	318	2	string	
35	ACAS Pointer Back to Previous Gen/Seg	prev_clm_seg_id	320	321	2	string	
36	Traditional Claim ID	derived_tcn_nbr	323	337	15	string	
37	Expense/Pay Line Number	src_claim_line_id	339	341	3	string	
38	Claim Line ID (Assigned in Data Warehouse)	claim_line_id	343	354	12	decimal	
39	Subscriber Network ID	ntwk_srv_area_id	356	360	5	string	
40	Servicing Provider Network ID	paid_prvdr_nsa_id	362	366	5	string	
41	Referral Type	srv_capacity_cd	368	368	1	string	
42	PCP's IRS Tax Identification Number (TIN) Form	tax_id_format_cd	370	370	1	string	
43	PCP's IRS Tax Identification Number (TIN)	tax_id_nbr	372	380	9	string	
44	PCP's Name (Last or Full)	print_nm	382	421	40	string	
45	Servicing Provider Tax ID Number (TIN) Format	tax_id_format_cd	423	423	1	string	
46	Servicing Provider Tax ID Number (TIN)	tax_id_nbr	425	433	9	string	
47	Servicing Provider PIN	srv_prvdr_id	435	441	7	decimal	
48	Servicing Provider Name (Last or Full)	print_nm	443	482	40	string	
49	Servicing Provider Street Address 1	address_line_1_txt	484	518	35	string	
50	Servicing Provider Street Address 2	address_line_2_txt	520	554	35	string	
51	Servicing Provider City	city_nm	556	585	30	string	
52	Servicing Provider State	state_postal_cd	587	588	2	string	
53	Servicing Provider Zip Code	zip_cd	590	594	5	string	
54	Servicing Provider Type *	provider_type_cd	596	598	3	string	
55	Servicing Provider Specialty Code *	specialty_cd	600	604	5	string	
56	Assignment of Benefits to Provider Code	payee_cd	606	606	1	string	
57	Participating Provider Code	paid_prvdr_par_cd	608	608	1	string	
58	Date Claim Submission Received	received_dt	610	619	10	date	CCYY-MM-DD
59	Date Processed (Non-HMO Only)	adjn_dt	621	630	10	date	CCYY-MM-DD
60	Date Service Started	srv_start_dt	632	641	10	date	CCYY-MM-DD
61	Date Service Stopped	srv_stop_dt	643	652	10	date	CCYY-MM-DD
62	Date Processed (All)	paid_dt for file_id 03 else adjn_dt for file_id	654	663	10	date	CCYY-MM-DD
63	Filler Space Reserved for Future Use	FILLER	665	670	6	string	Reserved for Future Use

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Field #	Field Name (Business)	Field Name (Technical)	Start	End	Length	Type	Format/ Comments
64	Filler Space Reserved for Future Use	FILLER	672	677	6	string	Reserved for Future Use
65	Filler Space Reserved for Future Use	FILLER	679	684	6	string	Reserved for Future Use
66	Major Diagnostic Category (MDC) *	mdc_cd	686	687	2	string	
67	Diagnosis Related Group (DRG) *	drg_cd	689	691	3	string	
68	Line-Level Procedure Code (CPT, HCPCS, ADA,C	prcdr_cd	693	697	5	string	
69	Line-Level Procedure Code Modifier *	prcdr_modifier_cd	699	700	2	string	
70	Line-Level Procedure Code Type *	prcdr_type_cd	702	702	1	string	
71	Filler Space Reserved for Future Use	FILLER	704	708	5	string	Reserved for Future Use
72	Filler Space Reserved for Future Use	FILLER	710	714	5	string	Reserved for Future Use
73	Filler Space Reserved for Future Use	FILLER	716	720	5	string	Reserved for Future Use
74	Type of Service *	type_srv_cd	722	723	2	string	
75	Service Benefit Code *	benefit_cd	725	727	3	string	
76	Tooth Number	tooth_1_nbr	729	733	5	string	
77	Place of Service	plc_srv_cd	735	736	2	string	
78	UB92 Patient/Discharge Status *	dschrg_status_cd	738	739	2	string	
79	UB92 Revenue Center *	revenue_cd	741	744	4	string	
80	UB92 Bill Type *	hcfa_bill_type_cd	746	748	3	string	
81	Number/Units of Service	unit_cnt	750	759	10	decimal	implied 10.2
82	Source Number/Units of Service	src_unit_cnt	761	772	12	decimal	implied 12.2
83	Gross Submitted Expense ***	src_billed_amt	774	783	10	decimal	implied 10.2
84	Net Submitted Expense ***	billed_amt	785	794	10	decimal	implied 10.2
85	Not Covered Amount 1	not_covered_amt (1)	796	805	10	decimal	implied 10.2
86	Not Covered Amount 2	not_covered_amt (2)	807	816	10	decimal	implied 10.2
87	Not Covered Amount 3	not_covered_amt (3)	818	827	10	decimal	implied 10.2
88	Action or Reason Code 1	clm_ln_msg_cd (1)	829	832	4	string	
89	Action or Reason Code 2	clm_ln_msg_cd (2)	834	837	4	string	
90	Action or Reason Code 3	clm_ln_msg_cd (3)	839	842	4	string	
91	Covered Expense	covered_amt	844	853	10	decimal	implied 10.2
92	Allowed Amount	allowed_amt	855	864	10	decimal	implied 10.2
93	Filler Space Reserved for Future Use	FILLER	866	875	10	string	Reserved for Future Use
94	Copayment Amount	srv_copay_amt	877	886	10	decimal	implied 10.2
95	Source Copayment Amount	src_srv_copay_amt	888	897	10	decimal	implied 10.2
96	Deductible Amount	deductible_amt	899	908	10	decimal	implied 10.2

