The following plan benefit information is being provided to notify City of New York of some important information related to Aetna's group Medicare Advantage PPO plan ("MA plan") and group standalone Medicare prescription drug plan ("PDP").

The MA plan and PDP rates and benefit plan designs provided in this proposal are effective September 1, 2023 through December 31, 2024.

Medicare Advantage – Medical Plan Information

End stage renal disease - This section applies to Aetna's group MA and PDPs (collectively, "Aetna Group Medicare Plans"). We assume that you don't enroll retirees and their dependents who are Medicare beneficiaries diagnosed with End Stage Renal Disease ("ESRD Beneficiaries") in the Aetna Group Medicare Plans during their 30-month coordination period, unless the ESRD beneficiaries maintain coverage under your commercial group health plan as the primary payer during their 30-month coordination period and the Aetna Group Medicare Plan is the secondary payer.

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

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

Rate and benefit approval - This proposal is subject to Centers for Medicare and Medicaid Services ("CMS") annual filing approval for the Medicare Advantage and Medicare prescription drug contracts, applications and service areas for calendar year 2023. Filed benefits, including cost sharing amounts and premiums, are subject to regulatory approval(s), where applicable, and are effective September 1, 2023 through December 31, 2023 and January 2024 through December 31, 2024 for Medicare Advantage benefits and Prescription Drugs benefits.

Implementation/Communication allowance - We are including in the Aetna Medicare Plan ("Plan") costs an allowance of $3.93 per enrolled member per month up to a maximum of $6,000,000 for Option A, $3.93 per enrolled member per month up to a maximum of $6,000,000 for Option B, or $3.93 per enrolled member per month up to a maximum of $6,000,000 that may be used towards transition costs associated with implementing your new Plan. These funds will be available **September 1, 2023** for Option A and B and may be used to fund any cost incurred since 7/1/2021 that support the transition to your new Medicare Advantage Plan. Any amounts of the allowance remaining 15 months after the Effective Date of the Plan will be forfeited. This provides you with a budget or allowance of money from which you can draw to offset reasonable, identifiable implementation and communication costs incurred during the implementation period. You cannot draw on more than the amount of the allowance provided. You may only use the implementation/communication allowance to offset expenses you actually incur as a result of moving your business to Medicare Advantage or promoting/communicating your new Medicare Advantage Plan. The allowance can be applied to reimburse you for identifiable charges for the reasonable value of services performed. Some examples of transition-related expenses it could be applied against are:

- Customized Member I.D. cards (creating, printing & mailing)
- Maintaining Member records due to the transition of business
- Handling Member enrollment, including the hiring of temporary customer service staff to work in the City's office to educate/ promote and communicate about the new Medicare Advantage Plan
- City and MLC Consulting Services related to implementation and education
- Special programming in order to transmit data to Aetna
- Open Enrollment kits and flyers
- Plan Highlights Brochure Mailings
- Healthy Home Visit Mailers
- Medicare Calendars
- Care Advocacy Mailing

Reimbursement of implementation/communication-related expenses will be made to you and/or your contracted vendor. Ongoing business expenses and compensation paid to your

employees/staff (excluding temporary customer service staff hired solely to educate/promote and communicate about the new Medicare Advantage Plan) will not be reimbursed using the allowance. Reimbursement will be made once the expenses are incurred and invoice(s) are provided. Invoices must be submitted to us by fifteen months after the Effective Date. Should you terminate your agreement with us the allowance cannot be used to fund implementation/communication expenses related to your new group health insurance plan. Reimbursements made by Aetna using the allowance are contingent on Aetna's receipt of a current W9 for any contracted vendor used by you (if applicable).

Any expenses beyond the implementation/communication allowance are your responsibility. Any amounts reimbursed by us to you for expenses incurred as a result of contracting with us to offer the Aetna Medicare Plan will be paid in accordance with applicable law. You must determine appropriate accounting for these payments with your own counsel or accountant. We advise all plan sponsors receiving an implementation/communication allowance or other payments from us that offset or reimburse expenses that would otherwise be paid from plan assets to consult with their ERISA counsel to determine if such allowance must be credited to plan assets. You should also consult with counsel regarding the accounting or reporting of such payments. We assume the funding of any implementation/communication budget is either at the request of your Plan Administrator acting in their fiduciary capacity to your Plan or for the exclusive benefit of your Plan.

