AGREEMENT TO CLARIFY TERMS

This agreement is dated December 2, 2025 and is between Aetna Life Insurance Company, a Connecticut company in its role as a stop loss insurer ("Insurer"), and Lee County, a Florida county in its role as insured under a stop loss insurance policy ("Insured").

The Insured has purchased stop loss coverage from the Insurer and is covered under Stop Loss Policy 811673. In discussions between Insured and Insurer, both parties want to clarify the meaning and interpretation of certain terms in the Policy.

Insured and Insurer therefore agree as follows:

1. **Scope of Agreement; Binding Nature.** This agreement is a legally binding and enforceable contract between the parties and governed by Florida State law, without giving effect to its principles of conflicts of law. The Policy shall be interpreted and construed in accordance with the language contained in this agreement. In the event that the Policy and this agreement directly conflict, the terms of this agreement shall prevail. The terms of this agreement shall be incorporated into the Policy.

2. **Term.** The terms of this agreement shall be effective as of January 1, 2026, and shall remain inforce for the term of the Policy.

3. **Clarifications.**
   a. *Applicable Law.*
   The Policy will be construed in accordance with Florida law.

   b. *Optional Policy Renewal*
   The policy will renew on the policy anniversary date, only upon the insured's written acceptance of the renewal terms, unless it has otherwise terminated or is subject to termination in accordance with the termination provisions.

   c. *Subrogation/Right of Recovery.*
   Should the Plan refuse to pursue any claims or actions against a responsible party, then Plan Sponsor agrees that Aetna will be subrogated or assigned Plan Sponsor's reimbursement rights and shall assume the plan's rights to pursue any claims against any parties.

   Subject to the provisions of Florida Statutes section 768.28, should the Plan Sponsor refuse to pursue any claims or actions against a responsible party within 120 days after receipt of a written request from Aetna, the Plan will be responsible for any reasonable expenses incurred in the pursuit of such claims, including the fees and costs charged by a contracted subrogation vendor or

attorney and any additional legal costs.

d. *Notice of Actions.*
Subject to the provisions of Florida statute section 768.28, the Insured will be responsible for attorney's fees, expenses of experts and investigations, and any damages (excluding exemplary or punitive damages) payable by Aetna in connection with any litigation in which Aetna is determined by a Court of Law to have no fault or liability where Aetna becomes involved through or on account of this Policy or the Plan.

If any time limitation of this policy is less than that permitted by the law of Florida, the limitation is hereby extended to agree with the minimum permitted by the law of Florida.

4. **Incorporation of Insured's Solicitation Documents.** To procure the products and services supplied by the Insurer, the Insured issued Lee County Solicitation No. RFP250254JLO on September 12, 2025, which is deemed incorporated into this agreement as if attached hereto. The Insurer's submission in response to the Insured's solicitation is also incorporated into this agreement as if attached hereto.

5. **Severability.** The parties intend as follows:
   a. that if any provision of this agreement is to be held to be unenforceable, then that provision will be modified to the minimum extent to make it enforceable, unless that modification is not permitted by law, in which case that provision will be disregarded;

   b. that if an unenforceable provision is modified or disregarded in accordance with this section, then the rest of the agreement will remain in effect as written; and

   c. that any unenforceable provision will remain as written in any circumstances other than those in which the provision is held to be unenforceable.

6. **Counterparts.** If the parties sign this agreement in several counterparts, each will be deemed an original, but all counterparts together will constitute one instrument.

7. **Entire Agreement.** This agreement supersedes all other agreements, whether written or oral, between the parties on clarifications and interpretation of the Policy. It does not supersede or limit the Insured's rights under the Policy but provides common understanding between the parties regarding terms in the Policy.

The parties are signing this agreement on the date stated in the introductory clause.

WITNESS:

Signed By: James Chapdelaine

Print Name: James Chapdelaine

AETNA LIFE INSURANCE COMPANY

Signed By: Shannon Blakeslee

Print Name: ShannonBlakeslee

Title: Lead Director, Medical Underwriting

Date: 11/25/2025

LEE COUNTY

BOARD OF COUNTY COMMISSIONERS
OF LEE COUNTY, FLORIDA

Signed By: Signed by: Cecil Pendergrass
773513F34F2140B...

Print Name: Cecil Pendergrass

Title: County Commissioner- Chairman

Date: 12/8/2025 | 11:48 AM EST

ATTEST:
CLERK OF THE CIRCUIT COURT

DS
SEAL

BY: Signed by: kevin karnes
7687653FFAF549B...

APPROVED AS TO FORM FOR THE
RELIANCE OF LEE COUNTY ONLY:

BY: Signed by: Andrea Fraser
07BDA4624B5E448...

OFFICE OF THE COUNTY ATTORNEY

Aetna Life Insurance Company
Stop Loss Application and Schedule of Insurance

151 Farmington Avenue
Hartford, CT 06156

Policyholder Information

Policyholder name (full legal name of entity): LEE COUNTY BOARD OF COUNTY COMMISSIONERS

Street:	2115 2ND ST.		
City:	FORT MYERS	State: FL	Zip Code: 33901
Email:	hpeterson@leegov.com	Phone: (239) 533-0822	

Policy period start: 01/01/2026 Policy period end: 12/31/2026

Total number of employees/covered units covered under the policy: 4,325

Pre-65 Retirees: ☑ Included ☐ Excluded | Retirees 65+: ☑ Included ☐ Excluded

Medical paid claims basis: ☐ Issued ☑ Cleared ☐ N/A

Business Type: ☐ Corporation ☑ Government ☐ Association ☐ Union ☐ Other

Affiliates or subsidiaries included? ☑ No ☐ Yes If yes, list name(s) and address state of the primary location(s) below.

Affiliate full legal name(s):	Address state of Primary location(s):
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Third Party Administrator? ☑ No ☐ Yes If yes, complete for each administrator or vendor.

Medical:

Prescription drug:

Other:

Individual Stop Loss Coverage (ISL)

Individual Stop Loss coverage? ☐ No ☑ Yes | Individual Stop Loss amount: $475,000

Does individual Stop Loss amount differ by plan or class? ☑ No ☐ Yes

If yes, please include the plan(s)/class(es) and amounts below.

Plan/class:	Individual Stop Loss amount: $
Plan/class:	Individual Stop Loss amount: $
Plan/class:	Individual Stop Loss amount: $

Plan/class: Individual Stop Loss amount: $

Plan/class: Individual Stop Loss amount: $

High risk individual Stop Loss amount(s)* included? ☐ N/A ☑ No ☐ Yes **See Coverage Limitations identified below.*

Covered benefits: ☑ Medical ☑ Prescription drug ☐ Other

Contract type: Claims incurred from through or ☑ paid basis

Claims paid from 01/01/2026 through 12/31/2026

Maximum run-in claims: ☑ N/A or $ ☐ per covered person ☐ in total

Individual coinsurance percentage reimbursable: 100%

IOE transplant Stop Loss amount: ☐ N/A ☑ No or $

Family individual Stop Loss amount: ☐ N/A ☑ No or $

Aggregating Specific Stop loss amount: ☐ N/A ☑ No or $

Maximum lifetime individual Stop Loss payment amount: ☑ Unlimited or $

Experience Refund Option included? ☐ N/A ☑ No ☐ Yes

Experience refund period: Start date through

Loss ratio threshold: % Refund share: %

Maximum refund: % Large claim adjustment: ☑ No or Adjustment is:

Large claim identifier: Date of birth:

Large claim identifier: Date of birth:

Large claim identifier: Date of birth:

Large claim identifier: Date of birth:

Large claim identifier: Date of birth:

Premier product included? ☐ N/A ☑ No ☐ Yes

Renewal risk cap included? ☐ N/A ☑ No ☐ Yes Cap: %

Other rate cap included? ☑ N/A ☐ No ☐ Yes Cap: %

Terminal run-out coverage for claims incurred prior to policy termination and paid after termination? ☑ No ☐ Yes

Terminal reserve or liability period: months

Reimbursement types:

Immediate reimbursement (Aetna as claims administrator): ☐ N/A ☐ No ☑ Yes

Individual accelerated claim reimbursement (TPA as claims administrator): ☐ N/A ☑ No ☐ Yes

Other conditions or provisions:

Aggregate Stop Loss Coverage (ASL)

Aggregate Stop Loss coverage? ☑ No ☐ Yes | Aggregate Stop Loss percentage: %

Covered benefits: ☐ Medical ☐ Prescription Drug ☐ Dental ☐ Vision ☐ Other

Contract type: Claims incurred from through or ☐ paid basis

Claims paid from through

Maximum run-in claims: ☑ N/A or $ ☐ per covered person ☐ in total

Individual Stop Loss insurer: ☑ Aetna or

Minimum aggregate Stop Loss amount: ☑ N/A $

Individual internal limit: ☑ N/A ☐ No ☐ Yes If yes, amount: $

Maximum annual aggregate Stop Loss payment amount? ☑ N/A ☐ No ☐ Yes If yes, amount: $

Deficit recoup provision? ☑ N/A ☐ No ☐ Yes If yes, deficit cap: %

Termination provision? ☑ N/A ☐ No ☐ Yes

Terminal run-out coverage for claims incurred prior to policy termination and paid after termination? ☑ No ☐ Yes

Terminal reserve or liability period: ☐ months

Reimbursement types:

Monthly budget feature (Aetna as claims administrator): ☑ N/A ☐ No ☐ Yes

Aggregate accelerated claim reimbursement (TPA as claims administrator): ☑ N/A ☐ No ☐ Yes

Other conditions or provisions:

Coverage Limitations

Mental Health claim expenses are ☑ Included ☐ Excluded

Transplant coverage is ☑ Included ☐ Excluded

Is the policyholder a hospital or hospital group? ☑ No ☐ Yes

If yes, are drafts suppressed for domestic claims? ☑ N/A ☐ No ☐ Yes

If yes, domestic claims are reimbursed at? ☑ N/A ☐ 100% ☐ 0% ☐ Other %

Are any of these limitations included under this Stop Loss policy?

Pre-existing conditions exclusion?	☑ No	☐ Yes
Dependent non-confinement?	☑ No	☐ Yes
Actively at Work?	☑ No	☐ Yes

High Risk Individual Stop Loss amounts:

Member Identifier	Date of Birth	Amount	Description
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	
		$	

Premium Rates and Factors

Premium rate:

ISL composite rate: $66.87 per employee per month (PEPM)

ASL composite rate: $ per employee per month (PEPM)

Terminal liability premium rate:

*Composite: $ per employee per month (PEPM) or ☑ N/A

*If individual and aggregate Stop Loss coverage is included, the premium rate is combined.

Aggregate Stop Loss factor:
Composite: $ per employee per month (PEPM) or ☑ N/A

Terminal Liability Stop Loss factor:

Composite: $ per employee per month (PEPM) or ☑ N/A

Certification and Signature

You hereby represent that the information contained in this *Stop Loss Application and Schedule of Insurance*, any *Disclosure* statement, and all other information and documents provided by you to us, is true and complete to the best of your knowledge and belief.

Printed name of authorized representative: Signature of authorized representative:

Official Title: Date:

Agent of Record

Agent's name: on file
Agent's firm: on file Tax ID #: on file
Agent's FL License #: on file
(If countersignature laws require commission sharing with a duly licensed resident agent in another jurisdiction, the above designation will be modified to the extent required by law.)

Fraud Notice

WARNING: 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.

State-specific notices:

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR: 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.

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

CO: 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. 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.

DC: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FL: 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.

KY: 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 material fact thereto, commits a fraudulent insurance act, which is a crime.

LA: 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.

ME: 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.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: 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 civil fines and criminal penalties.

NY: 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 material fact thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OH: 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.
OK: 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.
OR: 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 may be guilty of a crime and may be subject to civil fines and criminal penalties.
RI: 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.
TN: 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.
VA: Any person who, with the 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 may have violated state law.
WA: 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.
WV: 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.