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Field #	Field Name (Business)	Field Name (Technical)	Start	End	Length	Type	Format/ Comments
97	Coinsurance	coinsurance_amt	910	919	10	decimal	implied 10.2
98	Source Coinsurance Amount	src_coins_amt	921	930	10	decimal	implied 10.2
99	Benefit Payable	bnft_payable_amt	932	941	10	decimal	implied 10.2
100	Paid Amount	paid_amt	943	952	10	decimal	implied 10.2
101	COB Paid Amount	cob_paid_amt	954	963	10	decimal	implied 10.2
102	Aetna Health Fund - Before Fund Deductible	ahf_bfd_amt	965	974	10	decimal	implied 10.2
103	Aetna Health Fund - Payable Amount	ahf_paid_amt	976	985	10	decimal	implied 10.2
104	Savings - Negotiated Fee ***	negot_savings_amt	987	996	10	decimal	implied 10.2
105	Savings - R&C	r_c_savings_amt	998	1007	10	decimal	implied 10.2
106	Savings - COB	cob_savings_amt	1009	1018	10	decimal	implied 10.2
107	Savings - Source COB	src_cob_svngs_amt	1020	1029	10	decimal	implied 10.2
108	Medicare Code	pri_payer_cvg_cd	1031	1031	1	string	
109	Type of Expense - COB	cob_type_cd	1033	1033	1	string	
110	COB Code	cob_cd	1035	1035	1	string	
111	National Drug Code *	prcdr_cd_ndc	1037	1047	11	string	
112	Member 'CUMBID'	src_clm_mbr_id	1049	1070	22	string	
113	Status of Claim	clm_ln_status_cd	1072	1072	1	string	
114	Non-SSN Subscriber ID	src_member_id	1074	1095	22	string	
115	Reversal Code	reversal_cd	1097	1098	2	string	
116	Admit Counter	admit_cnt	1100	1101	2	string	
117	Administrative Savings Amount	admin_savings_amt	1103	1112	10	decimal	implied 10.2
118	Aexcel Provider Designation Code	adj_prvdr_dsgnn_cd	1114	1116	3	string	
119	Aexcel Plan Design Code	aex_plan_dsgntn_cd	1118	1118	1	string	
120	Aexcel Benefit Tier Code	benefit_tier_cd	1120	1121	2	string	
121	Aexcel Designated Provider Specialty	aex_prvdr_spctg_cd	1123	1126	4	string	
122	Product Distinction Code	prod_distnctn_cd	1128	1128	1	string	
123	Billed Eligible Amount (DO NOT USE IF UNMAS	billed_eligible_amt	1130	1139	10	decimal	implied 10.2 - do not use; see data dictionary for further information
124	Servicing Provider Class Code *	srv_provider_class_cd	1141	1143	3	string	
125	Present on Admission Code (1) *	poa_cd (1)	1145	1145	1	string	
126	Present on Admission Code (2) *	poa_cd (2)	1147	1147	1	string	
127	Present on Admission Code (3) *	poa_cd (3)	1149	1149	1	string	