Audit Allowance – We are including in the Aetna Medicare Plan ("Plan") costs a pre-implementation audit allowance of up to $60,000 and a post-implementation audit of up to $75,000 that may be used towards certain audit-related expenses associated with your Plan incurred during the 2023 Plan year. These funds will be available September 1, 2023 for Options A and B, and after the September 2023 Plan premium has been paid for Option C. Any amounts of the allowance remaining on December 31, 2023 will be allocated to the Implementation/Communications allowance. Should the Audit Allowance funds be allocated to the Implementation/Communication allowance, it will be subject to the terms and conditions of set forth for Implementation/Communication allowance. This provides you with a budget or allowance of money from which you can draw to offset reasonable, identifiable audit costs that are mutually agreed upon by you and Aetna and incurred during the 2023 Plan year. You cannot draw on more than the amount of the allowance provided. You may only use the audit allowance to offset expenses you actually incur as a result of auditing the Plan. The allowance can be applied to reimburse you for identifiable charges for the reasonable value of services performed.

Reimbursement of audit-related expenses will solely be made to you and/or your contracted vendor. Ongoing business expenses and compensation paid to your

employees/staff will not be reimbursed using the allowance. Reimbursement will be made once the expenses are incurred and invoice(s) are provided. Invoices must be submitted to us by December 1, 2023. Should you terminate your agreement with us the allowance cannot be used to fund audit expenses related to the new carrier's policy. Reimbursements made by Aetna using the allowance are contingent on Aetna's receipt of a current W9 for any contracted vendor used by you (if applicable).

Any expenses beyond the audit allowance are your responsibility. Any amounts reimbursed by us to you for expenses incurred as a result of contracting with us to offer the Aetna Medicare Plan will be paid in accordance with applicable law. You must determine appropriate accounting for these payments with your own counsel or accountant. We advise all plan sponsors receiving an audit allowance or other payments from us that offset or reimburse expenses that would otherwise be paid from plan assets to consult with their ERISA counsel to determine if such allowance must be credited to plan assets. You should also consult with counsel regarding the accounting or reporting of such payments. We assume the funding of any audit budget is either at the request of your Plan Administrator acting in their fiduciary capacity to your Plan or for the exclusive benefit of your Plan.

Alternate Office Processing - Aetna will adjudicate all claims within the United States. The additional cost for this type of claim adjudication is included in your rates.

Network

Out-of-Network Providers

If a member's provider does not participate in the Aetna Medicare network ("out-of-network provider") but the provider is willing to accept the MA PPO ESA Plan and is eligible to participate in Medicare, the member can receive medical services covered under the Plan ("covered services") from the out-of-network provider.

If a member chooses to receive covered services from an out-of-network provider that does not accept the MA PPO ESA Plan and bills the member directly for covered services, the member's Evidence of Coverage ("EOC") describes the requirements and process that apply for seeking reimbursement from Aetna. Consistent with the member's EOC, Aetna will reimburse a member for Aetna's share of the cost for covered services received from an out-of-network provider if the provider is eligible to participate in Medicare. If the out-of-network provider is not eligible to participate in Medicare, the member will generally be responsible for the full cost of the services he/she receives.

CMS group enrollment waiver

CMS has established a waiver of network service area requirements ("Waiver") for some employer/union groups. Under this waiver, the employer/union may enroll their retirees in

an MA HMO or PPO plan even if they reside in a service area that does not have access to network providers. We refer to these non-network service areas as "Extended Service Areas" (ESA).

In order to be eligible for the Waiver, at least 51 percent of your retirees and dependents must live in a service area that provides adequate access to network providers. Aetna will apply the CMS network requirements when determining if a county or service area meets adequate access requirements.
It is important to know that:

- Members enrolled in an MA PPO ESA Plan may not have access to an Aetna network of providers that meets CMS network adequacy requirements.
- Providers who are not contracted with Aetna are not required to accept the Aetna MA PPO ESA Plan, except when a member requires emergency or urgently needed care. However, if a member is currently receiving treatment from a non-contracted Medicare-eligible physician, Aetna will take the following steps as part of its Provider Pass program:
    - Aetna will attempt to contract with the non-contracted physician to participate in the Aetna network if the physician is eligible to receive Medicare payment ("Non-Contracted Physician").
    - If the Non-Contracted Physician does not agree to participate in the Aetna network, an Aetna Customer Service Representative will educate the Physician regarding the MA PPO ESA Plan and encourage the Physician to accept the Plan and bill Aetna for services that are covered and medically necessary under the Plan ("Covered Services)".
    - If a member calls Aetna to advise that a Non-Contracted Physician refuses to accept the MA PPO ESA Plan and is attempting to require that the member pay for Covered Services up front at his/her office visit, the call will be referred to an Aetna Member Services Supervisor who will authorize a one-time payment for this office visit, up to a $1,000 maximum.
    - Aetna will track the results of these efforts through system-generated tracking and will report the results on a quarterly basis ("Quarterly Status Report"). The Quarterly Status Report will track the number of member calls referred to the Aetna Member Services Supervisor for PG tracking purposes.
    - If a member needs a follow up visit for treatment received at this visit, the Aetna Supervisor with approval from Senior Leadership can approve an additional office visit.
    - Aetna will work with members who use this program to transition their care to an in-network physician, as needed.

We will monitor network adequacy throughout the year to confirm that CMS standards are met. Our network teams will work to strengthen our provider networks to meet CMS network adequacy requirements to help avoid potential disruption to our members.
As of August 2022, 98% of your members reside in service areas that meet CMS network adequacy requirements. If the total percentage of members who reside in a service area that meets CMS network adequacy requirements falls below 51 percent by the date of your Aetna MA PPO plan renewal, we cannot offer you our MA PPO ESA plan. However, we will work with you to evaluate other group health plan options that can be offered in these extended service areas to help reduce potential Member disruption.

Part D Information

Prescription drug coverage

Our retiree pharmacy coverage consists of two components: basic Medicare Part D benefits and supplemental benefits.

- We offer Medicare Part D plan coverage pursuant to our contract with the CMS. We receive monthly payments from CMS for the Part D portion of your coverage.
- We offer supplemental coverage that wraps around the basic Medicare Part D benefits, allowing you to offer enhanced pharmacy benefits. We receive monthly premium payments from you and/or your retirees for the supplemental coverage. Depending on your plan design, supplemental coverage may also include benefits for non-Part D covered drugs.

We will report drug claims information to CMS, based on the source of the applicable coverage payment - Medicare Part D, plan sponsor or member.

To support the transition of members to the Aetna Part D plan:

- Aetna's plan includes an **Open** formulary; this means that **all Part D FDA-approved prescription drugs** will be **covered.** Aetna has also included a supplemental benefit rider to include FDA-approved prescription drugs not covered by Part D.
- To ensure members keep a consistent drug regimen when changing to the Aetna Part D plan, **Medicare Prescription Drug Plans (PDP) include a Transition of Coverage (TOC)** provision for Part D medications that are in our precertification or step therapy programs. The TOC process allows the member to obtain one 30-day fill within the first 90 days of coverage. When the member receives the transition supply of their medication, the member will receive a mail notification within three business days stating that the drug requires prior authorization. We will also notify the prescribing doctor by mail. This policy provides for up to two more refills for members living in a long-term care (LTC) facility.

For the retirees currently in a Group Part D plan, the transition experience can be enhanced through the following processes:

- The City will request the data from the current carrier to provide Aetna with an Rx claims history file from another carrier. We will load the claims history file and use the information to simplify claims processing and inform coverage determination decisions (eg. to identify drugs previously taken by the member and not require repeat requests for step therapy or prior authorization.)
- Open mail order scripts can be transferred from the current Group Part D mail order carrier.
- Aetna can agree to honor prior authorizations currently in place, *but only IF* we receive timely data from the current group Part D plan. In order for us to successfully enter prior authorizations in our system prior to the effective date, upon the City's request, the City's PBM would need to provide to Aetna with an initial, complete prior authorization file from the current carrier no later three months prior to the effective date; then, two follow-up files to identify new utilizers would be required one month prior to and 15 days after the effective date. It will be important for the City to work with the current group Part D carriers to ensure these files are received within the necessary timelines. Aetna will provide the City with the necessary data fields needed for the claims history and the honor prior authorization processes.

Pharmacy plans - This proposal assumes that where our standalone Medicare Prescription Drug plan (PDP) is a retiree option alongside any competitor plan, our benefit design is not positioned as the richest pharmacy plan available.