Aetna Life Insurance Company

151 Farmington Avenue
Hartford, CT 06156

Stop Loss insurance policy

This **policy** is made by and between **Aetna Life Insurance Company** (**Aetna**) and

LEE COUNTY BOARD OF COUNTY COMMISSIONERS (**policyholder**)

Policy number:	811673
Policy effective date:	01/01/2026
State of issuance:	FLORIDA
Date of issuance:	November 13, 2025

Welcome to **Aetna**. This is your Stop Loss **policy**, including the *Stop Loss Application and Schedule of Insurance*. This **policy** replaces any Stop Loss **policies** previously provided and may have riders or amendments added that alter the coverage.

Throughout the **policy**:

- "You" and "your" mean the **policyholder**
- "Us," "we," and "our" mean **Aetna**
- Words in **bold** are defined in the *Glossary* section

This **policy** is underwritten by **Aetna** and governed by applicable federal law and the laws of the state of issuance shown above.

The **policy** is issued based on the **policyholder's** signed *Stop Loss Application and Schedule of Insurance*, the *Disclosure* statement, if required, and premium payments made in compliance with the terms stated in this **policy**. In return, **Aetna** agrees to pay the **policyholder** for **eligible claim expenses** for benefits covered by the self-insured **plan(s)** and exceeding the Stop Loss coverage amounts, in accordance with the *Stop Loss Application and Schedule of Insurance*, terms, and conditions of the **policy**.

All periods of coverage begin at 12:00 a.m. and end at 11:59 p.m. local time for the principal location of the **policyholder**.

Signed at **Aetna's** home office, 151 Farmington Ave, Hartford, CT 06156.

Katerina Guerraz
Executive Vice President,
Chief Operating Officer of Aetna Life Insurance Company

Angela Woodard
Director, Insurance and Risk Management

Special Notice

Important information Regarding Your Insurance

Insurance Contact Notice

In the event you need to contact someone about this insurance for any reason please contact your local Aetna representative. If you have additional questions or need to resolve complaints you may contact the insurance company issuing this insurance at the following address and telephone number:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
1-800-872-3862

Table of Contents

The policy

The entire policy

This Stop Loss **policy** is non-participating. It consists of the following documents:

- Your signed *Stop Loss Application and Schedule of Insurance*
- A signed *Disclosure*, if required
- This **policy**
- Any riders or amendments to the **policy**
- A copy of the self-insured **plan** document(s) for each benefit **plan** covered by this **policy**

A non-participating **policy** is one that you do not share (do not participate) in any surplus earnings or profit made by us. A participating **policy** is one that you share (participate) in any surplus earnings or profit made by us.

Your *Stop Loss Application and Schedule of Insurance*

We relied on your answers to all questions in the process to request coverage when we issued the **policy** to you. It is your responsibility to make sure the *Stop Loss Application and Schedule of Insurance* is accurate and complete. It is important that you notify us immediately of any mistakes that you find in your *Stop Loss Application and Schedule of Insurance*.

By applying for coverage under this **policy** and accepting its benefits, you (or the person acting for you):

- Represent that all information in your *Stop Loss Application and Schedule of Insurance* and statements given to us as part of your process to request coverage under this **policy** are true, correct and complete, to the best of your knowledge and belief
- Agree to all terms, conditions and provisions of the **policy**

If we learn that you, your **agent**, or a **covered person** defrauded us or misrepresented or omitted material facts when providing us information in the *Stop Loss Application and Schedule of Insurance*, *Disclosure*, application process, or submission requesting coverage, we may cancel the **policy**. We may also report fraud to criminal authorities. See the *Fraud, deception, or misrepresentation* section of this **policy** for more information.

Effective date

Coverage under this **policy** is not effective until:

- We have received, examined, and accepted your **plan** document(s) and all other information relevant to underwriting or premium rating, whether or not specifically requested
- We have received, examined, and accepted your signed *Disclosure* statement, if applicable
- We have received the signed *Stop Loss Application and Schedule of Insurance*
- We have received your first premium payment

Conformity with law

In the event of a conflict or apparent conflict between or among the terms and provisions of this **policy** and applicable laws of the state of issuance or federal law, the provisions in this **policy** will be given their broadest interpretation in order to reconcile the conflict or apparent conflict. If an interpretation is not possible and any provision in this **policy** conflicts with any applicable law of

the state of issuance or federal law, the provision is amended to conform to the minimum requirements of the law.

Severability

Any provision or condition of this **policy** deemed void, voidable, invalid, or otherwise unenforceable does not make any of the remaining provisions of this **policy** invalid.

Incontestability

We can take legal or other action, using statements made in signed applications, disclosures, or other documents by you, your **agent**, or any **covered person**, during the first 2 years after the **policy effective date**. However, in the event of fraud, we may take legal or other action at any time as permitted by applicable law.

The validity of this **policy** will not be contested, except for non-payment of premium, after it has been in force for 2 years from the **policy effective date**.

Policy changes

Modifications

This **policy** may be changed in whole or in part. Any change will be valid upon approval, in writing, by an officer of **Aetna**. The approved change must be endorsed and made part of this **policy**. No other person or entity has the authority to alter this **policy** in any manner.

When your consent is needed, payment of premium by the **effective date** of any change will be considered as your consent.

Waiver

Only an officer of **Aetna** may waive a requirement of the **policy**. No waiver will be valid unless it is endorsed and made a part of the **policy**.

We may fail to implement or enforce compliance with a provision of the **policy** at any given time or under any circumstance. Our failure to do so is not a waiver of our right to implement or enforce compliance with that provision at any other time or under the same or different circumstances.

Right to recalculate

Aetna has the right to recalculate premium rates and Stop Loss factors for each **policy renewal date**.

Aetna also reserves the right to change the premium rate or any **aggregate Stop Loss factor** as of the date of any change to the underlying assumptions or information that impacts the risk assumed for the insurance we are providing under the **policy** or if the change affects the initial underlying assumptions made, as of the **effective date** of coverage. Changes include, but are not limited to:

- Any change of +/- 15% in **employees** or **covered units**
- Any change to the **plan** document(s) that will change the risk assumed under this **policy**
- Any change to this **policy**
- Any addition or deletion of a unit, division, subsidiary, affiliated or associated company from this **policy**

- Any change in federal or state law or regulation that impacts this **policy** or the coverage provided
- Any change impacting the risk we have assumed, including but not limited to: age, gender, geography, occupation, incorrect or incomplete information provided in Disclosure statements, etc., that we determine impacts the nature of the risk by more than 15%
- Any change in **claims administrator**, provider network or cost containment vendor, provided we have consented to the change in writing
- Any change in the **claims administrator's** claim payment system or payment practices that causes a variation of +/- 5% versus the most recent 12 month average of claims processing time

Any failure by **Aetna** to adjust any premium rate or Stop Loss factor during a **policy period** will not prohibit us from making an adjustment during any subsequent **policy period**.

Changes to the plan

This section is applicable if **Aetna** is not your **claims administrator**, network provider, or cost containment vendor for any **covered benefit**. **Aetna** has the right to approve any change to the **plan** if the change impacts the **eligible claim expenses** or assumptions under this **policy**.

You must notify us promptly, in writing, at least 30 days before the **effective date** of any **plan** change or change in **claims administrator**, provider network, or cost containment vendor. **Aetna's** prior written agreement is required before the coverage under the **policy** will apply to the changes. Otherwise, benefits under the **policy** will be paid based on the **plan** as it existed when last approved by **Aetna**, and **Aetna** reserves the right to terminate the **policy** upon discovery of such change.

Fraud, deception, or misrepresentation

Aetna pursues all appropriate and available legal remedies in the event of insurance fraud.

The decision to issue this **policy** to you, as well as the premium rates and any Stop Loss factors associated with it, are based on information provided by you, a **covered person**, your **agent**, or **claims administrator**. If we learn that you or anyone acting on your behalf defrauded us or misrepresented or omitted material facts that we relied upon in the decision to issue this **policy** at the coverage levels and premium rates identified in this **policy**, we reserve the right to take actions that can have serious consequences for your coverage. Any behaviors on your part include, but are not limited to:

- Filing a false claim,
- Providing false, incomplete, or misleading information during the underwriting process

Potential serious consequences include, but are not limited to:

- Denial of claims
- Recalculation of premium rates or redetermination of the terms and conditions of this **policy**
- Termination of this **policy**, including retroactively back to its **effective date**
- Recovery of amounts we have already paid
- Prosecution to the full extent under state and federal law

Bankruptcy

Other than the liability required by this **policy**, we are not liable to you, your **plan**, or your **claims administrator** for:

- Bankruptcy
- Insolvency
- Financial impairment
- Receivership
- Voluntary plan of arrangement with creditors
- Your dissolution or the dissolution of your designated **claims administrator(s)** and/or vendor(s)

Your insolvency will not make **Aetna** liable to your creditors, including **covered persons** under the **plan**. In the event of your insolvency or bankruptcy, subject to the terms and conditions of this **policy**, we may pay to your receiver, trustee, liquidator or legal successor amounts otherwise payable to you under this **policy**. We will make payments only if you have paid all required premiums and have complied with your obligations under this **policy**. Nothing in this section increases our liability beyond what would have existed had you not become insolvent or bankrupt.

What is covered

Aetna will reimburse you for **eligible claim expenses** paid under the **plan** and according to the coverage levels and features indicated in the *Stop Loss Application and Schedule of Insurance* and the terms and conditions of this **policy**.

Individual Stop Loss

If the *Stop Loss Application and Schedule of Insurance* indicates an **individual Stop Loss amount** is included under this **policy**, we will pay you the amount that a **covered person's** total **eligible claim expenses** exceed the **individual Stop Loss amount** during the **policy period**, adjusted for any **contract type**, if applicable. The amount payable will also be adjusted by any applicable individual coinsurance percentage, **family individual Stop Loss amount**, or aggregating specific Stop Loss amount. The total amount payable is also subject to any **maximum annual individual Stop Loss payment amount** or **individual lifetime Stop Loss payment amount**, as indicated on the *Stop Loss Application and Schedule of Insurance*.

If the *Stop Loss Application and Schedule of Insurance* indicates an **IOE transplant Stop Loss amount** is included under this **policy**, we will pay you the amount that a **covered person's** total **eligible claim expenses** exceed the **IOE transplant Stop Loss amount** during the **policy period**, adjusted for any **contract type**, if applicable. The amount payable will also be adjusted by any individual coinsurance percentage, **family individual Stop Loss amount** or aggregating specific Stop Loss amount. The total amount payable is also subject to any **maximum annual individual Stop Loss payment amount** or **individual lifetime Stop Loss payment amount**, as indicated on the *Stop Loss Application and Schedule of Insurance*.

A **high risk individual Stop Loss amount** may be assigned to any **high risk covered person** during the underwriting process for any **policy period**, in accordance with the terms and provisions of this **policy** and as indicated in the *Stop Loss Application and Schedule of Insurance*.

If individual Stop Loss coverage terminates before the end of the **policy period**, the **individual Stop Loss amount** will not be reduced.

Individual coinsurance percentage

Once the **individual Stop Loss amount** or **IOE transplant Stop Loss amount** is met for a **covered person**, we will pay you the percentage of **eligible claim expenses** as indicated on the *Stop Loss Application and Schedule of Insurance*.

Aggregating specific amount

As indicated on the *Stop Loss Application and Schedule of Insurance*, the aggregating specific amount is an optional Stop Loss feature that adds to your liability by providing a second amount (the aggregating specific amount) that must be met before **eligible claim expenses** are reimbursed under individual Stop Loss coverage. **Eligible claim expenses** in excess of the **individual Stop Loss amount** for any **covered person** are added together until the cumulative total equals the aggregating specific amount. Once the aggregating specific amount is met, whether by one or multiple **covered persons**, it is considered satisfied for the **policy period**.

When you elect this feature, we will not pay an individual Stop Loss benefit until you have also met the aggregating specific Stop Loss amount. **Eligible claim expenses** used to satisfy the aggregating specific Stop Loss amount will apply toward the **aggregate Stop Loss corridor**.