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Field #	Field Name (Business)	Field Name (Technical)	Start	End	Length	Type	Format/ Comments
128	Filler Space Reserved for Future Use	FILLER	1151	1156	6	string	Reserved for Future Use
129	Filler Space Reserved for Future Use	FILLER	1158	1163	6	string	Reserved for Future Use
130	Filler Space Reserved for Future Use	FILLER	1165	1170	6	string	Reserved for Future Use
131	Pricing Method Code	pricing_mthd_cd	1172	1172	1	string	
132	Servicing Provider Type Class Code	type_class_cd	1174	1174	1	string	
133	Servicing Provider Specialty Category Code *	specialty_ctg_cd	1176	1179	4	string	
134	Servicing Provider NPI	srv_prvdr_npi	1181	1200	20	string	
135	Total Deductible Met Indicator	ttl_ded_met_ind	1202	1202	1	string	Placeholder-Do Not Use
136	Total Interest Amount	ttl_interest_amt	1204	1213	10	decimal	implied 10.2
137	Total Surcharge Amount	ttl_surcharge_amt	1215	1224	10	decimal	implied 10.2
138	Filler Space Reserved for Future Use	FILLER	1226	1229	4	string	Reserved for Future Use
139	HCFA Place of Service Code *	hcfa_plc_srv_cd	1231	1232	2	string	
140	HCFA Admit Source Code	hcfa_admit_src_cd	1234	1234	1	string	
141	HCFA Admit Type Code	hcfa_admit_type_cd	1236	1236	1	string	
142	Admission Date	src_admit_dt	1238	1247	10	date	CCYY-MM-DD
143	Discharge Date	src_discharge_dt	1249	1258	10	date	CCYY-MM-DD
144	Line-Level Procedure Code Modifier (2) *	prcdr_modifier_cd(2)	1260	1261	2	string	
145	Line-Level Procedure Code Modifier (3) *	prcdr_modifier_cd(3)	1263	1264	2	string	
146	Present on Admission Code (4) *	poa_cd (4)	1266	1266	1	string	
147	Present on Admission Code (5) *	poa_cd (5)	1268	1268	1	string	
148	Present on Admission Code (6) *	poa_cd (6)	1270	1270	1	string	
149	Present on Admission Code (7) *	poa_cd (7)	1272	1272	1	string	
150	Present on Admission Code (8) *	poa_cd (8)	1274	1274	1	string	
151	Present on Admission Code (9) *	poa_cd (9)	1276	1276	1	string	
152	Present on Admission Code (10) *	poa_cd (10)	1278	1278	1	string	
153	Diagnosis Code 1 *	pri_icd9_dx_cd	1280	1287	8	string	
154	Diagnosis Code 2 *	icd9_dx_cd (2)	1289	1296	8	string	
155	Diagnosis Code 3 *	icd9_dx_cd (3)	1298	1305	8	string	
156	Diagnosis Code 4 *	icd9_dx_cd (4)	1307	1314	8	string	
157	Diagnosis Code 5 *	icd9_dx_cd (5)	1316	1323	8	string	

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Field #	Field Name (Business)	Field Name (Technical)	Start	End	Length	Type	Format/ Comments
158	Diagnosis Code 6 *	icd9_dx_cd (6)	1325	1332	8	string	
159	Diagnosis Code 7 *	icd9_dx_cd (7)	1334	1341	8	string	
160	Diagnosis Code 8 *	icd9_dx_cd (8)	1343	1350	8	string	
161	Diagnosis Code 9 *	icd9_dx_cd (9)	1352	1359	8	string	
162	Diagnosis Code 10 *	icd9_dx_cd (10)	1361	1368	8	string	
163	ICD Procedure Code 1 *	icd9_prcdr_cd (1)	1370	1376	7	string	
164	ICD Procedure Code 2 *	icd9_prcdr_cd (2)	1378	1384	7	string	
165	ICD Procedure Code 3 *	icd9_prcdr_cd (3)	1386	1392	7	string	
166	ICD Procedure Code 4 *	icd9_prcdr_cd (4)	1394	1400	7	string	
167	ICD Procedure Code 5 *	icd9_prcdr_cd (5)	1402	1408	7	string	
168	ICD Procedure Code 6 *	icd9_prcdr_cd (6)	1410	1416	7	string	
169	Aetna Health Fund Determination Order Code	ahf_det_order_cd	1418	1420	3	string	
170	Aetna Health Fund Member Share of Coinsuran	ahf_mbr_coins_amt	1422	1431	10	decimal	implied 10.2
171	Aetna Health Fund Member Copay Amount	ahf_mbr_copay_amt	1433	1442	10	decimal	implied 10.2
172	Aetna Health Fund Member Deductible Amoun	ahf_mbr_ded_amt	1444	1453	10	decimal	implied 10.2
173	Filler Space Reserved for Future Use	FILLER	1455	1455	1	string	Reserved for Future Use
174	Filler Space Reserved for Future Use	FILLER	1457	1457	1	string	Reserved for Future Use
175	ICD-10 Indicator	icd-10_ind	1459	1459	1	string	Y = ICD-10's on record, N = ICD-9's on record, Blank = neither ICD-9's nor ICD-10's on record
176	Exchange ID	xchng_id (org_id)	1461	1469	9	string	default value '999999999'
177	Filler Space Reserved for Future Use	FILLER	1471	1478	8	string	Reserved for Future Use
178	End of Record Marker	not applicable	1480	1480	1	string	value 'X'

