AETNA MEDICARE GROUP AGREEMENT

This Group Agreement is by and between the Aetna entity or entities identified in Section 1.2 below ("Aetna") and Lee County Board of County Commissioners (the "Contract Holder"). This Group Agreement takes effect on January 1, 2021 (the "Effective Date").

This Group Agreement consists of the combination of the following documents:

- The **Evidence of Coverage** issued to Members in connection with this Group Agreement, including the attached Schedule of Copayments/Coinsurance (the "EOC"). The EOC is issued by Aetna to Members on an annual basis. Upon request, Aetna will provide Contract Holder with a copy of the EOC.
- The most recent **rate exhibits, plan designs and financial conditions** issued by Aetna to the Contract Holder in connection with the original issuance and renewal of this Group Agreement, and, if Aetna is billing both the Contract Holder and Members a portion of the monthly premium, the **Service Agreement** between Aetna and Contract Holder that describes this split billing arrangement. These documents are collectively referred to herein as the "Financial Documents".
- This **Group Agreement**, including the attached CMS/Regulatory Requirements Addendum and the Addendum labeled "Aetna Medicare Advantage HMO Affiliate Addendum".
- Contract Holder's **Group Application** (the "Group Application").
- Any riders, amendments, inserts or attachments issued pursuant to any of the foregoing documents.

The Group Application, EOC and Financial Documents are collectively referred to as the "Incorporated Documents."

Aetna and Contract Holder agree as follows

Section 1. COVERAGE

1.1. **Covered Benefits.** The Financial Documents identify the fully-insured Aetna Medicare Plan(s) (the "Plan(s)") offered to the Contract Holder under this Group Agreement for the corresponding time periods and the service area(s) (the "Service Area(s)") where the Plans are offered. Aetna shall provide coverage to Members for all of the health care services and supplies that are covered by the Plan(s) (the "Covered Benefits").

Aetna Insurer/HMO. Aetna's Medicare Advantage PPO Plans are offered by Aetna Life Insurance Company, Coventry Health and Life Insurance Company, HealthAssurance Pennsylvania, Inc., and Coventry Health Care of Illinois, Inc. With regard to such Plans,

"Aetna" means Aetna Life Insurance Company, Coventry Health and Life Insurance Company, HealthAssurance Pennsylvania, Inc., and Coventry Health Care of Illinois, Inc.

Aetna Medicare Rx Plans are offered by SilverScript Insurance Company. With regard to such Plans, "Aetna" means SilverScript Insurance Company,

With regard to Medicare Advantage HMO Plans, "Aetna" means the licensed HMO(s) identified in the Addendum to this Group Agreement labeled "Aetna Medicare Advantage HMO Affiliate Addendum".

Section 2. TERM

2.1. **Term.** The term of this Group Agreement (the "Term") will be 12 months beginning at 12:01 a.m. on January 1, 2021 (the "Effective Date").

Section 3. PREMIUMS

3.1 **Premiums.** Aetna uses three different methods for billing premiums. A monthly premium can either be billed to the Member ("Direct Billing"), to the Contract Holder ("Contract Holder Billing") or to both the Member and the Contract Holder ("Split Billing"). In some cases, Aetna uses multiple billing methods for the same Contract Holder. The Group Application will indicate the billing method(s) that apply to the Plan(s) under this Agreement. If Contract Holder and Aetna agree to change the billing method(s) applicable to the Plan(s) after the Term, the Financial Documents will indicate the billing method(s) that apply to the Plan(s) under this Agreement. In all cases, the "Premium Due Date" shall be the Effective Date and the 1st day of each succeeding calendar month.