Aggregate Stop Loss

If the *Stop Loss Application and Schedule of Insurance* indicates aggregate Stop Loss is included under this **policy**, we will pay you the amount that total **eligible claim expenses** exceed the **aggregate Stop Loss corridor** during the **policy period** adjusted for any **contract type,** if applicable. The amount payable will be reduced by any **eligible claim expenses** exceeding any:

- **Individual Stop Loss amount**
- **IOE transplant Stop Loss amount**
- **High risk individual Stop Loss amount**
- **Individual internal limit**
- Other provision of this **policy**, as applicable

The total amount payable is also subject to the **minimum aggregate Stop Loss amount** and any **maximum annual aggregate Stop Loss payment amount**, as indicated on the *Stop Loss Application and Schedule of Insurance*.

Stop Loss reimbursements

Aetna will make Stop Loss reimbursements due under the terms of this **policy** and according to the **contract type** indicated on the *Stop Loss Application and Schedule of Insurance*. If **Aetna** is not your **claims administrator**, we will reimburse you after satisfactory proof of loss is submitted by you or your **claims administrator**, according to the conditions and provisions of this **policy**.

Aetna has the right to deduct any due but unpaid premium that would otherwise be payable by you from any Stop Loss reimbursement. This right will not prevent the termination of this **policy** for non-payment of premium in accordance with the *Termination* section of this **policy**.

Any **eligible claim expense** that is reimbursable under this **policy** due to exceeding the individual, aggregate, or any other Stop Loss amounts, and that is also funded as a reimbursable **eligible claim expense** under another Stop Loss policy:

- Is not eligible for reimbursement under this **policy**
- Must be repaid to us if we previously reimbursed it

Immediate reimbursement

Benefits

Immediate reimbursement is only available when **Aetna** is the **claims administrator** for your **plan**. If you purchase individual Stop Loss coverage, **eligible claim expenses** that exceed the **individual Stop Loss amount** under this **policy** may be reimbursed on an immediate funding basis. Availability of immediate funding for individual Stop Loss reimbursements is dependent upon the **individual Stop Loss amount** and other **policy** features that you select. You will be notified by us, in writing, before the **effective** or **renewal date** if the coverage you have selected is not eligible for immediate reimbursement.

Immediate reimbursement is provided subject to the following terms and conditions:

- Essential legal documents of the **policy** must be fully executed by all applicable parties and on file with us

- Only **covered benefits** that **Aetna** administers are eligible
- The coverage levels and **policy** features selected by you must be available (i.e. system-supported) for immediate reimbursement
- **Eligible claim expenses** must exceed the **individual Stop Loss amount** and any other applicable Stop Loss amount available under individual coverage before any individual Stop Loss payment will be made

Certain claims are not eligible for immediate reimbursement. These include, but are not limited to:

- Claims paid by a third party **claims administrator**
- **Eligible claim expenses** paid outside of system-supported claim processing procedures
- Run-in claims and, under certain circumstances, run-out claims (i.e. coverage crossing multiple reimbursement periods and/or **policy periods**)

Immediate reimbursement is not a guarantee of coverage. After the end of each **policy period**, as adjusted for any **contract type**, we will perform a reconciliation to verify all individual Stop Loss reimbursements were made in accordance with the terms of the **policy**.

What is not covered – exclusions and limitations

This section outlines what is not covered as an **eligible claim expense** under this **policy**.

Exclusions related to eligibility and enrollment

- Expenses paid for an **employee**, **covered unit**, and any associated dependents that did not enroll according to the terms of the **plan** until they are enrolled in accordance with the terms of the **plan**.
- Expenses **incurred** by any individual who is not a **covered person** under the **plan** when the expense is **incurred**.
- Expenses paid for **covered persons** of a unit, division, subsidiary, affiliate, or associate company added after the **effective date** of this **policy** unless approved in writing by us prior to their **effective date** of coverage under the **plan**.
- Expenses paid for a **covered person** following termination of coverage under the **plan** for any class, unit, or division of participants that includes the **covered person** and any associated dependents.
- Expenses **incurred** by a late Consolidated Omnibus Budget Reconciliation Act (COBRA) enrollee. Except for a clerical error as described in the *General provisions* section of this **policy**, the **policy** will exclude any claim expenses for a **covered person** whose eligibility for, or coverage under, COBRA is continued beyond the timeframes specified by federal law for any reason including your clerical error. This exclusion includes those individuals who:
  - Do not receive a valid COBRA extension offer from you, in accordance with federal law, within the 30 days immediately following a COBRA qualifying event
  - Fail to make a valid, signed COBRA election within the 60 days immediately following the receipt of COBRA election rights from you
  - Fail to make COBRA premium payments within the time period specified by federal law

  We may require written documentation that these requirements have been satisfied.

Exclusions related to plan administration

- Costs related to the administration of the **plan** including, but not limited to:
  - Claim payment functions
  - Cost containment administrative fees
  - Large case management
  - Audit
  - Negotiation
  - PPO access fees
  - Premium functions
  - Claim review
  - Consultant fees
- Costs associated with extra-contractual damages, compensatory damages or punitive damages assessed against you.
- Legal expenses, court costs, or interest upon judgments.

- Expenses for taxes, fees, assessments and surcharges that may be assessed on claims under the **plan** by any government body. This exclusion does not apply to the MA Uncompensated Care Pool, Minnesota Care Provider Tax, or New York Health Care Reform Act surcharges unless the surcharge relates to excess or punitive payments made on behalf of you to fund indigent care and graduate medical education solely as a result of your decision not to pay directly into the pool.

Exclusions related to claim administration

- Expenses paid by you or the **claims administrator** that are **incurred** prior to the **effective date** of this **policy** unless otherwise indicated in the *Stop Loss Application and Schedule of Insurance*.
- Expenses for drugs or medications, treatment, services or supplies that are considered **experimental or investigational**, and any service or treatment resulting from complications of **experimental or investigational** treatment.
- Expenses paid for services, medications, or supplies that are not **medically necessary**, and any service or treatment resulting from related complications.
- Expenses resulting from treatment provided outside the United States, and any service or treatment resulting from related complications, unless approved by us in writing before the service is provided.
- Expenses paid at your direction but that we determine are not payable under the **plan**, in accordance with our current established claim practices or in excess of the **reasonable and customary** charge.
- Expenses resulting from capitation payments, defined as contractually determined, regularly-scheduled payments to certain providers based on the number of **plan** participants entitled to receive services from that provider. In return, the providers provide certain agreed-upon services to eligible **plan** participants.
- Incentive payments, care coordinator payments, risk share payments, and other non-fee-for-service payments paid or received in connection with an agreement with an accountable care or similar provider organization.
- **Eligible claim expenses** not submitted to us within 6 months after the end of the **policy period**. If the *Stop Loss Application and Schedule of Insurance* indicates coverage under a terminal liability period, terminal reserve period, or **run-out period** associated with a specific **contract type**, the 6 month submission period will begin at the end of these periods.
- Expenses for claims not submitted to the **claims administrator** within 12 months of the date **incurred**.
- Expenses for benefits that are reimbursable under any under workers' compensation or a similar program under local, state, or federal law for any illness or injury related to employment or self-employment, even if the **covered person** fails to claim rights to those benefits.

General exclusions

- If you have valid and collectible insurance, reinsurance, indemnity, or any reimbursement agreements covering **eligible claim expenses** in excess of individual, aggregate, or aggregating specific amounts also covered by this **policy**, this **policy** is in excess of and will not contribute with the other insurance, reinsurance or indemnity.
- Expenses paid for any benefits not indicated on the *Stop Loss Application and Schedule of Insurance* as **covered benefits** under any applicable i**ndividual Stop Loss amount** or **aggregate Stop Loss corridor**.

- Expenses not **incurred** or paid within the **contract type** as indicated in the *Stop Loss Application and Schedule of Insurance*.
- Expenses paid according to changes or an amendment to the **plan** not agreed to in writing by us.
- Expenses not specifically covered under the terms of the **plan**.
- Expenses for any other benefits that you and we mutually agree will not be subject to the Stop Loss insurance as indicated in this **policy**.
- **Eligible claim expenses** paid or benefits that were originally denied by the **claims administrator** and are adjusted by the **claims administrator** more than 2 years after the original coverage determination date are not eligible for coverage under the **policy**.
- Expenses for a **covered person** if the **covered person's** medical conditions or claim information was not disclosed to us as part of the underwriting of this **policy** or upon request.
- Any expense that is determined to be fraudulent.

Premium

Premium – rates

The **policy period's** monthly premium rate is indicated in the *Stop Loss Application and Schedule of Insurance*.

Premium due – calculation

Premium:

- Will be calculated and payable on a monthly basis or any other basis you and we mutually agree upon
- Is based on the premium rate indicated in the *Stop Loss Application and Schedule of Insurance* and the number of **employees** or **covered units** covered at the time the invoice is prepared
- May be adjusted due to factors outlined in the *Right to recalculate* section

Premium due – how billed and paid

We may bill you electronically and you may pay premium due to us electronically. If you are not billed electronically, you must send your premium to us at the address shown on the invoice on or before the **premium due date**.

Payment occurs when we receive sufficient funds. A check does not constitute payment until it is honored by a bank. We may return a check issued against insufficient funds without making a second deposit attempt. We may accept a partial payment of premium without waiving our right to collect the entire amount due. Premium payments will be credited first to any past due and unpaid premium, in the order it is due.

We may choose not to accept premium that is paid for you by someone else unless we are required to by law.

If the total actual premium due (determined at the financial accounting) is less than the amount of premium paid, the difference will be paid to you at the time the accounting is provided to you. If the total actual premium due exceeds the amount paid, you must pay us the difference within 30 days of the date the accounting is provided to you.

Premium – when due

Premium is due on the **premium due date**.

You will pay all premium payments in U.S. dollars no later than 15 days after the **premium due date**. If we have not received premium due by the due date, the **policy** will automatically terminate without further notice to you and all rights to benefits under this **policy** will end. Premiums will be due for any period the **policy** was in force. Refer to the *Termination* section of this **policy**.

Premium – insufficient funds and overdue amounts

A service charge may be assessed when there are insufficient funds to pay premium due.

If you don't pay your premium on time, we may charge you interest in the amount of 12% per annum on the amount that is overdue. Overdue premium includes amounts not paid by 15 days

after the **premium due date**. We may also recover from you the costs of collecting any unpaid premium, including reasonable attorney fees and costs of suit.

Aetna will reduce any payment due to you under this **policy** by:

- The amount of any premiums due and unpaid
- Any overpayments or other reimbursements made in error if incorrect information is received
- Any other amounts due to us

Termination

Automatic termination

This **policy** will terminate if:

- You have not paid us all premiums due. The **policy** and all coverage will automatically terminate on the last day of the period that premiums have been paid.
- The **plan** terminates. This **policy** will automatically terminate on the same date and time that the **plan** terminates.

Termination by the policyholder

You may terminate coverage under this **policy** effective on any **premium due date** by providing us at least 45 days advance written notice. The **policy** may also be terminated on any other date you and we agree to.

Termination by Aetna

We may terminate the **policy** and all coverage it provides under the following conditions:

- If you, your **agent**, or a **covered person** perform any act or practice that constitutes fraud or if you, your **agent**, or a **covered person** make any misrepresentation of, or any omission of, a material fact relevant to the coverage, we may cancel the **policy** and all coverage it provides, either prospectively or retroactively to the date the fraudulent event occurred or back to the **effective date** if the event occurred prior to the **effective date**. See the *Fraud, deception, or misrepresentation* section.
- If a **claims administrator**, network provider, or vendor is added, canceled, or changed without our prior written consent, we may terminate the **policy** as of the date of the change in **claims administrator**, network provider, or vendor.
- If the **plan** is changed and we have not agreed in advance and in writing to continue the **policy**, we may terminate the **policy** as of the date and time the **plan** change is effective.
- If you fail to pay claims under the **plan** or make available funds to pay claims as required by the **plan**, we may terminate the **policy** as of the first day that you failed to fund claims.
- If you fail to meet the underwriting requirements we have established in our current underwriting guidelines, including any applicable participation or contribution requirements, or fail to have a minimum 51 **employees** or **covered units** under the **plan**, we may terminate the **policy** as of the first day of the first month when the underwriting requirement was not met.
- If you do not comply with or fail to meet your obligations under any material terms and conditions of the **policy**, including, but not limited to, providing required reports or other information we have reasonably requested from you that is related to our administration of the **policy**, we may terminate the **policy** as of the date you failed to comply.
- If you suspend active business operations, become insolvent, or are placed in bankruptcy or receivership, we may terminate the **policy** as of the date any of these occur.
- If there is any change in federal or state law or regulation that materially impacts this **policy** or the coverage provided, we may terminate the **policy** effective on the date the change in the law is effective.
- If you are an employer group and cease to be a group as defined under applicable state law, we may terminate the **policy** as of the date you no longer qualify as an employer group.
- If you are an employer group that is subject to ERISA, and you become exempt from ERISA, we may terminate the **policy** as of the date you are no longer subject to ERISA.