*** For Full-Risk records, this field may show as blank on specific records deemed to contain sensitive information.**

***** This field will be masked on all files. Financial/numeric fields that are masked will contain 3 zeros and will be right justified; text fields that are masked will be blank.**

This file is tab delimited, fixed length, and does not contain a header (see "Header" tab for header record on this spreadsheet).

Do not use a text editor to view Universal files.

Contractor Initials: RAP
Date: 7/6/20

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Contractor Initials: PAF
Date: 7/6/20

Appendix E: Tier 1 Subcontractor List

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Contractor Initials:
Date: 7/6/20

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
Accenture	New York, NY	Data entry of individual and group enrollments. Processes fallout of electronic individual enrollment feeds only. Index of all work. If an enrollment is identified for Tier II onshore processing, enrollments directed to onshore via AHAP system for processing onshore in Blue Bell, PA	Offshore	2006
Access2Care		Provides Non-Emergency Medical Transportation, more specifically, ambulatory (sedan), wheelchair access and stretcher van transportation.		
American Specialty Health, Inc.	San Diego, CA	Manage the Healthyroads Coaching Programs providing members with ongoing support and coaching	Domestic	2006
Arna Marketing Group, Inc.	Branchburg, NJ	Enterprise wide print and direct mail communications	Domestic	2006
Aspire Health Partners	Nashville, TN	Aspire Health has served our sickest members in IL and KS/MO by rendering In-Home palliative care services. We are in the process of discontinuing our relationship with Aspire Health and engaging our members in our care management programs.	Domestic	2015
CDR Associates (Conduent, formerly part of Xerox)	Florham Park, NJ	Hospital credit balance reviews		
Change Healthcare	Lombard, IL	Performs Medical Claim Overpayment Recovery for the following services: hospital bill audits, DRG audits and high cost drug	Domestic	2000
Clarity Software Solutions, Inc.	Guilford, CT	Production of ID cards	Domestic	2018
Concentrix	**Onshore:** Greenville, SC **Offshore:** Gurgaon/Pune, India; Manila, Philippines; San Jose, Costa Rica;	**Supplemental claims processing services** Call, claim adjudication, claim and correspondence processing, complaints grievances and appeals, overpayment recovery, quality audits, repricing, provider coding and reimbursement.	Domestic/ Offshore	2015

Contractor Initials: CAF
Date: 7/6/20

	Managua, Nicaragua	<<For claims and enrollment, processors get the same training as internal Aetna processors and their work is subject to the same security, quality, and audit standards as claims and enrollment processed in the United States. It should also be noted that offshore vendors are not authorized to make medical necessity decisions or carry out clinical claim review.>>		
Subcontractor	**Corporate Location**	**Scope**	**Domestic or Offshore**	**Doing business since date**
Connexion Point	Sandy, UT San Antonio, TX	Telesales support for Pre-Enrollment calls by prospective members with questions regarding the plan benefits, upcoming changes, etc. Support is also provided for RSVPs for scheduled informational live meetings or conference calls. includes support for: • Inbound Telephonic Pre-Enrollment support • Inbound Telephonic RSVP support • Inbound Telephonic Enrollment (select plan sponsors only) • Inbound Telephonic "Opt-Out" support • Outbound Telephonic Pre-Enrollment support • Outbound Telephonic RSVP support • Outbound Provider Outreach support.	Domestic	2016
Conduent Credit Balance Solutions	Hunt Valley, MD	Performs Medical Claim overpayment recovery for the following services hospital credit balance	Domestic	2006
Continuum/ Conduent/ACS/Xerox		Claim imaging and data entry. Overpayment recovery for hospital credit balance review, HMO claims.		
Cotiviti	Blue Bell, PA	Performs Medical Claim overpayment recovery for the following services: coordination of benefits, contract compliance, data mining, duplicates, cross platform drug, high drug cost, retro	Domestic	2000