- For Members who are subject to Direct Billing, Aetna will charge the Member a monthly premium (the "Member Premium") determined by Aetna based on the Member Premium in effect on the Premium Due Date, as stated in the Financial Documents.
- Where Contract Holder Billing is applicable, Aetna will charge the Contract Holder a monthly premium (the "Contract Holder Premium") determined by Aetna based on the Contract Holder Premium in effect on the Premium Due Date, as stated in the Financial Documents.
- Where Split Billing is applicable, Aetna will charge the Contract Holder and each Member a monthly premium (comprised of both Member Premiums and Contract Holder Premiums aggregating to a "Split Billing Premium") determined by Aetna based on the Split Billing Premium in effect on the Premium Due Date, as stated in the Financial Documents.

"Member Premium", "Contract Holder Premium" and "Split Billing Premium" are collectively referred to herein as "Premium".

Members shall pay all Member Premium and the Contract Holder shall pay all Contract Holder Premium to Aetna on or before each Premium Due Date. Membership as of each Premium Due Date will be determined by Aetna in accordance with Aetna's Member records.

Aetna may change the rates for the Member Premium, the Contract Holder Premium and the Split Billing Premium and the Covered Benefits at the beginning of any Subsequent Term. The applicable Financial Document may identify certain circumstances when Aetna may change the rates for the Contract Holder Premium or the Split Billing Premium (other than the Member Premium portion) during the Term.

A Premium payment check does not constitute payment until it is honored by a bank. Aetna may return a check issued against insufficient funds without making a second deposit attempt.

Aetna may accept a partial payment of Premium without waiving the right to collect the entire amount due. If the Group Agreement terminates for any reason, the Members will continue to be held liable for all Member Premiums due and unpaid before the termination and the Contract Holder will continue to be held liable for all Contract Holder Premiums due and unpaid before the termination.

3.2 **Membership Adjustments.** Aetna may make retroactive additions of Members at its discretion based upon Aetna's eligibility and enrollment guidelines consistent with all Mandates. Such additions are subject to the payment of all applicable Premiums.

Aetna may also make retroactive adjustments to the Contract Holder's billings for the termination of Members, but only for a maximum of 1 billing periods.

Section 4. ENROLLMENT/DISENROLLMENT

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

- At least once during the Term, the Contract Holder shall hold an open enrollment period ("Open Enrollment Period") when all eligible individuals may enroll in the Plan(s). The Open Enrollment Period shall be held at the same time as the open enrollment period for all other group health benefit plans being offered by the Contract Holder to retirees.
- The Contract Holder shall also enable all eligible individuals to enroll in the Plan(s) within 31 days of becoming eligible to receive coverage under the Plan(s).

All eligible individuals and dependents not enrolled in the Plan(s) within the Open Enrollment Period or within 60 days of becoming eligible may be enrolled during any subsequent Open Enrollment Period. Coverage under the Plan(s) will not become effective until confirmed by Aetna. The Contract Holder shall permit Aetna

representatives to meet with eligible individuals and dependents during each Open Enrollment Period.

4.2 **Eligibility.** The Contract Holder shall not change the Open Enrollment Period or any other eligibility requirements of the Plan(s) unless Aetna agrees to the change in writing. Actively working employees and their dependents are not permitted to enroll in the Plan(s).

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 Contract Holder to accept enrollment/disenrollment requests on its behalf.

Aetna will not be liable to Members for the fulfillment of any obligation before Aetna receives enrollment and eligibility information for the Member in a form satisfactory to Aetna. The Contract Holder must notify Aetna of the date in which a Member's eligibility ceases for the purpose of termination of coverage under this Group Agreement.

SECTION 5. TERMINATION

5.1 **Termination by Contract Holder.** The Contract Holder may terminate this Group Agreement in its entirety or in any particular Service Area, for any reason, by giving Aetna at least 60 days prior written notice of when such termination will become effective. The notice shall specify the effective date of the termination, which shall be the first day of the month, and the Plan(s) and Service Areas to be terminated if not the entire Group Agreement. *(Note: Aetna requires 60 days' notice in order to provide sufficient time to meet the CMS requirement to provide Members with at least 21 calendar days' notice of termination.)*

5.2 **Termination by Aetna.** An individual Member's coverage under this Group Agreement may be terminated by Aetna in compliance with Mandates if all Member Premiums are not received by Aetna from that Member within 3 months following the Premium Due Date (the "Member Grace Period").