Use of pharmacy data for medical management - The enclosed medical rates assume that either, a) we are the pharmacy benefit administrator or PDP carrier or, b) we receive weekly pharmacy data feeds in an appropriate format from either you or your designated third party. The medical rates are subject to revision if either of these conditions does not occur.

Medicare Part D Formulary - The supplemental premium rate is limited to prescription drugs covered by our current formulary offering as of the date of this quote. Aetna reserves the right to adjust the premium if the formulary changes, per CMS review/approval of our formulary filing.

Mail Order refill data transfer- You must provide a Mail Order pharmacy open refill data file for electronic transfer of prescriptions to Aetna. The file must be received two months prior to the effective date. Aetna does not charge a fee for incoming open refill files.

New York Mandates -

The premium for the standalone Aetna Medicare Prescription Drug Plan (PDP) includes coverage mandated under New York State law for enteral formulas. Additionally, the PDP formulary includes coverage for the following medications mandated under New York State law: some oral cancer medications, some oral contraceptives, off-label cancer drug use in certain situations, and eye medications refills within a specified time period. CMS does not mandate the inclusion of this coverage in Medicare Part D plans.

In the event additional coverage is mandated under New York State law for a plan year (e.g., coverage for medications not already covered by the CMS-approved Aetna PDP formulary), Aetna shall provide the City with at least 60-days advance notice of any medications that will be added to the PDP formularies. Aetna will not remove any medications from the PDP formularies if it determines that coverage for such medications under the PDP is required to ensure Aetna's compliance with CMS and/or New York State laws, rules and regulations. Due to New York State law, the City agrees to a retrospective claim reconciliation arrangement. Under this arrangement, Aetna will calculate the amount of PDP claims costs incurred and paid for the additional coverage required under New York State law. The City will remit payment to Aetna in the amount of those PDP paid claims incurred according to the following annual schedule:

Reconciliation Period Example using plan year 2024	**Statement of Reconciliation/ Accounting**	**Payments Due to Aetna by**
January 1, 2024 through December 31, 2024 **Final settlement reconciliation**	June 30, 2025	October 1, 2025

Aetna Mail Order and Specialty

Aetna's mail order benefits are filled by CVS Caremark® Mail Service Pharmacy. This mail order service supplies medications for drugs taken on a regular basis, sometimes referred to as maintenance drugs. Examples of maintenance drugs include medications used to treat chronic conditions such as arthritis, high cholesterol, asthma, or high blood pressure. CVS Caremark® Mail Service Pharmacy does not supply medications used for short-term illnesses, such as cold medications or antibiotics. Additionally, certain drugs that require special handling may not be available through CVS Caremark® Mail Service Pharmacy. These drugs are sometimes called specialty drugs and may require storage at controlled temperatures or other unique handling requirements which cannot be accommodated through a traditional mail order arrangement. Therefore, most specialty drugs are not available at the mail order benefit (cost share) and instead will pay at the

retail benefit (cost share). Also, specialty drugs are generally limited to a 30-day fill, to reduce waste of these high-cost drugs.

Legal Entity and Administrative Platform

The Aetna Medicare Rx Prescription Drug Plan (PDP) is offered by SilverScript Insurance Company (SilverScript). SilverScript is a CVS affiliate and is contracted with CMS for 2023. CVS is the parent company of both Aetna and SilverScript.

Administration of the Open formulary
Newly approved drugs won't be covered until they've undergone internal clinical review as well as external review by our Pharmacy and Therapeutics (P&T) Committee. Following the review, we will determine in which tier the drug will reside, include any applicable utilization management edits as approved by the P&T committee, and release the drug for coverage under open formulary plans.

Medicare Part D creditable coverage
If an applicant cannot demonstrate that he/she had prior creditable coverage, the applicant may incur late enrollment penalties, consistent with laws, rules, and regulations applicable to the Part D program.

Premiums

- **Medicare Advantage – Premium Requirements** - The following requirements apply only if Aetna is offering a Medicare Advantage HMO or PPO Plan to your members, and you and your members are paying any portion of the premium for the Medicare Advantage benefit ("MA Premium"). CMS requires that we notify you of these requirements. You must comply with the following conditions with respect to any subsidization of MA Premium and any required MA Premium contribution by the member:

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

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

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

Premium and Low Income Subsidy ("LIS") Requirements and Late Enrollment Penalty ("LEP") - City of New York will comply with the following conditions with respect to any subsidization of that portion of premiums paid by City of New York for the Medicare Prescription Drug benefit ("PD Premium") and any required PD Premium contribution by members enrolled in PDPs ("Members"):

- City of New York may subsidize different amounts of PD Premium for different classes of Members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Classes of Members and their dependents cannot be based on eligibility for the Low-Income Subsidy ("LIS").