Non-renewal for failure to respond

We require you tell us if you intend to renew the **policy**. You must reply, in writing, within 2 weeks of your receipt of the request or within 15 days prior to the **renewal date**, whichever is later. If you do not reply, we will terminate coverage as of the **renewal date**.

Effective time of termination

The **policy** and its coverage end as of 11:59 p.m. local time at your principal location on the day of termination.

Effect of termination

Following termination, you and we continue to be responsible for duties we acquired prior to the termination of the **policy**. One of your duties includes payment of premium due for coverage up to the date of termination. We are required to continue paying you for coverage of **eligible claim expenses incurred** and paid under the **plan** prior to the **termination date**.

You and we also continue to be responsible for any duties that the **policy** states are to occur following termination.

If the **policy** terminates before the end of the **policy period**:

- The **contract type** under this **policy** is limited to **eligible claim expenses incurred** and paid up to the **termination date**
- The **individual Stop Loss amount** will not be reduced
- The **minimum aggregate Stop Loss amount** will not be pro-rated

Reinstatement

You may request that we reinstate the **policy** and coverage after we terminate it. You must make the request within 30 days of the **termination date**. We are not obligated to reinstate the **policy** as of the **termination date**. If we do, we will require you to pay all amounts due in full before reinstatement and give us reasonable assurances that you can and will fulfill all of your obligations under the **policy**.

Optional policy renewal

Unless the **policy** has terminated or is subject to termination in accordance with the *Termination* section on or before the end of the **policy period**, we may offer you a renewal. At that time, we have the right to revise the terms and conditions of the **policy**, including, but not limited to, premium rates, factors, and coverage levels by providing written notice to you. If you accept the renewal provisions, the **policy** will renew on the **policy renewal date**, subject to receipt of your acceptance in writing prior to the **renewal date**.

If you use a separate **claims administrator**, a renewal offer for this **policy** is contingent upon receipt of any requested **plan**, census, or claim information for use in the underwriting process prior to the beginning of the subsequent **policy period**.

Responsibility and conduct

Responsibility for our employees

We are responsible to you for what our employees and others that work on our behalf do as it pertains to Stop Loss coverage under this **policy**. If **Aetna** is also your administrator, any disputes regarding administration of the **plan** must be brought under the terms of the *Master Services Agreement*, which determines claims administration.

We are not responsible to you for what is done by others, commonly referred to as "independent contractors."

Appeals process

You may appeal any claim determination made by us under this **policy** by submitting a written appeal to: **Aetna**, 151 Farmington Avenue, Hartford, Connecticut 06156. You must file an appeal within 60 days after the date of our determination. Your appeal must state the detailed basis of your disagreement with our determination and must include all documentation and information supporting your appeal that has not been previously provided to us.

If any claim determination made by us meets one or more of the following conditions:

- Not **medically necessary**
- Cosmetic
- **Experimental or investigational** treatment
- Requires medical judgment

then the appeal of the claim determination must include an Independent Review Organization (IRO) report that includes each panel member's report and the panel's consensus report. The IRO's report is to be provided at your expense. The members of the IRO must be mutually acceptable to you and us.

In addition, the individual Stop Loss **contract type** and the aggregate Stop Loss **contract type**, as indicated in the *Stop Loss Application and Schedule of Insurance*, will be extended for a period not to exceed 3 months to cover only reversals of claim denials. See the *IRO overturn of claim denials* section in this **policy**.

Any **eligible claim expenses** reimbursed pursuant to the terms and conditions of this **policy** will apply to the **policy period** that it was **incurred** and will be treated as if it had been paid on the date you sent notice of denial to the **covered person**. These **eligible claim expenses** will be excluded from any other **policy period**.

Arbitration

Any disagreement, controversy, or claim involving us that arises out of, or relates to, this **policy** or its breach may be settled by binding arbitration under the rules of the American Arbitration Association with the stipulation that the arbitrator(s) will abide by the terms of the **policy** and will apply the applicable rules of the law. A single arbitrator will decide all matters. Judgment for the award made by the arbitrator may be entered into any court having jurisdiction. This provision survives the termination of this **policy.**

Indemnification – in general

To the extent allowed by law, we agree to indemnify and hold you harmless against that portion of your liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by our willful misconduct, criminal conduct, or material breach of this **policy**.

To the extent allowed by law, you agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your:

- Negligence
- Breach of the **policy**
- Breach of applicable federal and state laws
- Willful misconduct
- Criminal conduct
- Fraud
- Breach of a fiduciary responsibility in the case of an action related to, or arising out of, this **policy** or your role as employer or **plan** sponsor

These indemnification rights and obligations apply during the term of the **policy** and to a claim made in writing within one year after termination of the **policy**.

Your and our rights and duties in this section survive termination of the **policy**.

Indemnification – liability

We have neither the responsibility nor the obligation under this **policy** to directly pay any **covered person** or provider of **eligible claim expenses** for any benefit you have agreed to provide through the terms of the **plan(s)**. Our only liability under this **policy** is to you, subject to the terms, conditions, and limitations of this **policy**.

No Employee Retirement Income Security Act (ERISA) of 1974 liability

Under no circumstances will we accept responsibility as an administrator or be deemed a **plan** fiduciary under your **plan**, as these terms are defined and used in the ERISA Act of 1974 and as amended.

General provisions

This section provides details on additional terms and conditions under this **policy**.

Recovery of overpayments

If **eligible claim expense** amounts change as a result of a coordination of benefit change, a subrogation recovery, audit, or billing or payment errors, we may have overpaid you. If we have overpaid you, you will promptly refund the overpaid amount to us. If you fail to refund the overpayment to us in a timely manner, we have the right to reduce any future payments due under this **policy** by the amount we overpaid until repayment is made in full. If this **policy** terminates, any reimbursements made for claims paid by you after the date of termination will immediately be refunded to us.

Reports

You will promptly provide us with any information we determine is necessary to carry out the provisions of this **policy**.

Assignment and delegation

You will not assign any right or delegate any duty under the **policy** unless we approve it in writing, and in advance. This includes assignment to any person or entity, including, but not limited to, any **covered person**, medical provider, or creditor. If you do so without our written approval, we are not bound by your assignment or delegation.

If you use any **claims administrator**, vendor, or **agent**, you are responsible for authorizing the release of any information we request to underwrite, review potential claims, make claim determinations, calculate potential reimbursements, or perform other obligations under this **policy**. If we do not receive requested information, it may result in the delay, reduction or denial of a reimbursement request.

Aetna may delegate some of our functions under this **policy** to third parties, (i.e. an authorized representative, subsidiary, affiliate or parent of **Aetna**). We may also change or end these delegations. We do not need your consent or need to give you advance notice to enter into, change, or end these arrangements. These delegations will not increase or reduce our or your rights or responsibilities under this **policy**.

We may also assign this **policy** to an affiliate within our corporate family without your consent. An assignment will not increase or reduce either of our rights or responsibilities under this **policy**.

IRO overturn of claim denials

Coverage under the **policy** will be extended for a period not to exceed 3 months from the last **paid date** of the **policy period** to cover only reversals of claim denials related to an adverse benefit determination when the claim denials by the **plan** are subsequently overturned by Independent Review Organizations (IROs), subject to the following:

- Your **plan** is subject to external review under the Affordable Care Act (ACA) and this status is communicated to us during the underwriting of the **policy**
- **Eligible claim expenses** are paid, in whole or in part, for a **covered person** due to, and consistent with, the overturning of a claim denial by an IRO conducted pursuant to the applicable external review process established under the ACA

- **Eligible claim expenses** associated with a previously denied claim were **incurred** by the **covered person** during the **policy period**
- **Eligible claim expenses** paid after the last paid claims date of the **policy period** indicated in the *Stop Loss Application and Schedule of Insurance* are not eligible for payment under any other coverage, but are otherwise payable under the terms of the **policy**
- You or your **claims administrator** advises us that the denied claim for **eligible claim expenses** has been submitted to the IRO within 10 days of being submitted to the IRO
- You have received notice from the IRO that a decision was made to pay the denied claim and that you must pay the denied claim within 10 days of receiving the decision
- You or your **claims administrator** advises us of the IRO's decision prior to payment of the claim
- Satisfactory proof that you paid the denied claim and complied with all terms and conditions of the **policy** must be submitted to us by you or your **claims administrator** within 30 days of payment of the claim

An **eligible claim expense** reimbursed pursuant to the terms and conditions above will relate back to the **policy period** it was **incurred** and will be treated as if it had been paid on the date you sent notice of claim denial to the **covered person**. These **eligible claim expenses** will be excluded from any other **policy period**.

Correcting clerical errors

A clerical error may be made by you, any **claims administrator**, a **covered person**, vendor, **agent**, or us in keeping records or providing required information. A clerical error alone will not determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in premium or factors if correction of the error or delay changes coverage or the risk assumed. **Aetna** is not required to honor a notification of a **covered person's** enrollment or termination of eligibility which **Aetna** receives more than 30 days after the qualifying event.

We may correct, withdraw, or replace the **policy**, *Stop Loss Application and Schedule of Insurance*, and any other document issued with an error or issued in error. A clerical error does not include your:

- Intentional acts
- Intentional omissions
- Failure to comply with the **plan** or this **policy**

When you use a **claims administrator** that is not **Aetna**, your failure to report the existence of a **covered person** or claimant or your failure to report notice or proof of claim loss in a timely manner does not constitute clerical error.

Legal action

The time limit on legal actions related to coverage under the **policy** is subject to applicable law in the state where the **policy** was issued.

We encourage you to complete the appeal process before you take any legal action against us for any disapproval of coverage. If you disagree with our coverage decision, you may not start legal or other action against us regarding your claim until 60 days after proof of **eligible claim expense** has been rejected by **Aetna**.

No legal action may be brought against us after 5 years from the time written proof of loss is required from you.

Cost containment

If you use a **claims administrator** or other vendor other than **Aetna**, we have the right to participate in any cost savings or cost containment program that you may have in connection with your **plan**. At our expense, we have the right to retain the services of a medical management vendor or other service provider to perform the following duties:

- Assist us with cost containment with respect to claims under the **plan**
- Provide services to you to reduce cost, risk, or expenses under the **plan**

We may also request a medical management vendor or other service provider that we may have negotiated a set or discounted rate to contact you if, in our determination, the medical management vendor or other service provider described above provides a service that may reduce the risk, costs and expenses under the **plan**.

Notice of legal actions

You agree to:

- Notify us immediately of any event or development that might result in an action of law or equity related to this **policy**
- Forward promptly to us copies of any pleadings and reports of investigation that we request
- Immediately provide to us a copy of any documents filed by or against you in any court in connection with any litigation under the **plan**

You are responsible for paying all attorneys' fees, expenses of experts and investigations, and any damages (including exemplary or punitive damages) incurred by **Aetna** in connection with any litigation in which we will, without fault, become involved through or on account of this **policy** or the **plan**.

If any time limitation in this **policy** is less than that permitted by the law of the state that the application was signed, the limitation is hereby extended to agree with the minimum period permitted by the law.

Taxes

You will hold us harmless for any taxes we are assessed that are beyond any tax payable on premium we have received. You are responsible for reimbursing us for any taxes we paid that are beyond any tax payable on premium we received.

Workers' compensation or state disability insurance

This **policy** does not replace or affect the requirements for coverage under any workers' compensation or state disability insurance.