Contractor Initials: RAF
Date: 7/6/20

		terminations, implant audits, DRG audits, short stay audits, specialty audits (SNF, IRF, RUGS)		
DSS Research	Arlington, TX	**Member satisfaction survey** Our telephone-based Aetna Performance Tracking Member Satisfaction Survey - comprehensive assessment of how well our health plans are meeting member expectations.	Domestic	1999
End-Game Strategy, Inc.	Berlin, CT	Perform Medical Claim Overpayment recovery for the following services: contract compliance, duplicate claim review, data mining	Domestic	2010
Equian	Warrenville, IL Indianapolis, IN	Performs Medical Claim Overpayment Recovery for the following services: contract compliant, duplicate payment, data mining, retro termination, hospital bill audit, subrogation and works compensation	Domestic	2004
Subcontractor	**Corporate Location**	**Scope**	**Domestic or Offshore**	**Doing business since date**
EquiClaim, Inc. (owned by Change Healthcare)	Lombard, IL	**Overpayment Recovery** Overpayment recovery for high cost drug audits, implant audits, medical bill audit (hospital bill audit, DRG audit and inpatient contract compliance audit)	Domestic	2000
eviCore Healthcare	Bluffton, SC	Utilization management for the following services: High-tech outpatient diagnostics imaging procedures such as MRI/MRA, nuclear cardiology, PET scan and CT scan, including CTA Non-emergent outpatient stress echocardiology Non-emergent outpatient diagnostic left and right catheterization Insertion, removal and upgrade of elective implantable cardioverter defibrillator, cardiac resynchronization therapy defibrillator and implantable	Domestic	2003

Contractor Initials: [signature]
Date: 7/6/20

		pacemaker Polysomnology (attended sleep studies) Interventional pain management Musculoskeletal large joint (hip and knee) arthroplasty procedures Outpatient radiation therapy		
EXL Service Holdings, Inc.	Kochi, Noida India Manila, Philippines Cebu, Philippines Bogota, Columbia	Clinical services including Precertification Scope/ Steerage, Healthy Lifestyle Coaching/ Beginning Right Maternity Program, Outreach calls, Disease Management, outreach for Care Consideration alerts and identified gaps in treatment. Pre-Determination of services, Clinical Claim Review, HEDIS Abstraction for NCQA accreditation.	Offshore	2012
GA Foods	St. Petersburg, FL	Provides both in-patient post-discharge and chronic meal delivery of frozen meals designed for those with diabetes, hypertension, and cardiac restrictions.	Domestic	
Health Management Systems	Buffalo, NY	Performs Medical Claim Overpayment Recovery for the following services: hospital bill audit, DRG audit, short stay audit, works compensations	Domestic	2009

Subcontractor	**Corporate Location**	**Scope**	**Domestic or Offshore**	**Doing business since date**

Contractor Initials: CAF
Date: 7/6/20

Hinduja Global Solutions Limited (HGSL)	**Onshore:** El Paso, TX **Offshore:** Bangalore/ Mumbai, India; Alabang, Quezon City, Philippines	HGSL supplements domestic claim processing services (including reprocessing), accounts receivable activity (billing), enrollment processing and provider phone calls, helping us meet our service level agreements and contracted guarantees throughout fluctuations in volume. <<For claims and enrollment, processors get the same training as internal Aetna processors and their work is subject to the same security, quality, and audit standards as claims and enrollment processed in the United States. It should also be noted that offshore vendors are not authorized to make medical necessity decisions or carry out clinical claim review.>>	Domestic / Offshore	2017
Iron Mountain, Inc.	Boston, MA	Records storage, retrieving, transportation, destruction services and restoration. Archive tape storage and tape / data destruction	Domestic	1995
Matrix Medical Network	Scottsdale, AZ	**In home assessments** Perform In Home Assessments used to promote better health and care coordination. The IHA program coordinates with other AETNA clinical programs if applicable, Case Management, Community Resources, Addressing/Closing Gaps in Care, HEDIS/STARs, Risk for falls, etc. The assessments are NCQA approved.		
Morely	Saginaw, MI	Outbound call campaigns	Domestic	2018
National Imaging Associates	Hackensack, NJ	Precertify physical medicine services for Medicare members in PA, DE, WV, NY and NJ.		
OmniClaim, Inc.	Woburn, MA	Performs Medical Claim Overpayment Recovery for the following services: DRG audits, implant audits, outpatient audits	Domestic	2009
On24	50 Beale Street, 8th Floor	Provides virtual environment platform and virtual webcasts	Domestic	