If the Contract Holder has not paid all Contract Holder Premiums within 30 days following the Premium Due Date (the "Contract Holder Grace Period"), Aetna may terminate the Group Agreement immediately upon notice to Contract Holder.

This Group Agreement may also be terminated by Aetna as follows:

- Upon 30 days written notice to the Contract Holder if the Member Premiums owed by ten percent or more of Members remain unpaid at the end of the applicable Member Grace Period;
- Upon 30 days notice to the Contract Holder if the Contract Holder has committed fraud or any intentional misrepresentation of a material fact relevant to the coverage provided under this Group Agreement;
- Effective upon any anniversary of the Effective Date if Aetna will no longer offer any of the products most recently offered to Contract Holder in any Service Areas covered under this Group Agreement, because: (1) CMS terminates or otherwise non-renews the Aetna's CMS Contract, or (2) Aetna terminates its CMS Contract or reduce the Service Areas referenced in Aetna's CMS Contract;
- Immediately upon notice to the Contract Holder if the Contract Holder no longer has any Member under the Plan(s) who resides in the Service Area;
- Upon 30 days' written notice to the Contract Holder if the Contract Holder (i) breaches a provision of this Group Agreement and such breach remains uncured at the end of the notice period; (ii) fails to meet Aetna's contribution or participation requirements applicable to this Group Agreement as set forth in the applicable Financial Document; (iii) provides 30 days' written notice to Members stating that coverage under this Group Agreement will no longer be provided to Members; (iv) changes its eligibility or participation requirements without Aetna's consent; or (v) 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 90 days' written notice to the Contract Holder (or such shorter notice as may be permitted by Mandates, but in no event less than 30 days) if Aetna ceases to offer a product or coverage in any market in which Members covered under this Group Agreement reside;
- Upon 60 days' written notice to the Contract Holder for any other reason which is acceptable to CMS and consistent with HIPAA or other Mandates; or
- Upon 60 days' written notice to the Contract Holder if the Contract Holder is a member of an employer-based association group, and the Contract Holder's membership in the association ceases.

This Group Agreement may also be terminated in part as to a particular Plan within one or more Service Areas by Aetna upon any anniversary of the Effective Date if Aetna will no longer offer that Plan in any Service Areas covered under this Group Agreement because (1) CMS terminates or otherwise non-renews the applicable Aetna CMS Contract, (2) Aetna terminates the applicable CMS Contract or reduce the Service Areas referenced in the applicable CMS Contract, or (3) Aetna or Contract Holder cease 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.

5.3 **Effect of Termination.** No termination of this Group Agreement will relieve Aetna or the Contract Holder 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 Contract Holder must continue to pay all Contract Holder Premiums due and unpaid before the termination, including Member Premiums and Contract Holder Premiums due during the applicable Member or Contract Holder Grace Period. Members also remain responsible for Member cost sharing and other required contributions during the Member Grace Period.

5.4 **Auto-Enrollment Upon Termination of Plan**. This Section 5.4 only applies if Contract Holder terminates this Group Agreement or any Plan is terminated in any Service Area, and Contract Holder elects to offer health insurance policies to Members through a public or private exchange in which Contract Holder participates.

If this Group Agreement is terminated or any Plan is terminated in any Service Area, certain Mandates permit Aetna to disenroll Members from the Plan and automatically enroll such Members in a comparable individual Medicare plan offered by Aetna ("Aetna Individual Medicare Plan"), unless the Member opts out or makes another health plan choice.

