Medical
CBIA HC ConnectiCare Fixed Funding Solutions
51+ Full Time Equivalent Employees

Underwriting Rules and Disclaimers

General

Each plan listed above is self-funded according to a standard design. Stop loss coverage, however, provides insurance protection to the employer under a stop loss policy issued by ConnectiCare Insurance Company, Inc. or its affiliate ("CICI"). An expected claim fund account is set up in a designated bank and funded monthly by the employer under an Administrative Services Agreement ("ASA"). The monthly costs shown above include components for administrative fees, stop loss premium, claims funding and terminal reserves. Nothing in this Final Quote shall supersede the provisions in those plan documents.

Rates and Fees

CICI reserves the right to reprice due to:

1. Failure to meet the underwriting caveats and quote assumptions explained below;
2. Changes in your Plan, claim payment requirements, account structure;
3. A decision is not reached within 60 days from release of quote;
4. Changes in law or regulation or interpretations thereof.

Important Note for Self-Funded Plans Up For Renewal - Stop-Loss and ASA Notice

The following statement provides you with advance written notice of termination: If we don't receive your written acceptance of the renewal terms by the date indicated in this Final Proposal, we elect to terminate, at your renewal date, your stop loss policy and your ASA.

Plan Designs

Plans are designed for group health plans governed by the Employee Retirement Income Security Act of 1974 ("ERISA"). Fixed Funded Solutions products ("FFS") are not available to non-ERISA groups.

A description of each available self-funded benefit plan can be found in the Summary of Benefits and Summary of Benefits and Coverage (SBC's) at cbia.com/FFS_Benefits.

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State benefit mandates

State benefit mandates do not apply to the self-funded ERISA groups. However, FFS plans provide the same benefits as fully-insured plans for the services listed below:

- Allergy Injection
- Autism services: behavioral therapy; direct or consultative psychiatric and psychological services; physical and occupational therapies; speech and language pathology services; drugs prescribed for treatment of symptoms and comorbidities, even when the drugs may be covered for other diseases and conditions.
- Birth to 3 (early intervention services)
- Breast implant removal
- Breast reconstruction
- Contraceptives, devices, drugs, etc.
- Diabetes equipment and education
- Infertility services, including prescription drugs for diagnosis or treatment
- Lead poisoning in children
- Lyme disease
- Mammograms
- Prescription eye drops (including refills)
- Rehabilitative therapies
- Scalp/hair prostheses
- Treatment of mental health and substance abuse, including medical complications
- Unlimited routine foot care (2023 Federal mandate)

The FFS plans do not provide the same coverage as fully-insured plans for the following services.

Services or treatment	With a Fixed Funding Solutions plan
Medically necessary anesthesia for the treatment of dental conditions in an outpatient setting	Not covered
Ostomy equipment and supplies	Not covered
Craniofacial disorder treatment	Not covered
Hearing aids	Not covered
Infant formulas, food supplements, nutritional supplements and enteral nutritional therapy	Not covered
Testing for bone marrow	Not covered
Pediatric dental	Not covered
Pediatric vision	Not covered

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Gender reassignment surgery and all related services	Not covered
TMJ disorders	Not covered

Check plan documents for details. The above listing in this section heading is for informational purposes only and is not an invitation to contract or solicit medical advice. It contains only a partial, general description of certain plan benefits and does not constitute a contract. It is not intended to be an exhaustive comparison of the benefits covered under the plans. While this information is believed true at time of Final Proposal, it is subject to change without notice.

Other Plan Features and Rules

- HSA plans are available with or without Health Equity integration with no cost differential.
- Pharmacy benefits are included.
- Dependent limiting age is up to age 26.
- Quote assumes no grandfathering.
- Some plan benefits are subject to age and frequency schedules, limitations or visit maximums.
- Members or Providers may be required to pre-certify or obtain approval for certain services.
- Deductibles, copays and coinsurance apply to the out-of-pocket limit (OOP).
- Plan features and availability may vary by location and group size.
- Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage.
- Coordination of Benefit rules assume that plan will always pay claims secondary to no-fault automobile personal injury protection coverage. You agree to make Members aware of this rule.
- CICI receives and retains rebates from drug manufacturers that may be considered when determining its preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions.
- Plan features are subject to change to the extent permitted by law and contract.
- The ASA and associated Stop Loss Policy may be terminated on any anniversary date by providing at least 60 days prior written notice to the Employer and as otherwise permitted in the agreements.
- Unless required by law, we do not produce EOBs for claims when there is no member liability.

Administrative Services

- Claims processing assumes a 48-month run-out timeframe.
- Details of Administrative Services are within the ASA**.**

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- **A broker fee of $40 PEPM is included as part of the administrative fees and is not part of your Stop Loss Policy premium.**