Contractor Initials: RAF
Date: 1/6/20

	San Francisco, CA 94105			

Subcontractor	Corporate Location	Scope	Domestic or Offshore	Doing business since date
OptumInsight Inc.	Franklin, TN	Performs Medical Claim Overpayment Recovery for the following services: hospital credit balance, coordination of benefits, contract compliance, duplicate, data mining, high cost drug, retro termination and PRS (Payment Resolution Services) - client referred overpayments	Both	1996
OrthoNet	White Plains, NY	OrthoNet is a vendor that providers credentialing, utilization management and claims processing (Aetna's network) of free standing PT/OT providers in the state of CT.		
Rawlings Company	La Grange, KY	Performs Medical Claim Overpayment Recovery for the following services: coordination of benefits, cross platform drug, high cost drug, subrogation and works compensation	Domestic	1998
ScioHealth Analytics	Pittsburgh, PA Hartford, CT Jacksonville, FL Miramar, FL	Performs Medical Claim Overpayment Recovery for the following services: hospital bill audit, DRG audit, and outpatient audits	Domestic	2019
Signify Health	Dallas, TX	**In home assessments** Perform In Home Assessments used to promote better health and care coordination. The IHA program coordinates with other AETNA clinical programs if applicable, Case Management, Community Resources, Addressing/Closing Gaps in Care, HEDIS/STARs, Risk for falls, etc. The assessments are NCQA approved.	Domestic	

Contractor Initials: RAF
Date: 7/6/20

Solera	Phoenix, AZ	Solera Health is contracted to provide a network of CMS recognized Health Coaches and Dieticians to administer the CMS required Medicare Diabetes Prevention Program to eligible members	Domestic	2018
Taylor Communications (formerly Standard Register)	Mankato, MN	Programmed mailings and management of our stationery website		
Tivity Health	Franklin, TN	Administer Silver Sneakers		
Total Benefits Consulting (formerly Ascensus)	1117 Perimeter Center West, Suite N-102 Atlanta, GA 30338	Provides staff to attend OE meetings when Aetna does not have enough resources	Domestic	
Welltok	Denver, CO	Administration of the Health Risk Assessment survey to all new members within 90 days of enrollment and annually thereafter as required by CMS	Domestic	2017
Subcontractor	**Corporate Location**	**Scope**	**Domestic or Offshore**	**Doing business since date**
WiPro	East Brunswick, NJ	Provide access to CMS database so we can check MBI electronically via a file or on demand lookup	Both	2006
Akorbi		Translation services		
CQ Fluency		Translation services		

Contractor Initials: RF
Date: 7/6/20

State of New Hampshire
Department of State

CERTIFICATE

I, William M. Gardner, Secretary of State of the State of New Hampshire, do hereby certify AETNA LIFE INSURANCE COMPANY is a Connecticut corporation registered on June 29, 2020. I further certify that articles of dissolution have not been filed with this office.

INFORMATION REGARDING ANNUAL REPORTS AND/OR FEES MUST BE OBTAINED FROM THE NEW HAMPSHIRE INSURANCE DEPARTMENT.

Business ID: **845331**
Certificate Number: **0004938620**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 29th day of June A.D. 2020.

William M. Gardner
Secretary of State

Officer's Certificate - Delegation of Authority
Aetna Life Insurance Company

I Edward C. Lee hereby certify that I am the duly elected Secretary and Officer of Aetna Life Insurance Company. I hereby certify the following is a true copy of a vote taken at a meeting of the Board of Directors/shareholders, duly called and held on June 29, 2020, at which a quorum of the Directors/shareholders were present and voting.

VOTED: that Richard A. Frommeyer is duly authorized to enter into contracts or agreements on behalf of Aetna Life Insurance Company with the State of New Hampshire and any of its agencies or departments and further is authorized to execute any documents which may in his/her judgment be desirable or necessary to effect the purpose of this vote.

I hereby certify that said vote has not been amended or repealed and remains in full force and effect as of the date of the contract to which this certificate is attached. This authority remains valid for thirty (30) days from the date of this Corporate Resolution. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person listed above currently occupies the position indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in its contracts with the State of New Hampshire, all such limitations are expressly stated herein.

AETNA LIFE INSURANCE COMPANY

By: _____
Edward C. Lee
Vice President and Secretary

June 29, 2020

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/19/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA, INC. 99 HIGH STREET BOSTON, MA 02110 Attn: CVSCaremark.CertRequest@marsh.com Fax:212-948-5338 CN101226639-ALL-GAW-20-21	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED AETNA, INC./AETNA LIFE INSURANCE COMPANY 151 FARMINGTON AVENUE HARTFORD, CT 06156	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : ACE American Insurance Company — 22667 INSURER B : Indemnity Insurance Company of North America — 43575 INSURER C : ACE Fire Underwriters Insurance Company — 20702 INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** NYC-010912706-01 **REVISION NUMBER:** 8