The Contract Holder agrees that if it establishes a Health Reimbursement Account ("HRA") and provides a subsidy for use by Members to pay health insurance premiums for individual health insurance policies, the Contract Holder will allow Members who are automatically enrolled in an Aetna Individual Medicare Plan as described in this Section 5.4 to continue to receive the same level of subsidy and use such HRA to pay the health insurance premium for the Aetna Individual Medicare Plan. The Contract Holder will not limit such Members' use of the HRA solely to health insurance policies issued through a public or private exchange in which the Contract Holder participates.

Section 6. PRIVACY AND SECURITY OF INFORMATION

6.1. **Compliance with Privacy and Security Laws.** Aetna and the Contract Holder 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.** Aetna will not provide protected health information ("PHI"), as defined in HIPAA, to the Contract Holder, and the Contract Holder will not request PHI from Aetna, unless the Contract Holder has provided the

certification required by 45 C.F.R. § 164.504(f) and amended the Contract Holder's Plan documents to incorporate the necessary changes required by such rule.

Section 7. INDEPENDENT CONTRACTOR RELATIONSHIPS

7.1. **Relationship Between the Parties.** The relationship between the Parties is a contractual relationship between independent contractors. Neither Party is an agent or employee of the other in performing its obligations pursuant to this Group Agreement.

Relationship Between Aetna and Network Providers. The relationship between Aetna and providers contracted with Aetna 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 Aetna nor is Aetna an agent or employee of any Network Provider.

Network Providers are solely responsible for any health services rendered to their patients. Aetna 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 Contract Holder or Members, subject to Mandates. Network Providers provide health care diagnosis, treatment and services for Members. Aetna 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 Aetna and CMS under which Aetna 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 Plan(s), subject to the terms and conditions of this Group Agreement and the EOC.

8.8. "Party, Parties" means Aetna and the Contract Holder.

Section 9. MISCELLANEOUS

9.1. **Delegation and Subcontracting.** Aetna may delegate functions and services under this Group Agreement to third party vendors (i.e., pharmacy, behavioral health vendors). Aetna's arrangements with third party vendors are subject to change in accordance with Mandates. Aetna shall be responsible for its third party vendors, including their compliance with Mandates and other legal requirement.

9.2. **Disease Management and Care Management Programs**. From time to time, Aetna 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"). Aetna will administer Disease and Care Management Programs consistent with any applicable Mandates. The Contract Holder acknowledges that Aetna may alter or discontinue the Disease and Care Management Program offered to Members at any time, consistent with all Mandates.

9.3. **Prior Agreements; Severability**. As of the Effective Date, this Group Agreement replaces and supersedes all other prior agreements between the Parties as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the Parties related to matters covered by this Group Agreement or the documents incorporated herein. If any provision of this Group Agreement is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this Group Agreement shall continue in full force and effect.

9.4. Claim Determinations and Administration of Covered Benefits. Aetna is a fiduciary for the purpose of Section 503 of Title 1 of ERISA. Aetna 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. Aetna shall be deemed to have properly exercised such authority unless it abuses its discretion by acting arbitrarily and capriciously. Aetna'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.

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

- No statement made by the Contract Holder 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.
- No statement made by Contract Holder shall be the basis for voiding this Group Agreement after it has been in force for two years from the Effective Date.

9.6. **Assignability.** No rights or benefits under this Group Agreement are assignable by Contract Holder to any other Party unless approved in advance by Aetna. Aetna may without Contract Holder's consent (but upon 30 days' written notice to Contract Holder) assign this Group Agreement to an affiliate, consistent with CMS requirements without the prior approval of the Contract Holder.

9.7. **Waiver.** Aetna'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 Aetna's right to implement or insist upon compliance with that provision at any other time or times.

9.8. **Conflict.** In the event of a conflict between the terms of this Group Agreement and any of the Incorporated Documents or among any of the Incorporated Documents, the order of priority shall be as the listing of incorporated documents set forth in the second paragraph of this Group Agreement. Any riders, amendments, inserts and attachments shall have the same priority as the document to which they are attached.