Subrogation - right to recovery

Your **plan** is required to include a comprehensive provision for subrogation and reimbursement in its Summary Plan Description. The **plan** must enforce this provision. If you fail to pursue any recovery or action against a responsible party, then you agree that **Aetna** will:

- Be subrogated to or assigned your reimbursement rights
- Will assume the **plan's** rights to pursue any recovery against any and all parties

You will be responsible for any and all reasonable expenses incurred in the pursuit of recovery, including the fees and costs charged by any contracted subrogation vendor or attorney and any additional legal costs.

We have the right to pursue any and all recoveries covered under this **policy** and paid by the **plan**, and to pursue these actions in the name of the **plan**. This includes both the portion of the **plan** benefits that the **plan** has been paid under this **policy** and the portion of the claim consisting of benefits paid by the **plan** but not payable under this **policy**.

You:

- Must notify **Aetna** within 30 days of receiving any information that may lead to our subrogation rights
- Must cooperate fully with us and do all things necessary and required for **Aetna** to pursue any action to recover against a responsible party
- May not take any action, or neglect to take any action, that will prejudice or impair our rights to pursue recovery from any other responsible party
- May not, without our written consent, settle or give release for any claim to any other party if doing so would impair or prevent **Aetna** from exercising its rights of recovery

If the **plan:**

- Receives a recovery prior to our reimbursement of any **eligible claim expenses** under the **policy**, the **plan** must deduct the amount of the recovery from any reimbursement request
- Receives a recovery after we have made payment to the **plan** for some or all of a particular claim, the **plan** must reimburse us to the full extent of the payment made by us

We are under no obligation to reduce the amount we are due for any reason, even to help you pay for a lawyer or pay other costs you incurred to get a recovery.

The **plan** must:

- Still reimburse us regardless of whether this **policy** is still in force on the date of recovery
- Reimburse us within 30 days of any recovery by the **plan** or **plan** sponsor
- Account to us for all amounts recovered

The rights and obligations of the **plan** in this section extend beyond the termination of the **policy**.

Aetna's additional responsibilities

We will prepare the legal documents of the **policy** as required by applicable federal and state laws. We will provide them to you in electronic form. We will also provide them to you in paper form if you request it.

We will provide the coverage stated in the **policy** and *Stop Loss Application and Schedule of Insurance*. We will administer the coverage as required by the **policy** and applicable federal and state laws.

We will protect personal health information, as required by federal and state laws. We will use it and share it with others only as needed to help us administer the **policy**. For a copy of our Notice of Privacy Practices log on to https://www.aetna.com/.

Our duties in this section survive termination of the **policy**.

When Aetna is not your claims administrator

Third party administrator (TPA) responsibilities

When **Aetna** is not your only administrator or ancillary services vendor (i.e. subrogation, case management, etc.), you are solely responsible for the actions of your designated TPA, including **claims administrators**, network providers, vendors, and **agents**.

Without waiving any of our rights under this **policy**, and without making the TPA a party to this **policy**, we agree to recognize the TPA for the administration of your **plan(s)**, subject to these conditions:

- Your TPA is responsible on your behalf for:
  - Auditing, calculating, and processing all **eligible claim expenses** for the underlying **plan** within a reasonable amount of time
  - Preparing reports as required by us
  - Maintaining and making available to us, at all times, any information as we may reasonably require for proof of coverage
- Your TPA must perform any other duties as we may reasonably require, including, but not limited to, maintaining an accurate record of **covered persons** under the **plan**
- We are not responsible for, nor will this **policy** reimburse, any compensation or fees due to the TPA for functions performed by them on your behalf in relation to this **policy**

Notice from us to your TPA under the provisions of this **policy** will be considered notice to you. Also, notice from us to you will be deemed notice to the TPA.

If you engage a TPA without our prior approval, in addition to any other rights we have by law or under this **policy**, we may:

- Terminate the **policy** as of the date the unapproved TPA began to administer the **plan**
- Exclude any **eligible claim expenses** paid by the unapproved TPA

Proof of eligible claim expenses

Proof of **eligible claim expense** losses must be provided to us and must establish the nature and extent of the covered loss. **Eligible claim expenses** that are not submitted to us in accordance with the requirements of this section of the **policy** are not reimbursable and are not be considered **eligible claim expenses** under the **policy**.

Individual Stop Loss

If the *Stop Loss Application and Schedule of Insurance* indicates individual Stop Loss coverage under this **policy**, you must provide us with written proof of **eligible claim expenses** within 60 days after any **individual Stop Loss amount**, **high risk individual Stop Loss amount**, or **IOE transplant Stop Loss amount** has been exceeded by a **covered person**. If it is not possible to submit proof within this time period, proof must be given as soon as reasonably possible. Proof of loss may not be given later than 6 months after the end of the **policy period** that the **claims administrator** paid the loss, adjusted for any **contract type**, if applicable.

Proof must be provided in a form and content satisfactory to us and must consist of the following:

- Completed claim form(s)
- Proof of the **covered person's** original enrollment record under the **plan**, and any changes and other applicable eligibility information, including the most current certification of

coverage as required by state or federal law

- For each **covered person** exceeding the **individual Stop Loss amount**, **high risk individual Stop Loss amount**, or **IOE transplant Stop Loss amount**, proof of payment by the **plan** for **eligible claim expenses** submitted for reimbursement, including a paid claim detail report which includes for each claim:
  - **Incurred** date
  - Provider name and tax identification number (TIN)
  - Billed amount, allowed amount, and paid amount
  - **Paid date**
  - Relevant International Classification of Diseases (ICD-10) codes, Current Procedural Technology (CPT) codes, and National Drug Code (NDC) codes
- Copies of all relevant provider bills, reports and electronic data transactions
- Copies of relevant pre-certification forms and case management reports
- Proof of deductible and out-of-pocket maximums, if applicable
- For all accident claims, copies of the police report and any signed subrogation agreement
- Any other information we may need to fulfill our obligations under this **policy**

Aggregate Stop Loss

If the *Stop Loss Application and Schedule of Insurance* indicates aggregate Stop Loss coverage under this **policy**, you must give us written proof of loss within 60 days after the end of the **policy period** adjusted for any **contract type**, if applicable. If it is not possible to give proof within this time period, proof must be given as soon as reasonably possible. Proof of loss may not be given later than 6 months after the end of the **policy period** that the **claims administrator** paid the loss adjusted for any **contract type**, if applicable.

Proof must be provided in a form and content satisfactory to us, and must consist of the following:

- A written request for reimbursement, including the calculation of the aggregate reimbursable amount
- A detailed claim history report by claimant for all **eligible claim expenses incurred** and paid during the **policy period** as adjusted for any **contract type**, including:
  - **Incurred** date
  - Provider name and tax identification number (TIN)
  - Billed amount, allowed amount, and paid amount
  - **Paid date**
  - Relevant International Classification of Diseases (ICD-10) codes, Current Procedural Technology (CPT) codes, and National Drug Code (NDC) codes
- A listing of all **covered persons** eligible for benefits under the **plan** at any time during the **policy period**
- If prescription drug coverage is indicated as an **eligible claim expense** on the *Stop Loss Application and Schedule of Insurance*, a detailed claim report of all prescription drug claims including:
  - The amounts of any rebates you received
  - A copy of the check register
  - A summary of claimants exceeding the **individual Stop Loss amount**
  - A summary of the benefit analysis
  - A copy of the loss ratio report
  - Any other information we may need to fulfill our obligations under this **policy**

Required reporting

You and your **claims administrator** or other **agents** will maintain records as may be required by us for the administration of this **policy**. You will provide us with all information we determine is necessary to carry out the provisions of the **policy** upon our request.

You must provide us with a copy of your underlying health benefit **plan** document(s), including any amendments or modifications. Any amendments or modifications must be submitted to us at least 60 days prior to the **effective date**.

Reports are to be provided within 30 days after the end of each **policy month**, in a form and content satisfactory to us, including:

- Aggregate Stop Loss
  - Total monthly paid claims for all **covered persons** in a format and with content that is satisfactory to us including:
    - The number of each type of **employee** or **covered unit** as of the first day of the **policy month**
    - Total **eligible claim expenses** for all **covered persons** that you paid for the **month**
    - A listing of claims for any **covered person** whose total **eligible claim expenses** on a paid basis during the month exceeds $25,000
    - Any other information that may be reasonably required
- Individual Stop Loss
  - Notice of any potential catastrophic claim via written submission on a form acceptable to us within 30 days of when:
    - A **covered person's eligible claim expenses** exceed 50% of the **individual Stop Loss amount**
    - If applicable, a family's **eligible claim expenses** exceed 50% of the **family individual Stop Loss amount**
    - You, your **claims administrator**, or any other **agent** acting on your behalf, are notified that a **covered person** has been diagnosed with or treated for any injury, illness or disease that is reasonably likely to result in **eligible claim expenses** expected to exceed 50% of the **individual Stop Loss amount** during the 12 months following notification
    - Any other information that may be reasonably required

You will provide all claim information and will not withhold or delay information on a particular claim beyond 30 days. If there are special circumstances, the 30 days may be extended for a mutually agreed upon time. If you or your **claims administrator** do not provide the required information on a timely basis, we reserve the right to revise premium rates, monthly factors, or coverage levels retroactively to the **policy effective date** or **renewal date**, as applicable, once the information is received.

Inspection and audit

We are permitted to inspect your, your **claims administrator's**, or any other vendor's or **agent's** records and procedures pertaining to the **plan** at any reasonable time while your **policy** is in force and within 3 **policy** years after termination to the extent that the records relate to the premium basis or **eligible claim expenses** under this **policy**.

We reserve the right to employ a third party, at our expense, to assist us with any audits. If you, your **claims administrator**, or any other **agent** fails to provide requested information, we will not reimburse you for **eligible claim expenses** under this **policy**.

Glossary

Aetna
Aetna Life Insurance Company, an affiliate, or third party vendor under contract with **Aetna**.

Agent
A designated person or entity that has, or reasonably appears to have, the authority to act on behalf of the **policyholder**. This includes:

- Consultants
- Brokers
- Counsel
- HR Representatives
- Any other person or entity that the **policyholder** designates as an **agent**

Aggregate Stop Loss corridor
When aggregate Stop Loss coverage is elected, it is the total dollar amount of **eligible claim expenses** that you must pay for all **covered persons** during the **policy period** before aggregate Stop Loss benefits are payable. The amount is determined at the end of the **policy period** and is the greater of:

- The sum of each month's number of **employees** or **covered units** multiplied by the **aggregate Stop Loss factor**, or
- The **minimum aggregate Stop Loss amount**

The **aggregate Stop Loss corridor** does not include claim payments made during a **policy period** for a **covered person** in excess of any:

- **Individual Stop Loss amount**
- **IOE transplant Stop Loss amount**
- **High risk individual Stop Loss amount**
- **Individual internal limit**
- Any other provision of this **policy**, as applicable

Aggregate Stop Loss factor
When aggregate Stop Loss coverage is elected, it is determined prior to the start of the **policy period**. It is calculated as the expected **eligible claim expenses** for the **policy period**, multiplied by the **aggregate Stop Loss percentage**, divided by the expected number of **employees** or **covered units** at the beginning of the **policy period**, and divided by the number of months in the **policy period**.

Aggregate Stop Loss percentage
When aggregate Stop Loss coverage is elected, it is the percentage amount above expected **eligible claim expenses** that you are liable for under the terms and conditions of the **policy** as indicated on the *Stop Loss Application and Schedule of Insurance*. Under no circumstances will the **aggregate Stop Loss percentage** be less than the percentage required by state or federal law.

Claims administrator
A firm or person you have designated and have a written agreement with to process claims and provide administrative services for your health **plan**. The term **claims administrator** as used in this

policy does not refer to the **plan** administrator used under ERISA, unless a participating employer has specifically appointed the administrator for that purpose. We must approve any administrator in advance and in writing, in accordance with the terms and conditions of this **policy**.

Contract type

Establishes the time periods that **eligible claim expenses** must first be **incurred** by a **covered person** through the **plan** and then paid by **Aetna** or the approved **claims administrator**.

Covered benefits

The benefits provided by the **policyholder** to **covered persons** included under the **plan** and included as reimbursable under this **policy** as indicated in the *Stop Loss Application and Schedule of Insurance*.

Covered person

Any person who meets the eligibility requirements of and is covered by the underlying self-insured health benefit **plan**.