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			XSLG71567850	01/01/2020	01/01/2021	EACH OCCURRENCE	$ 4,500,000
	[ ] [ ] CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
	X SIR: $500,000						MED EXP (Any one person)	$
	X LIQUOR LIABILITY INCLUDED						PERSONAL & ADV INJURY	$ 4,500,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 28,000,000
	X POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ INCLUDED
	OTHER:							$
A	AUTOMOBILE LIABILITY			ISAH2529449A	01/01/2020	01/01/2021	COMBINED SINGLE LIMIT (Ea accident)	$ 5,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
				SELF-INSURED PHY.DMG.				$
	[ ] UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
B C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N	N/A		See Page Two for Policy Numbers	01/01/2020	01/01/2021	X PER STATUTE [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [N] (Mandatory in NH)						E.L. EACH ACCIDENT	$ 2,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 2,000,000
							E.L. DISEASE - POLICY LIMIT	$ 2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

STATE OF NEW HAMPSHIRE IS/ARE INCLUDED AS ADDITIONAL INSURED (EXCEPT WORKERS' COMPENSATION) WHERE REQUIRED BY WRITTEN CONTRACT.

CERTIFICATE HOLDER

State of New Hampshire
25 Capitol Street
CONCORD, NH 03001-6312

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

AGENCY CUSTOMER ID: CN101226639

LOC #: Boston

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
MARSH USA, INC.	AETNA, INC./AETNA LIFE INSURANCE COMPANY 151 FARMINGTON AVENUE HARTFORD, CT 06156
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

WORKERS COMPENSATION DEDUCTIBLE PROGRAM:
POLICY DATES: JAN 1, 2020 TO JAN 1, 2021

Policy #	States Covered	Carrier
WLRC66926746	AOS	Indemnity Insurance Company of North America
SCFC66926825	WI	ACE Fire Underwriters Insurance Company
WLRC66926783	CA	ACE American Insurance Company
WCUC66926862	DC, MA, OH, RI	ACE American Insurance Company
WCUC66926904	CT, NC, NJ, VA	ACE American Insurance Company

LIMIT: $2,000,000
DEDUCTIBLE: $2,000,000

COMMON POLICY CONDITIONS
A. Cancellation
2. We [Carrier] may cancel this policy by mailing or delivery to the first Named Insured written notice of cancellation at least:
a. 10 days before the effective date of cancellation if we cancel for non payment of premium

1) General Liability Additional Insured - Where Required Under Contract or Agreement language per endorsement CG 2026 (04/13):

SECTION II - WHO IS AN INSURED, is amended to include as an additional insured:
Any person or organization for whom the Named Insured has agreed to provide insurance prior to loss as provided by the General Liability Policy but only to the limit and scope of insurance agreed to by the Named Insured but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by the Named Insureds acts or omissions or the acts or omissions of those acting on the Named Insured's behalf:

1. In the performance of your ongoing operations;
or
2. In connection with your premises owned by or rented to you.

2) General Liability Earlier Notice of Cancellation Provided By Us language per endorsement CG 02 24 10 93:

Number of Days' Notice 90

For any statutorily permitted reason other than nonpayment of premium, the number of days required for notice of cancellation, as provided in paragraph 2. of either the CANCELLATION Common Policy Condition or as amended by an applicable state cancellation endorsement, is increased to the number of days shown in the Schedule above.

3) GENERAL LIABILITY CANCELLATION NOTIFICATION TO OTHERS ENDORSEMENT
In the event coverage is cancelled for any statutorily permitted reason, other than nonpayment of premium, advanced written notice will be mailed or delivered to person(s) or entity (ies) by the Carrier according to the notification schedule shown below:

Name of Person(s) or Entity(ies):

AGENCY CUSTOMER ID: CN101226639

LOC #: Boston

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
MARSH USA, INC.	AETNA, INC./AETNA LIFE INSURANCE COMPANY 151 FARMINGTON AVENUE HARTFORD, CT 06156
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

Per the most current schedule maintained by Marsh USA, Inc. and furnished to Chubb no less than 45 days prior to the effective date of cancellation.