9.9. **Third Parties.** This Group Agreement does not give any rights or impose any obligations on third parties except as specifically provided herein.

9.10. **Non-Discrimination.** The Contract Holder 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.

9.11. **Compliance with Mandates; Amendment to Comply with Mandates.** Aetna and the Contract Holder shall comply with all Mandates applicable to the performance of their respective obligations under this Group Agreement. The Contract Holder shall comply

with the applicable provisions of the CMS/Regulatory Addendum, which is designed to ensure Contract Holder's and Aetna's compliance with specific Mandates.

9.12. **Applicable Law.** This Group Agreement shall be governed and construed in accordance with applicable federal law and the applicable law, if any, of the State of Florida .

9.13. **Force Majeure.** If due to circumstances not within Aetna's reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Aetna's Network Providers or entities with whom Aetna has contracted for services under this Group Agreement, or similar causes, the provision of medical or hospital benefits or other services provided under this Group Agreement is delayed or rendered impractical, Aetna shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by Aetna on the date such event occurs. Aetna is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

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

9.15. **Coordination of Benefits.** This Section 9.15 applies solely if the Contract Holder is a Member's former employer and the Member sustains a work related injury before he or she leaves employment, regardless of when symptoms become evident. In such event, the Contract Holder shall protect Aetna's interests in any workers' compensation claims or settlements with any Member by reimbursing Aetna for all paid medical expenses which have occurred as a result of the work related injury that is compensable or settled in any manner.

Upon Aetna's request, the Contract Holder shall also submit a monthly report to Aetna listing all workers' compensation cases for Members who have outstanding workers compensation claims involving the Contract Holder. The list shall contain the name of the Member, the date of loss and the diagnosis.

9.16. **Notices.** Any notice required or permitted under this Group Agreement shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application, or to

any more recent address of which the sending Party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.17. **Amendments.** This Group Agreement may be amended as follows:

- This Group Agreement shall be deemed to be automatically amended to conform with all Mandates promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over Aetna;
- By mutual written agreement between both Parties; or
- By Aetna upon 30 days' written notice to the Contract Holder.

The Parties agree that an amendment does not require the consent of any Member or other person. Except for automatic amendments to comply with Mandates, all amendments to this Group Agreement must be approved and executed by Aetna.

9.18. **Clerical Errors.** Clerical errors or delays by Aetna 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. Aetna may also modify or replace a Group Agreement, EOC or other document issued in error.

9.19. **Misstatements.** If any fact as to the Contract Holder or a Member is found to have been misstated, an equitable adjustment of Premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.20. **Public Records.** This Group Agreement is subject to the provisions of Chapter 768.28, Florida Statutes, except to the extent that Chapter 768.28, Florida Statutes conflicts with laws, rules and regulations applicable to the Medicare Advantage and Medicare prescription drug benefit programs, and nothing herein shall be considered a waiver of any of Contract Holder's statutory or constitutional sovereign immunity protections.

This Group Agreement is subject to Chapter 119, Florida Statutes, except to the extent that Chapter 119, Florida Statutes conflicts with federal laws, rules and regulations applicable to the Medicare Advantage and Medicare prescription drug benefit programs, including those CMS requirements set forth in Section 2.0 of the CMS/Regulatory Requirements Addendum to this Agreement. Aetna specifically acknowledges its obligations to comply with section 119.0701, Florida Statutes, with regard to public records, and shall:

1) keep and maintain public records that ordinarily and necessarily would be required by the Contract Holder in order to perform the services required under this Group Agreement;

2) upon request from the Contract Holder, provide the Contract Holder with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes, or as otherwise provided by law;

3) ensure that public records that are exempt for confidential and exempt from public records disclosure requirements are not disclosed, except as authorized by law; and

4) meet all requirements for retaining public records and transfer, at no cost to the Contract Holder, all public records in possession of Aetna upon termination of this agreement and destroy any duplicate public records that are exempt for confidential and exempt from public records disclosure requirements, as permitted under Mandates. All records stored electronically must be provided to the Contract Holder in a format that is compatible with the information technology system of the Contract Holder.