- PD Premium contribution levels cannot vary for Members within a given class.

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

City of New York will comply with the following conditions with respect to any LIS payment received from CMS for any LIS-eligible Member:

- Any monthly LIS payment received from CMS for a LIS-eligible Member shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of the City of New York's PD Premium contribution. However, if the sum of the Member Contribution and City of New York's PD Premium is less than the LIS payment, any portion of the LIS payment will be returned to CMS by Aetna.

- If the LIS payment for any LIS-eligible Member is less than the Member Contribution required by such individual (including the Member Contribution for supplemental benefits, if any), City of New York shall communicate with the LIS-eligible Member about the cost of remaining enrolled in City of New York's Plan versus obtaining coverage as an individual under another Medicare Part D Prescription Drug plan.

In the event that the LIS-eligible Member is due a refund of the LIS payment (i.e., there was no upfront reduction of the PD Premium by the LIS amount), such refund shall be completed by Aetna or City of New York, as applicable, within 45 days of the date Aetna receives the LIS payment for that Member from CMS.

Group Billed - If Aetna is billing and collecting the entire plan premium from City of New York and City of New York chooses to receive group list invoices, Aetna will apply LIS subsidy credits and LEP debits to the group invoice. City of New York must apply the LIS subsidy and collect the LEP consistent with applicable law.

Direct Billed - If City of New York chooses direct billing (i.e., Aetna directly bills and collects the entire plan premium from Members), Aetna will apply LIS to the Member invoice and will add LEP debits consistent with applicable law.

Additional Retiree Programs

Helping your retirees obtain Medicaid coverage
We're pleased to provide group plan sponsors with an outreach program through Change Healthcare™. The program provides continuous monitoring of social program eligibility and enrollment status to ensure appropriate access to benefits for which members are entitled.

The program includes:
- Initial Outreach
- Enrollment Assistance
- Annual Recertification
- Screen & Electronically Submit for Medicare's Part D Extra Help Program

We believe our Medicaid outreach program provides a valuable service to potentially eligible members by educating them about and screening for Medicaid programs. Medicaid eligibility may help reduce member out-of-pocket cost sharing and premiums. It can also help us reduce annual plan premium increases due to the additional payment we receive from CMS for these beneficiaries.

If your organization doesn't wish to participate and have your retirees contacted by Altegra Health, your organization may "opt-out" of our Medicaid outreach program. To do so, please contact your Aetna representative no later than two months prior to the effective date.

Please Note: If we don't receive your "opt-out" notification two months prior to the effective date, your organization will be included in our Medicaid outreach program.

Federal Information

Employer Reporting Requirements:
Under Internal Revenue Code (IRC) Section 6055 health insurance issuers, certain employers, government agencies and other entities that provide Minimum Essential Coverage (MEC) to individuals must report to the IRS information about the type and period of coverage and furnish related statements to covered individuals. This information is used by the IRS to administer the individual shared responsibility provision and by individuals to show compliance with the individual shared responsibility provision.
For Medicare plans (including Medicare Advantage), the reporting obligation under Section 6055 is on the Centers for Medicare and Medicaid Services (CMS) to the extent it applies. CMS will report the required information to the IRS about the type and period of coverage provided to each individual member enrolled in these plans and will furnish the required statements to subscribers.

IRC Section 6056 requires large employers (those having employed an average of 50 or more full-time employees during the preceding calendar year) to report to the IRS information about the health care coverage they have offered and also furnish applicable statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions.

To satisfy the 6056 employer reporting requirements, you must file the required returns with the IRS by no later than February 28 of the year following coverage (if filing on paper) or March 31 (if filing electronically), and furnish a statement to all full-time employees by January 31st of the year following the calendar year to which the return relates (i.e., January 31, 2023 for the 2023 calendar year).

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company and/or SilverScript Insurance Company (Aetna). Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. Limitations, co-payments, and restrictions may apply. Benefits, pharmacy network, provider network, premium and/or co-payments/co-insurance may change on January 1 of each year.