Number of Days Advanced Notice of Cancellation: 90

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
06/19/2020

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA, INC. 99 HIGH STREET BOSTON, MA 02110 Attn: CVSCaremark.CertRequest@marsh.com Fax:212-948-5338 CN101226639-ALL-GAW-20-21	CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:
INSURED AETNA, INC./AETNA LIFE INSURANCE COMPANY 151 FARMINGTON AVENUE HARTFORD, CT 06156	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : ACE American Insurance Company — 22667 INSURER B : Indemnity Insurance Company of North America — 43575 INSURER C : ACE Fire Underwriters Insurance Company — 20702 INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** NYC-010912708-01 **REVISION NUMBER:** 8

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	X COMMERCIAL GENERAL LIABILITY			XSLG71587850	01/01/2020	01/01/2021	EACH OCCURRENCE	$	4,500,000
	[ ] CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$	1,000,000
	X SIR: $500,000						MED EXP (Any one person)	$	
	X LIQUOR LIABILITY INCLUDED						PERSONAL & ADV INJURY	$	4,500,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$	28,000,000
	X POLICY [ ] PROJECT [ ] LOC						PRODUCTS - COMP/OP AGG	$	INCLUDED
	OTHER:							$	
A	AUTOMOBILE LIABILITY			ISAH2529449A	01/01/2020	01/01/2021	COMBINED SINGLE LIMIT (Ea accident)	$	5,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$	
	[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$	
	X HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$	
				SELF-INSURED PHY.DMG.				$	
	[ ] UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$	
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$	
	[ ] DED [ ] RETENTION $							$	
B C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [N] N/A If yes, describe under DESCRIPTION OF OPERATIONS below			See Page Two for Policy Numbers	01/01/2020	01/01/2021	X PER STATUTE [ ] OTHER		
							E.L. EACH ACCIDENT	$	2,000,000
							E.L. DISEASE - EA EMPLOYEE	$	2,000,000
							E.L. DISEASE - POLICY LIMIT	$	2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
STATE OF NEW HAMPSHIRE IS/ARE INCLUDED AS ADDITIONAL INSURED (EXCEPT WORKERS' COMPENSATION) WHERE REQUIRED BY WRITTEN CONTRACT.

CERTIFICATE HOLDER

State of New Hampshire
25 Capitol Street
CONCORD, NH 03001-6312

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee Manashi Mukherjee

ACORD®

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
MARSH USA, INC.	AETNA, INC./AETNA LIFE INSURANCE COMPANY 151 FARMINGTON AVENUE HARTFORD, CT 06156
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

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FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

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POLICY DATES: JAN 1, 2020 TO JAN 1, 2021

Policy #	States Covered	Carrier
WLRC66926746	AOS	Indemnity Insurance Company of North America
SCFC66926825	WI	ACE Fire Underwriters Insurance Company
WLRC66926783	CA	ACE American Insurance Company
WCUC66926862	DC, MA, OH, RI	ACE American Insurance Company
WCUC66926904	CT, NC, NJ, VA	ACE American Insurance Company

LIMIT: $2,000,000
DEDUCTIBLE: $2,000,000

COMMON POLICY CONDITIONS
A. Cancellation
2. We [Carrier] may cancel this policy by mailing or delivery to the first Named Insured written notice of cancellation at least:
a. 10 days before the effective date of cancellation if we cancel for non payment of premium

1) General Liability Additional Insured - Where Required Under Contract or Agreement language per endorsement CG 2026 (04/13):

SECTION II - WHO IS AN INSURED, is amended to include as an additional insured:
Any person or organization for whom the Named Insured has agreed to provide insurance prior to loss as provided by the General Liability Policy but only to the limit and scope of insurance agreed to by the Named Insured but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by the Named Insureds acts or omissions or the acts or omissions of those acting on the Named Insured's behalf:

1. In the performance of your ongoing operations;
or
2. In connection with your premises owned by or rented to you.

2) General Liability Earlier Notice of Cancellation Provided By Us language per endorsement CG 02 24 10 93:

Number of Days' Notice 90

For any statutorily permitted reason other than nonpayment of premium, the number of days required for notice of cancellation, as provided in paragraph 2. of either the CANCELLATION Common Policy Condition or as amended by an applicable state cancellation endorsement, is increased to the number of days shown in the Schedule above.

3) GENERAL LIABILITY CANCELLATION NOTIFICATION TO OTHERS ENDORSEMENT
In the event coverage is cancelled for any statutorily permitted reason, other than nonpayment of premium, advanced written notice will be mailed or delivered to person(s) or entity (ies) by the Carrier according to the notification schedule shown below:

Name of Person(s) or Entity(ies):

ACORD

ADDITIONAL REMARKS SCHEDULE

AGENCY	NAMED INSURED
MARSH USA, INC.	AETNA, INC./AETNA LIFE INSURANCE COMPANY 151 FARMINGTON AVENUE HARTFORD, CT 06156
POLICY NUMBER	
CARRIER / NAIC CODE	EFFECTIVE DATE:

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,
FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

Per the most current schedule maintained by Marsh USA, Inc. and furnished to Chubb no less than 45 days prior to the effective date of cancellation.

Number of Days Advanced Notice of Cancellation: 90