   If Aetna has questions regarding the application of Chapter 119, Florida statutes, to Aetna's duty to provide public records relating to the contract, contact the Custodian of Public Records at 239-533-2221. Address: 2115 Second Street, Fort Myers, Florida 33901, publicrecords@leegov.com;http://www.leegov.com/publicrecords

Signed as of the Effective Date.

Aetna:

By: Richard A. Frommeyer

Richard A. Frommeyer

Vice President, Group Medicare

Lee County Board of County Commissioners:

By: Brian Hamman

Name: Brian Hamman

Title: Chair

Approved as to Form for the
Reliance of Lee County Only

By: Andrea Fraser
Office of the County Attorney

CMS/REGULATORY REQUIREMENTS ADDENDUM

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

Section 1.0 CMS Uniform Premium Requirements.

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

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

- Contract Holder 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 Aetna must be passed through to reduce the amount of any required MA Premium payment by the Member.

1.2 **Part D – Premium and Low Income Subsidy Requirements**. This Section 1.2 applies only if Aetna is offering an Aetna Medicare Rx Plan or a Medicare Advantage HMO and/or PPO plan with Medicare prescription drug plan benefits to Members.

Contract Holder will comply with the following conditions with respect to any subsidization of that portion of Premiums paid by Contract Holder for the Medicare Prescription Drug benefit ("PD Premium") and any required PD Premium contribution by the Member:

- Contract Holder may subsidize different amounts of PD 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). Classes of Members and their dependents cannot be based on eligibility for the Low Income Subsidy ("LIS").
- PD Premium contribution levels cannot vary for Members within a given class.
- Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required PD Premium payment by the Member ("Member

Contribution") so the Member in no event shall be required to pay more than the sum of: a) the standard Medicare Part D premium, net of the direct subsidy payment from CMS, and b) one hundred percent (100%) for any supplemental coverage selected by the Member.

Contract Holder shall comply with the following conditions with respect to any LIS payment received from CMS for any LIS-eligible Member:

- Any monthly LIS payment received from CMS for an LIS-eligible Member shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of the Contract Holder's PD Premium contribution. However, if the sum of the Member Contribution and Contract Holder's PD Premium is less than the LIS payment, any portion of the LIS payment will be returned to CMS by Aetna.
- If the LIS payment for any LIS-eligible Member is less than the Member Contribution required by such individual (including the Member Contribution for supplemental benefits, if any), Contract Holder shall communicate with the LIS-eligible Member about the cost of remaining enrolled in Contract Holder's Plan versus obtaining coverage as an individual under another Medicare Part D Prescription Drug plan.
- In the event that the LIS-eligible Member is due a refund of the LIS payment (i.e., there was no upfront reduction of the PD Premium by the LIS amount), such refund shall be completed by Aetna or Contract Holder, as applicable, within 45 days of the date Aetna receives the LIS payment for that Member from CMS.

Section 2.0 Records.

2.1 **Maintenance of Information & Records**. Contract Holder 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**. Contract Holder will provide Aetna 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"). Contract Holder agrees to provide Aetna 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.

Section 3.0 Medicare Secondary Payer Requirements. Records.

3.1 **Generally**. Aetna and Contract Holder agree to comply with all Medicare Secondary Payer ("MSP") Mandates that apply to Contract Holder, the Plan and Aetna ("MSP Requirements").

3.2 **MSP Requirements Applicable to Medicare Beneficiaries Diagnosed with End Stage Renal Disease ("ESRD")**. Aetna and Contract Holder agree to comply with all MSP Requirements applicable to Contract Holder'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 Contract Holder 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 Contract Holder ("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 Contract Holder and regardless of whether the ESRD Beneficiary is a current employee or retiree.