Covered unit

A **covered unit** means the same as employee.

Domestic claim expenses

The medical expenses **incurred** for services delivered to **covered persons** within the healthcare facilities being insured by the Stop Loss **policy**.

Effective date

The date coverage begins under this **policy** in accordance with the *Effective date* section of this **policy**.

Eligible claim expenses

Expenses for **covered benefits** you paid based on the **plan** and that are included under the terms of this **policy**. **Eligible claim expenses** will include payments made to the MA Uncompensated Care Pool, Minnesota Care Provider Tax, or in New York, on your behalf, to fund indigent care and graduate medical education when paid directly into the pool.

Employee

An **employee** is defined in accordance with the eligibility requirements of, and is covered by, the underlying self-insured health benefit **plan**.

For purposes of premium, terminal liability, terminal reserve, and aggregate Stop Loss calculations, **employee** means an enrolled contract or unit (i.e. single individual, individual + spouse, individual + child(ren), family).

Also see **covered unit**.

Experimental or investigational

Any drug, device, procedure, treatment, or test not yet accepted by physicians or by insurance plans as standard treatment of a condition or illness.

They are **experimental or investigational** if:

- There is not enough outcome data available from controlled clinical trials published in peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved.
- The needed approval by the FDA has not been given for marketing.
- A national medical society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility or provider state that it is **experimental or investigational**.
- The **plan** deems a drug, device, procedure, test, or treatment as **experimental or investigational**.

Aetna's experimental or investigational determinations are documented in **Aetna's** Clinical policy bulletins.

Family individual Stop Loss amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, it is the dollar amount of **eligible claim expenses** per covered family (eligible **employees** or **covered units** and their enrolled dependents) that you must pay prior to any family individual Stop Loss benefit becoming payable under this **policy**.

High risk covered person

A **covered person** that has **eligible claim expenses** under the plan expected to exceed the **individual Stop Loss amount**. The **covered person** may have a separate higher **individual Stop Loss amount** or may be excluded from coverage under this **policy** as indicated on the *Stop Loss Application and Schedule of Insurance*.

High risk individual Stop Loss amount

The dollar amount of **eligible claim expenses** for a **high risk covered person** that you must pay before any individual Stop Loss benefit is payable under this **policy** as indicated in the *Stop Loss Application and Schedule of Insurance*.

Incurred

The date services are rendered or supplies are received by a **covered person** for medical services and supplies.

Inpatient facility charges with continuous facility stays that fall over two or more **policy periods** will be considered on a pro rata/per diem basis by dividing the total amount of **eligible claim expenses** by the total number of days of confinement and multiplying by the number of days of confinement per **policy period**. Professional visits that are billed for inpatient facility charges will be considered on the date they were provided to the **covered person**.

Individual internal limit

As indicated on the *Stop Loss Application and Schedule of Insurance*, it is the limit on **eligible claim expenses** that are paid by the **claims administrator** for any one **covered person** during the **policy**

period that can be used to satisfy the **aggregate Stop Loss corridor** or included in the aggregate benefit amount calculation for the **policy period**.

Individual lifetime Stop Loss payment amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, it is the maximum amount of **eligible claim expenses** that **Aetna** will fund as individual Stop Loss payments under the **policy** for any one **covered person** during their lifetime. If the **eligible claim expenses** paid by us under the individual Stop Loss coverage reach the **individual lifetime Stop Loss payment amount**, all subsequent **eligible claim expenses** for that **covered person** will be funded by you.

Individual Stop Loss amount

The dollar amount of **eligible claim expenses** per **covered person** that you must pay before any individual Stop Loss benefit is payable under this **policy** as indicated in the *Stop Loss Application and Schedule of Insurance*. Under no circumstances will the **individual Stop Loss amount** be less than the minimum amount allowed by state or federal law.

IOE transplant Stop Loss amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, and if the **covered person** elects to have the **transplant** performed at one of **Aetna's** Institute of Excellence® (IOE) facilities, it is the amount of **eligible claim expenses** for a **covered person** receiving a **transplant** at an IOE facility during the **policy period** that you must pay before any individual Stop Loss benefit is payable under this **policy**. For **transplant** claims and **eligible claim expenses** covered in the **policy period** that the **transplant** benefit is paid by the **claims administrator**, the **IOE transplant Stop Loss amount** is applied instead of the **individual Stop Loss amount**.

The **IOE transplant Stop Loss amount** may not be applicable to certain **transplant** types or a **covered person's transplant** claims as indicated in the *Stop Loss Application and Schedule of Insurance*.

Maximum annual aggregate Stop Loss payment amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, it is the dollar limit that **Aetna** will pay in any **policy period** under the aggregate Stop Loss coverage. If the **eligible claim expenses** paid by us under the aggregate Stop Loss coverage reach the **maximum annual aggregate Stop Loss payment amount**, all subsequent **eligible claim expenses** in that **policy period** will not be eligible for reimbursement by us.

Maximum annual individual Stop Loss payment amount

When indicated on the *Stop Loss Application and Schedule of Insurance*, it is the maximum amount of **eligible claim expenses** that **Aetna** will fund as individual Stop Loss payments under the **policy** for any one **covered person** in a **policy period**. If the **eligible claim expenses** paid by us under the individual Stop Loss coverage reach the **maximum annual individual Stop Loss payment amount** in a **policy period**, all subsequent **eligible claim expenses** for that **covered person** will be funded by you.

Medically necessary

In addition to any **medically necessary** definition cited in the **plan**, a health care service, drug, or device that we determine a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease

or its symptoms, and that we determine is:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, physician, or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Following the standards set forth in our clinical policies and applying clinical judgment

Minimum aggregate Stop Loss amount

The **minimum aggregate Stop Loss amount** applies when aggregate Stop Loss coverage is elected. It is the minimum amount of **eligible claim expense** liability that you must pay before any aggregate Stop Loss benefits may be payable. For any **policy period**, the **aggregate Stop Loss corridor** is subject to a **minimum aggregate Stop Loss amount**. This is the greater of:

- The **minimum aggregate Stop Loss amount** indicated on the *Stop Loss Application and Schedule of Insurance*
- The sum of the product of the number of **employees** or **covered units** on the first day of the first **policy month**, multiplied by the **aggregate Stop Loss factor**, multiplied by the number of months in the **policy period**, determined by mutual agreement between you and us at the beginning of the **policy period**

Paid date

The date the payment for **eligible claim expenses** is cleared by **Aetna** or an **Aetna**-approved TPA, **claims administrator**, vendor, or ancillary provider. The payment instrument must be supported by sufficient funds to be honored upon presentation and will coincide with the claims **paid date** definition of the administrative services, ancillary, and vendor agreement(s). If funding is not available, the expense will not be deemed to have been paid until funding is available to cover the full amount of the draft as determined by us.

In a cleared basis funding arrangement, check issuing systems issue payments and transmit them to the claims reporting system. These are processed and held until the checks clear the banking channels. Once checks clear the banking channels, the transactions then accumulate towards the Stop Loss **policy**

Any EFT payments are immediately funded and apply towards the Stop Loss **policy**.

Plan

Describes the self-insured health benefits you provide for **covered persons**. The **plan** is subject to ERISA, as applicable, and as is or as may be, amended and approved by **Aetna**. The health benefits are included under either individual Stop Loss, aggregate Stop Loss, or both as indicated in the *Stop Loss Application and Schedule of Insurance*.

Policy
Your Stop Loss **policy** consists of the following essential legal documents:

- Your signed *Stop Loss Application and Schedule of Insurance*
- *Disclosure*, if required
- This document (the **policy**)
- Any riders or amendments to the **policy**
- A copy of the self-insured **plan** document(s) for each benefit **plan** covered by this **policy**

Policyholder
The insured entity as defined on the cover page of this **policy**.

Policy month
A **policy month** is the same as a calendar month. The first **policy month** begins on the **effective date** of this **policy** and the last **policy month** ends on termination of this **policy**.

Policy period
A **policy period** typically coincides with the **plan's** benefit period. The first **policy period** begins on the **effective date** of this **policy**. Any **policy period** after the first **policy period** begins on the **policy renewal date**.

Premier product
In consideration of additional premium paid, the **Premier product** provides a commitment of no new **high risk individual Stop Loss amounts** or rate-ups for **covered persons'** medical conditions upon **policy** renewal.

Premium due date
When premium is not funded by automatic electronic funds transfer, the premium is due as of the date shown on the invoice.

Rate cap
The **rate cap** is a commitment that upon renewal, if offered, the premium increase will be capped at a specified percentage.

Reasonable and customary
Reasonable and customary is the portion of a bill for a drug, device, procedure, test, or treatment that is eligible for coverage based on the geographical area of service. It is the amount of any non-preferred or non-network charge under a network based plan or all charges under a non-network plan. **Reasonable and customary** charge means the same as allowed amount, recognized charge, and usual and customary charge. The actual **reasonable and customary** amount will be determined in accordance with the underlying **plan** that has been reviewed and approved by **Aetna**.

Renewal date
Each anniversary of the **effective date** of the **policy**, unless changed by written agreement between the **policyholder** and **Aetna**.

Renewal risk cap

The **renewal risk cap** is a commitment that upon renewal, if offered, there will be no new lasers and the premium increase will be capped at a specified percentage.

Run-in amount

The maximum amount we will pay per **covered person** as applied towards the annual **aggregate Stop Loss corridor** on **eligible claim expenses incurred** prior to the **policy effective** or **renewal date** and paid on or after the **policy effective** or **renewal date**.

Run-in period

The period of time immediately prior to the **policy effective** or **renewal date** when **eligible claim expenses** are **incurred** but not paid until after the **effective** or **renewal date** of this **policy**. All run-in **eligible claim expenses** paid by us or by your **claims administrator** must be paid based on the **plan** in effect during the **run-in period** and our current standard claim practices.

Run-out amount

The maximum amount we will pay per **covered person** as applied towards the annual **aggregate Stop Loss corridor** for **eligible claim expenses incurred** during the **policy period** but paid after the **policy period** end date.

Run-out period

The period of time immediately following termination of the **policy** when **eligible claim expenses incurred** prior to the **termination date** are being paid by you. The **run-out period** will apply only if the same **claims administrator** administers benefits for the **plan** during the **run-out period**.

Termination date

The date coverage under this **policy** ends at 11:59 p.m., in accordance with the *Termination* section.

Transplant

The **transplant** of human solid organs, specifically:

- Heart
- Heart/lung
- Lung
- Double lung
- Liver
- Pancreas
- Kidney
- Cornea

Transplant also includes:

- Bone marrow
- Peripheral blood stem cell **transplant**
- CAR-T cell therapy
- Transfusion
- Re-infusion

A **transplant** occurrence is considered to begin at the point of evaluation for a **transplant** and end either:

- 365 days from the date of the **transplant**
- On the date the **covered person** is discharged from the hospital or outpatient facility for the admission or visits related to the **transplant**, whichever is later

Lee County Board Of County Commissioners

Stop Loss Financials

Control #881673

Policy Perio January 01, 2026 through December 31, 2026

Status: Final/Firm

Valid until: December 5, 2025

- Please refer to the Stop Loss Assumptions and Caveats for additional information.
- Stop Loss rates and factors will be billed on a Composite PEPM basis.

Quote Specifications	Current	Renewal
Contract Situs	Florida	Florida
Policy Period Length (months)	12	12
Total Enrollment	4,229	4,325
Producer Commission	None	None
Terminal Liability Option	No	No

Individual Stop Loss (ISL) Coverage	Current	Renewal
Covered Benefits	Medical/Rx	Medical/Rx
Individual Stop Loss Amount	$475,000	$475,000
Lasered High Risk Claimants	No	No
Aggregating Specific Amount	None	None
Contract Type	Paid	Paid
ISL Coinsurance %	100%	100%
Maximum Annual ISL Payment Amount	Unlimited	Unlimited
Renewal Risk Cap	N/A	**50%**
ISL Composite PEPM Rate	$55.18	$66.87
Estimated ISL Policy Period Premium	$2,800,275	$3,470,553
% Change in Individual Stop Loss Premium		21.2%

This quotation is issued or underwritten by Aetna Life Insurance Company.

Lee County Board Of County Commissioners

Stop Loss Assumptions & Caveats — Effective Date: January 01, 2026

For the purposes of this document, Aetna may be referred to using "we", "our", or "us" and Lee County Board Of County Commissioners may be referred to using "you" or "your".

We are pleased to provide you with our renewal for Stop Loss insurance. These Assumptions and Caveats, in conjunction with the Stop Loss Financials exhibit, combine to form the entirety of this renewal. Please review them carefully and notify us immediately if any of the features do not meet your expectations or if any of our assumptions are incorrect. Changes in the features or assumptions may affect premium rates or claim factors.

Additional state-specific notices should be reviewed at this link:
https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/legal-notices/documents/stop-loss-underwriting-disclosures-06-06-2023.pdf

If you renew Aetna's Stop Loss coverage, you will receive your application for insurance electronically. You will access it via a link delivered by email and endorse it using electronic signature capabilities. You will also receive your policy electronically. This process requires a web browser which supports the HTTPS protocol, HTML, and cookies. You will also need to view PDF documents using software such as Adobe Reader or similar.
You have the right to request that these transactions occur by regular mail using paper copies, which would require you to physically sign your application and mail it back to us. Please contact your broker and/or your Aetna Account Manager to make this request.

Stop Loss policies and applications/schedules of insurance are updated annually upon renewal. Please contact your broker and/or your Aetna Account Manager for a copy of the Stop Loss policy.

This proposal assumes you have notified us of any known applicants for gene replacement therapy.

Renewal Status

This is a final, firm offer. You must accept the rates by December 5, 2025.
If you fail to accept the rates by December 5, 2025, we reserve the right to request updated underwriting data, which may alter the rates and terms of the offer.

Assumptions

- The policy period is indicated on the Stop Loss Financials. The Stop Loss policy period must agree with the self-funded plan's contract period, both of which must end on the next renewal date.
- It is assumed Aetna is also the claim fiduciary for the self-funded plan(s) covered by Stop Loss. Claims approved by fiduciary override/exception are not covered by Stop Loss.
- Eligibility for Stop Loss coverage will apply as described in the self-funded benefit plan(s) and in accordance with the Stop Loss policy provisions.
- In at least one quoted option, Pre-65 and post-65 retirees, and their dependents, have been included in Stop Loss coverage.
- There must be common ownership among all participating divisions or subsidiaries for this quote to remain valid.
- Your business and/or Standard Industrial Code is 9111.

What Is Covered

- Self-funded benefit plans covered by Stop Loss are identified on the Stop Loss Financials. All other benefit plans are excluded.

- Gene Replacement Therapy Drug coverage:
  - High Risk Individual Stop Loss Amounts (lasers) are not applied to an FDA-approved or pipeline gene replacement therapy drug dispensed as approved and directed.
  - Gene replacement therapy drug claims will not be included in the ISL claim experience used for rating purposes at the Stop Loss renewal.
  - This feature specifically applies only to the gene replacement therapy drugs approved to treat specific disease, age, and gene expressions via one-time infusion therapies – or curative treatments – for previously untreatable, often fatal, conditions.
- High Risk Individual Stop Loss Amounts may apply for all other diseases or drugs, including medical costs associated with the underlying condition or medical services associated with the gene replacement therapy treatment.
- Coverage of gene replacement therapy drugs will apply as follows:
  - When a gene replacement therapy drug is administered for the indicated disease, age, and gene expression by one of Aetna's "Gene-based, Cellular, and other Innovative Therapies" (GCIT) network providers, we will consider the eligible claim expense for the gene replacement therapy drug less the ISL amount shown on the Stop Loss Financials exhibit.
- Contract Type - As indicated on the Stop Loss Financials, eligible claim expenses will be covered for incurred and paid dates based on:
  - A Paid contract type - Claims paid during the policy period, regardless of the incurral date, are included under Stop Loss. However, if the prior policy period was covered by any Stop Loss policy with a run-out contract type or provision, claims paid during the prior policy's run-out period are not covered by this Stop Loss proposal.
- An Aggregating Specific Stop Loss amount is included in at least one quotation on the Stop Loss Financials. "Agg Spec" is a group-level Stop Loss amount that applies to the total of all Individual Stop Loss claims. Eligible claim expenses that exceed the Individual Stop Loss amount apply to the Agg Spec amount. It may be satisfied by ISL claims for one claimant or by the sum of ISL claims for many claimants. Our Individual Stop Loss liability does not begin until ISL claims have exceeded the Aggregating Specific amount.

What Is Not Covered

Coverage exclusions include but are not limited to the following:

- Expenses that are not payable under the plan or in accordance with Aetna's clinical policy and established claim practices. This includes expenses that are experimental or investigational, not medically necessary, in excess of the reasonable and customary charge, or any claim exception;
- Eligible claim expenses covered by another valid Stop Loss policy, including another Aetna policy, during the same time period, or run-in claims also covered by a prior policy carrier's run-out provision;
- Plan administration expenses including, but not limited to cost containment administrative fees, care management fees, and network access fees, with the exception of shared savings fees associated with our National Advantage Program (NAP);
- Assessments or surcharges applied to claims by any government body, with the exception of the MA Uncompensated Care Pool, Minnesota Care Provider Tax, or New York Health Care Reform Act surcharges;
- Incentive or risk share payments, care coordination payments, and other non-fee-for-service payments associated with any agreement with an accountable care or similar provider organization;
- Expenses for non-emergency services, treatment, or related complications provided outside the United States. This includes prescription drugs or medical supplies provided by non-U.S. based companies;
- Capitation payments excluded from Individual Stop Loss but included under Aggregate Stop Loss.

Stop Loss Guarantees

A Renewal Risk Cap is included on Individual Stop Loss quotations on the Stop Loss Financials. This feature caps the renewal policy period's Individual Stop Loss rate increase and guarantees we will not set new High Risk Individual Stop Loss amounts (lasers) for additional covered persons at renewal. The Renewal Risk Cap will apply assuming there are no material changes to the quotation assumptions during the policy period or at the subsequent renewal. Material changes are outlined within the Underwriting Requirements, Right to Recalculate caveat.

Adjustments for contract type changes at renewal (e.g.: 12/12 to a Paid basis) are not included in the Renewal Risk Cap.

The Renewal Risk Cap may be renewed, modified or cancelled for subsequent renewals at our discretion.

Stop Loss Reimbursement

- When Aetna is also the plan's administrator and the Stop Loss policy is in-force, eligible claims are funded by Stop Loss immediately, as they are approved for payment under the plan. This "Immediate Reimbursement" means that your cash flow is not impacted by waiting for reimbursement of claims exceeding the Stop Loss amount and claim reports are not required. Additional reconciliation is necessary when run-in or run-out is covered, or when other than a 12/12 or Paid contract type is utilized.
  When Aetna is not the claims administrator, reconciliation for reimbursable amounts is performed at the end of the policy period once you provide appropriate claim details and other necessary information.

Underwriting Requirements

- We reserve the right to amend or withdraw our offer to reflect the underwriting impact of any additional information we obtain or in the event you are unable to provide us any of the information we need to fully underwrite the risk.
- If you fail to meet the our underwriting requirements, including but not limited to a minimum of 51 eligible subscribers, our Stop Loss offer will be withdrawn.
- We reserve the right to adjust the premium rate or any aggregate Stop Loss factor as of the date of any change to the underlying assumptions that impacts the risk assumed. Changes include, but are not limited to:
  - Any change of +/- 15 percent in enrollment
  - Any change to the plan document(s) that will change the risk assumed under the Stop Loss policy
  - Any change to this policy
  - Any addition or deletion of a unit, division, subsidiary, affiliated or associated company exceeding 15 percent of existing enrollment
  - Any change in federal or state law or regulation that impacts the policy or the coverage provided
  - Any change impacting the risk we have assumed, including but not limited to: age, gender, geography, occupation, incorrect or incomplete information provided in Disclosure statements, etc., that impacts the nature of the risk by more than 15 percent
  - Any change in claims administrator, provider network or cost containment vendor, provided we have consented to the change in writing
  - Any change in the claims administrator’s claim payment system or payment practices that causes a variation of +/- 5 percent versus the most recent 12 month average claim processing time.

  New units, subsidiaries, etc., will be underwritten. Claim reports may be requested. If this information is not provided, we reserve the right to require a completed and signed Disclosure and may apply AAW/DNC rules on the acquired group.

Lee County Board Of County Commissioners

Stop Loss Overview **Effective Date: January 01, 2026**

What is Stop Loss insurance?

Stop Loss insurance allows plan sponsors to enjoy the benefits of self-funding their medical and pharmacy plans while protecting against the corresponding risk of unknown, higher than anticipated claims. These risks, such as an unexpected large claimant or adverse claim fluctuations across the entire covered group, could impact a plan sponsor's immediate cash flow or even bottom line results.

There are two types of Stop Loss coverage:

- **Individual Stop Loss (ISL)** provides protection above a specific claim amount per covered person against that person's potential for catastrophic losses during a policy period.
- **Aggregate Stop Loss (ASL)** insures against potential adverse losses over the entire group in excess of a pre-determined maximum liability during a policy period. This maximum liability is typically reflected as a percentage of total expected claims, such as 125 percent.

Coverage is available for Individual Stop Loss only or combined with Aggregate Stop Loss for extra protection and peace of mind. Claims covered by Individual Stop Loss do not apply to Aggregate coverage. Recommended coverage levels are determined based on total membership in the self-funded health plan.

What other Stop Loss features are available?

Stop Loss insurance has a number of additional features to assist plan sponsors with predicting their liability and controlling costs.

- **Contract Types** - A Contract Type defines the time periods during which first, eligible claim expenses must be incurred by a covered person, and then second, paid by the claims administrator. The time periods are noted in months.
  - Our standard for new Stop Loss policies is a 12/12 contract type. Only claims that are both incurred and paid during the initial 12-month policy period are covered. This is considered an immature policy.
  - Our Stop Loss renewals are standardly covered on a Paid contract type basis. This is a mature policy, covering claims paid during the 12-month policy period regardless of when they were incurred as long as the Stop Loss policy was in force at the time of incurral. For more information on the benefits of a Paid renewal contract type, see our Aetna Stop Loss Advantage - Paid Renewal Contract Type exhibit.
  - Additional incurred and paid contract types may be offered upon request. These include run-in contract types (15/12, 18/12), which cover claims incurred prior to but paid during a policy period, as well as run-out contract types, which cover claims incurred during the policy period but paid for a specific length of time after it ends.
- **Terminal Liability Option (TLO)** - TLO coverage provides run-out protection in the event of termination of the Stop Loss policy. It covers claims incurred under covered self-funded benefit plans while the Stop Loss policy is active and paid within a pre-determined timeframe after termination.
  - TLO may only be purchased at policy inception or added at a subsequent policy renewal. It cannot be added to the policy upon termination.
  - The Individual Stop Loss amount is continued from the final policy period through the run-out period.
  - The Aggregate Stop Loss corridor is increased by a specific number of months of additional claim liability corresponding to the run-out period selected.
  - You have the option to exercise the TLO with at least 30 days advance notice prior to termination and payment of a pre-defined number of months of premium based upon the length of the run-out period.
  - Run-out claims are reconciled and any reimbursements made once the run-out period is completed.

- **Experience Refund Option (ERO)** - You may receive a refund of a specific percentage of net Individual Stop Loss premium when actual experience results in a loss ratio that is better than the loss ratio threshold. If the actual loss ratio is greater than the loss ratio threshold, no refund is available. This feature is offered for either one- or two-year periods, and is subject to additional qualifications.
- **Prior Carrier Run-in Coverage** - For new Stop Loss policyholders, we may cover claims incurred during a pre-determined timeframe prior to the effective date of coverage and paid during the initial policy period. For such claims to be eligible for Stop Loss coverage, the member must be enrolled in the health plan on the initial effective date of Aetna's Stop Loss policy. Run-in limits, or 'caps', may also apply on a per covered person basis for Individual and in total for Aggregate Stop Loss. Additional rules may apply.