3.4 To ensure Aetna's and Contract Holder's compliance with ESRD MSP Requirements, Contract Holder agrees to confirm to Aetna 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 Contract Holder seeks to enroll an ESRD Beneficiary in a Plan, Contract Holder agrees to provide Aetna, upon request, with information or documentation to verify compliance with ESRD MSP Requirements, including any MSP reporting or other requirements established by CMS.

Section 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, Aetna 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.

Section 5.0 CMS Enrollment & Disenrollment Requirements.

5.1 To the extent that Contract Holder directly accepts enrollment and/or disenrollment requests from potential Members or Members that Contract Holder forwards to Aetna

for processing and submission to CMS, Contract Holder 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, Contract Holder will forward enrollment and disenrollment forms completed by potential Members or Members to Aetna 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 Contract Holder and when the enrollment/disenrollment request is received by Aetna, the enrollment/disenrollment transaction may not be processed by CMS, unless Aetna requests and CMS approves a retroactive enrollment/disenrollment transaction for the Member. Aetna will determine whether to submit retroactive enrollment and disenrollment transaction requests to CMS, and will make such determinations in accordance with Mandates.

All Members must be notified that they will be enrolled in a Plan. CMS requires that this notice be provided by Aetna or Contract Holder 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 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 Aetna received the enrollment or disenrollment request from the Contract Holder, and the enrollment or disenrollment form must be completed and signed by the Member prior to the requested enrollment or disenrollment effective date.

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

5.4 If Contract Holder elects to change Plan coverage offered to Members or to terminate a Member's coverage under the Plan(s), Contract Holder 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. Aetna will assist Contract Holder with developing appropriate notices.

5.5 Aetna 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. Aetna will work with Contract Holder 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 Contract Holder will produce, at Aetna's request, the original copy of any enrollment or disenrollment form or record received by Contract Holder.

Section 6.0 Notices to Members.

6.1 **Notice re Changes.** Contract Holder 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 Contract Holder does not distribute notices as required under this Section 6.0 Aetna may, at its discretion, distribute such notices to Members.

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

6.3 **Member Plan Materials.** The Contract Holder shall cause any Member Plan materials that have not been approved by CMS to comply with ERISA or, in the case of a non-ERISA Plan, any applicable alternative regulatory disclosure requirements.

6.4 **Plan Reporting and Disclosure Requirements.** The Contract Holder agrees that it is responsible for any and all Plan reporting and disclosure requirements imposed by ERISA and other applicable law, including updating the Summary of Benefits and Coverage (SBC) or Summary Plan Description (SPD) and other Plan documents and issuing any necessary summaries of material modifications to reflect any changes in benefits.

Section 7.0 Service Area Extension & Network Adequacy for Plan. This Section 7.0 only applies if Aetna 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").

Aetna and Contract Holder agree that Aetna 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 Aetna 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 Aetna MA HMO or PPO plans offered by Contract Holder must be enrolled in an Aetna 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, Contract Holder 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 Aetna 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.

AETNA MEDICARE ADVANTAGE HMO AFFILIATE ADDENDUM

Aetna's Medicare Advantage HMO Plans are offered by the following licensed HMOs or their successors in the following states:

State of Member's Permanent Residence	Aetna Affiliate offering the Plan[1]
Arizona, Colorado, Delaware, Illinois, Kansas, Kentucky, Maryland, Massachusetts, Missouri, Nevada, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Virginia & District of Columbia	Aetna Health Inc., a Pennsylvania corporation
California	Aetna Health of California Inc.
Arkansas, Kansas, Missouri, Illinois & Oklahoma	Coventry Healthcare of Missouri, Inc.
Connecticut	Aetna Health Inc., a Connecticut corporation
Florida & Iowa	Aetna Health Inc., a Florida corporation
Georgia	Aetna Health Inc., a Georgia corporation
Louisiana	Aetna Health Inc., a Louisiana corporation
Maine	Aetna Health Inc., a Maine corporation
New Jersey	Aetna Health Inc., a New Jersey corporation
New York	Aetna Health Inc., a New York corporation
Texas	Aetna Health Inc., a Texas corporation
Utah & Wyoming	Aetna Health of Utah Inc.
West Virginia	Coventry Health Care of West Virginia, Inc.