Additional Stop Loss features are available to plan sponsors willing to take on additional risk in return for reduced premiums. These features include:

- **Annual Payment Maximums** - Stop Loss reimbursement payments may be limited on a per covered person basis for Individual and in total for Aggregate Stop Loss.
- **ISL Coinsurance** - You share the liability for a covered person's eligible claims after the Individual Stop Loss amount has been met. Coinsurance is offered from 10 percent to 50 percent.
- **Aggregating Specific Amount** - An additional Individual Stop Loss amount that applies across all covered persons for whom the policy's ISL Amount has already been met. The "Agg Spec" amount must also be met before Individual coverage reimbursements begin.

How is Stop Loss priced?

Stop Loss rates are calculated based on the following group-specific information:

- Stop Loss coverage selected
- self-funded plan(s) covered
- demographics and industry
- policy period duration
- contract type
- leveraged trend
- expected claim projections
- known high risk claimants
- optional features chosen
- first-year immature to renewal mature basis

Additionally, known high risk covered persons may be subject to a separate higher individual Stop Loss amount, also referred to as a 'laser'. All quotes are subject to underwriting guidelines.

How is Aetna's Stop Loss coverage administered?

- Stop Loss premiums are billed monthly on a composite per employee/covered unit basis.
- When Aetna is also the claims administrator of the self-funded health plan(s), Individual Stop Loss claims are automatically funded by Aetna; no action by the plan sponsor is needed.
- Additionally, when Aetna is the claims administrator of the self-funded health plan(s), Aggregate Stop Loss provides cash flow protection by capping a plan sponsor's monthly claim liability.
- When a third party administers a health plan(s), Individual Stop Loss is reconciled after the close of each policy period.

Stop loss policies are insured or underwritten by Aetna Life Insurance Company.

This material is subject to change. For more information about coverage details, including limitations, exclusions and other plan requirements, please refer to a sample Stop Loss policy or contact an Aetna representative.

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Stop Loss - The Aetna Advantage — Effective Date: January 01, 2026

Why Choose Aetna for Stop Loss Insurance?

Aetna's Stop Loss product has a proven track record of more than 35 years helping self-funded plan sponsors control costs and gain flexibility within their health plan(s) while providing protection against the financial risk of catastrophic claims. Coverage is comprehensive, aligning with the self-funded plan when it is administered by Aetna and offering Paid renewal contract types as our standard, eliminating coverage gaps.

What are the Benefits of integrated Plan Administration and Stop Loss insurance?

Our Stop Loss coverage benefits expand significantly when bundled with our self-funded plan administration.

Peace of Mind that Claims are Covered	• The same clinical policies and large claim care coordination apply to our plan administration and Stop Loss coverage. Claims paid according to these standards are automatically covered. • Stop Loss-only carriers 'readjudicate' claims according to their own standards and policies, resulting in coverage denials that causes additional financial risk for the plan sponsor.
Improved Cash Flow and Budgeting	• Our Stop Loss is linked to the self-funded plan's administration. Your bank account is never debited for any eligible claim over the ISL or ASL Amount. • Annual claim liability is split into monthly allotments. • With Stop Loss-only carriers, there can be a one to twelve-month reimbursement delay until documentation is submitted to the Stop Loss carrier and approved for payment.
Streamlined processes and resource needs	• Stop Loss claims are funded automatically as the claim is initially paid.* There are no claim reports involved, which saves on administrative fees. • There is no chance of missing or failing to submit eligible claims to Stop Loss. • Stop Loss-only carriers require claim and medical management reports to determine reimbursement.

How does integrated Plan Administration and Stop Loss insurance operate?

- **Immediate Reimbursement* for Individual Stop Loss (ISL)**
  - With Immediate Reimbursement, we automatically fund a covered member's eligible claims once the claims exceed the ISL amount. You never fund claims over the ISL amount.
  - The change in the funding of claims is automatic; no action is needed on your part. When claims reach the ISL or ASL amount, our claim system automatically switches the financial indicator of future claims from “customer funded” to “Aetna funded”.

- **Aggregate Stop Loss Monthly Budget Feature***
  - The Monthly Budget Feature provides cash flow protection by capping your monthly claim liability.
  - If the plan's monthly claims paid are less than the maximum calculated payment, you fund the total monthly claims and the unused claim liability is carried forward to the next month.
  - However, if the monthly paid claims are greater than the maximum payment calculated, we fund the difference and you will pay that amount in next month's payment.
  - The claim funding change is automatic; no action is needed on your part. There is no wait for reimbursement.

**Run-in and run-out contract types require additional reconciliation at the close of the policy and/or contract period.*

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Aetna Stop Loss Advantage - Paid Renewal Contract Type — Effective Date: January 01, 2026

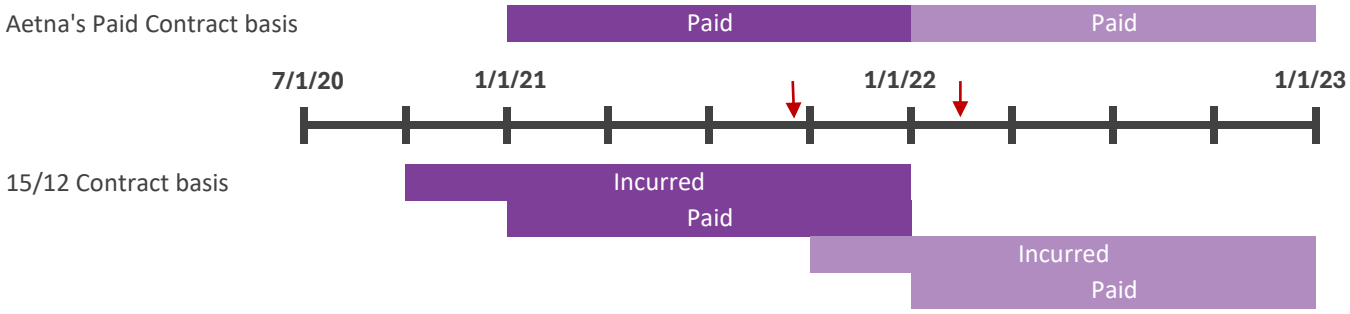
Why does a Paid Contract Type provide the best coverage?

- Covering eligible claims on a paid contract basis as of the first policy renewal is a significant advantage to having Stop Loss coverage with Aetna.
- A paid contract basis provides 100 percent seamless Stop Loss coverage year over year, as claims are covered during the policy period in which they are paid, regardless of incurred date, as long as Aetna's Stop Loss policy was active at the time of incurral.
- In comparison, incurred and paid contract types, such as 15/12 or 12/18, create coverage gaps that expose policyholders to increased risk.

Scenario 1: Paid versus 15/12 Contract Basis

– a 1/1 policy renewal date

– a $75,000 hospital stay incurred from 9/15/21 to 9/23/21 and paid on 2/15/22



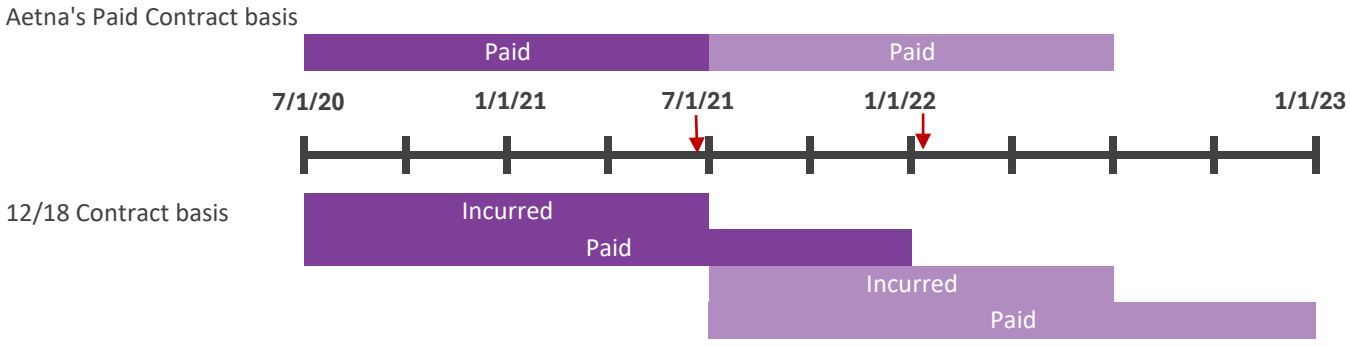
The claim is covered under Aetna's 2022 Paid policy period, but is *not covered under the 15/12 basis* because:

1) it is paid after the close of the 2021 period, but
2) it was incurred prior to the 2022 policy period.

Scenario 2: Paid versus 12/18 Contract Basis

– a 7/1 policy renewal date

– a $25,000 surgery performed on 6/30/21 and paid on 1/15/22



The claim is covered under Aetna's Paid contract basis, but is *not covered under the 12/18 basis* because:

1) it is paid after the close of the 7/1/20 period, but
2) it was incurred prior to the 7/1/21 policy period.

Stop loss policies are insured or underwritten by Aetna Life Insurance Company.

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Stop Loss Leveraged Trend Illustration — Effective Date: January 01, 2026

What is Leveraged Trend?

Leveraged trend is the single largest component of annual Stop Loss premium increases. Trend becomes 'leveraged' when the groups responsible for funding health care claims do not maintain the same share of potential claim liability year over year. With Stop Loss, this happens when a plan sponsor does not increase the Individual Stop Loss amount annually, resulting in a decreasing level of risk for the health plan's claim costs. Conversely, as leveraged trend causes the risk to shift to the Stop Loss carrier, premium charged to the plan sponsor is increased correspondingly.

To eliminate the leveraging impact on premium, a plan sponsor should increase its Individual Stop Loss amount by trend each year. This maintains the same proportion of risk between the plan sponsor and the carrier over time, as shown below.

Scenario 1

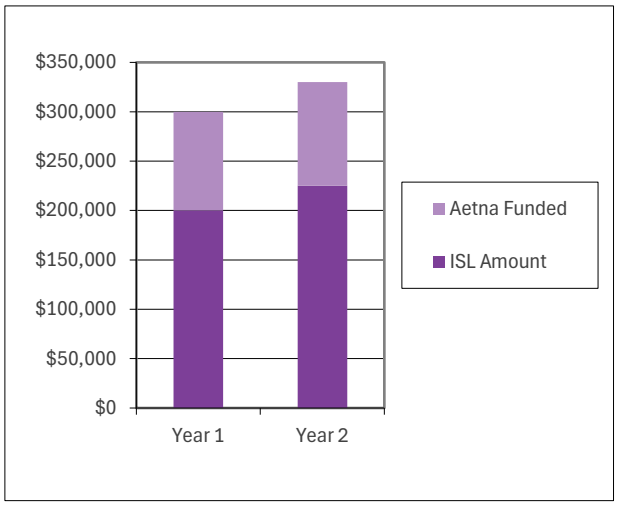
	Year 1	Year 2	Trend
Individual's Claim	$300,000	$330,000	10%
ISL Amount	$200,000	$200,000	0%
Aetna Funded Portion	$100,000	$130,000	30%

- The plan sponsor's Individual Stop Loss (ISL) amount is $200,000 in both Year 1 and Year 2.
- At 10 percent annual health care trend, a $300,000 claim in Year 1 increases in Year 2 to $330,000.
- Aetna's portion, however, increases from $100,000 in Year 1 to $130,000 in Year 2.
- While annual claim trend is only 10 percent, leveraged trend is 30 percent. This results in a sizeable rate increase for Year 2.

Scenario 2

	Year 1	Year 2	Change
Individual's Claim	$300,000	$330,000	10%
ISL Amount	$200,000	$225,000	13%
Aetna Funded Portion	$100,000	$105,000	5%

- The plan sponsor's Individual Stop Loss (ISL) amount is $200,000 in Year 1 and $225,000 in Year 2.
- At 10 percent annual health care trend, a $300,000 claim in Year 1 increases in Year 2 to $330,000.
- Aetna's portion increases from $100,000 in Year 1 to $105,000 in Year 2.
- Because the ISL Amount increases in Year 2, leveraged trend is only 5 percent, which reduces the Year 2 rate increase.



The scenarios above are illustrative; they do not reflect actual plan sponsor experience.

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