With regard to Medicare Advantage HMO Plans, "Aetna" means the licensed HMO(s) identified in the above table corresponding to each Member's state of permanent residence ("Affiliate"). To the extent that there are no Members permanently residing in a state or states listed in this Addendum, the corresponding Affiliate is not a party to this Group Agreement. Aetna may without Contract Holder's consent (but upon 30 days' prior written notice to Contract Holder) update this Addendum to change the list of Affiliates from time to time, consistent with CMS requirements. Aetna will provide an updated list of Affiliates to Contract Holder on reasonable request.

[1] The Affiliates that offer Medicare Advantage HMO plans to Members in the states of Illinois and Missouri vary. Aetna will provide a list of Affiliates offering Medicare Advantage HMO plans to Members in these two states to Contract Holder on reasonable request.

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MEDICARE ADVANTAGE RATE PROPOSAL

Plan Sponsor Name:	**Lee County Board of County Commissioners**
Group Number:	**AE467172**
Policy Period Start Date:	**01/01/2021**
Policy Period End Date:	**12/31/2021**
Medical Plan:	**Medicare (V01) ESA PPO**
Pharmacy Plan:	**Rx $10/$20/$35/$35**

- Please refer to the Financial Conditions and Plan Design Exhibits for an outline of the level of benefits quoted, as well as the terms and conditions of this proposal.
- Your Aetna Group Medicare Plan for January 1, 2021 will be automatically renewed if we do not hear from you by October 1, 2020.
- Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year and are subject to CMS contract approval.
- All rates are on a Per Member Per Month (PMPM) basis.
- These rates exclude commissions.
- **Affordable Care Act – fees and assessments** -The Affordable Care Act (ACA) imposes several fees/assessments. The Health Insurance Provider Fee (HIF) is one such fee and was applicable in 2020, but a federal omnibus bill signed on December 20, 2019 repealed the HIF for 2021 and beyond.

NATIONAL RATES

	Medical Rate	Pharmacy Rate	Total Rate
Current	$148.32	$231.47	$379.79
Proposed	$133.89	$250.36	$384.25
Change	-$14.43	$18.89	$4.46

Total Medicare Eligible Members	493

State	Medicare Eligible Members	Medical Rate	Pharmacy Rate	Total Rate
Arizona	1	$133.89	$250.36	$384.25
Arkansas	2	$133.89	$250.36	$384.25
California	3	$133.89	$250.36	$384.25
Florida	424	$133.89	$250.36	$384.25
Georgia	8	$133.89	$250.36	$384.25
Illinois	2	$133.89	$250.36	$384.25
Indiana	1	$133.89	$250.36	$384.25
Kentucky	1	$133.89	$250.36	$384.25
Louisiana	1	$133.89	$250.36	$384.25
Michigan	5	$133.89	$250.36	$384.25
Mississippi	2	$133.89	$250.36	$384.25
Missouri	1	$133.89	$250.36	$384.25
North Carolina	11	$133.89	$250.36	$384.25

Ohio	5	$133.89	$250.36	$384.25
Pennsylvania	5	$133.89	$250.36	$384.25
South Carolina	6	$133.89	$250.36	$384.25
Tennessee	7	$133.89	$250.36	$384.25
Texas	1	$133.89	$250.36	$384.25
Virginia	7	$133.89	$250.36	$384.25
Wisconsin	0	$133.89	$250.36	$384.25