Claims Funding

- The employer is required to pre-fund claims in a designated bank account and is responsible for claims up to the aggregate attachment point which is the greater of 120% of the monthly Expected Claims Cost, $4,000 per employee per year or $20,000 per group per year.
- Estimated Claim Costs and other component costs vary based on actual enrolled Employees by month.
- The stop loss policy covers employer liability for claims exceeding the Individual and Aggregate attachment points.
- If the employer's actual claims responsibility is greater than the Claims Funding amount, the plan will be in a deficit. If the employer's actual claims responsibility is less than the Claims Funding Amount, the plan will be in a surplus.
- Surplus will be shared on a 50%/50% basis between the employer and CICI except no surplus will be payable if employer terminates or does not renew. Following renewal of a ConnectiCare medical product offering, 50% of the surplus will be returned to the employer according to the plan documents.
- In addition to standard fee-for-service rates, contracted rates with network providers may also be based on case and/or per diem rates and in some circumstances, include risk-adjustment calculations, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. We may also make accountable care payments ("ACPs") to your locally based network providers. ACPs provide funding to help locally based network providers to improve quality, reduce costs and enhance the patient experience. We treat ACPs as Covered Benefits under your plan, and with one exception (discussed in the next sentence) we charge the ACPs to your Actual Claim Costs when we make the payments. Because we make ACPs retrospectively, we reflect anticipated ACPs for the fourth quarter of your Plan Year in the following Agreement Period or as an increase to your Run-off Claim Costs if you terminate with us.

This proposal is only a summary of the benefits in the solution being suggested for your company and does not constitute a final agreement. Final cost and eligibility will be determined upon actual enrollment and rates then in effect. Illustration does not guarantee rates. Rates are subject to change based on employee and employer demographics.

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- On your behalf, we have secured Rawlings & Associates to provide comprehensive recovery services. They charge a contingency fee for each service as follows:

Service	% of Savings
Coordination of Benefits	18%
Subrogation	23%
Workers Compensation	19%

ConnectiCare is paying this fee on your behalf but reserves the right to credit your claims fund account with the recovery minus the contingency fee. We will provide 30 days prior notice before doing so.

Stop Loss Policy

- Stop loss is quoted on a 12-month incurred, 15 months paid basis, with a terminal run-out period of 48 months (see **Terminal Reserve Obligation** heading below).
- Run-in stop loss coverage is not available.
- Stop loss policy contains exclusions and limitations consistent with the standard plans.
- An application for stop loss coverage must be completed to obtain coverage unless waived in writing by CICI.
- CICI or its affiliate must be the stop loss carrier.
- Stop loss policy contains terminal reserves.
- Lasers will not apply.

Terminal Reserve Obligation

- Provides run-out protection for claims in excess of the applicable Aggregate and Individual Stop Loss Amounts and is effective only at termination.
- At termination the Aggregate Stop Loss amount will be adjusted to include the balance of the Terminal Reserve Obligation.
- Additional Stop Loss Premium is not required at termination.
- Aggregate and Individual Stop Loss Amounts in the final policy year will include claims incurred prior to termination and paid within the 48 months run-out period.

Group Eligibility Requirements

- Eligible Employers must operate in Connecticut with a majority of their employees working or residing in Connecticut.
- CICI must be offered as the sole administrator/stop loss carrier.
- Minimum 75% participation after the following approved coverage waivers: spousal, Medicare, Medicaid, Military, parental, and individual.

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- Participation and Contribution Guidelines can be found on the Employer Participation Agreement and in the CBIA Administration Manual.
- Employer must contribute a minimum of 50% of the single employee rate for the designated base plan toward all plans and coverage “tiers” (i.e., family coverage).
- CICI reserves the right to reprice, terminate or decline to quote if the employer funds more than 50% of the plan deductible or provides an underlying plan that partially or completely subsidizes the member.
- CICI reserves the right to reprice, terminate or to decline to quote if enrollment changes.
- Completion of Individual Medical Questionnaires is not required in all cases. However, CICI reserves the right to require them as needed. Quoted rates may change or the group may be declined due to the results of the Individual Medical Questionnaires.
- Retirees and their dependents are not eligible.
- Fixed Funding Solutions products (“FFS”) are not available to non-ERISA groups.
- Certification of small or large group status is required upon initial enrollment and upon renewal.
- For multiple affiliated groups in multiple states, Underwriting will determine if the groups can legally be considered affiliated and offered an FFS plan.

Employee/dependent eligibility requirements

- To be eligible, the employee must be considered permanent and working 30-hours or more in a scheduled work week.
- Employees must show proof of employment and proof of income to be eligible for coverage.
- Unpaid employees, retirees and their dependents are not eligible.
- New Hire waiting period must not exceed 90 calendar days from date of hire.

An eligible dependent is defined as follows

- Spouse, or domestic partner, if the employer elects to offer coverage.
- Any child (recognized natural child, adopted child, or stepchild) up to age 26.
- Dependents who reach the age of 26 will have coverage through the end of the policy year.
- A child becomes a dependent at birth or when the employee legally adopts or retains physical custody of the child to be adopted.
- A stepchild becomes a dependent when the employee marries the natural or adopted child’s parent.

Enrollment

- Enrollment documents including member applications must be received within 3 days prior to the effective date.

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- If enrollment documents are not received 3 days prior to the requested effective date approval is not guaranteed.
- No retroactive enrollments allowed.
- Employer eligibility, final enrollment, rates and fees are subject to underwriting, and approval by ConnectiCare Insurance Company Inc.

Other plan features and rules

- HSA plans are available with or without Health Equity integration with no cost differential.
- Plan features and availability may vary by location and group size.
- Employer may choose up to the maximum five plan designs.
- State benefit mandates do not apply to the self-funded ERISA groups. The FFS suite of plans do not provide the same coverage as fully insured plans for some services. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage.
- Plan features are subject to change to the extent permitted by law and contract.

COBRA/Continuation

- Employers with 20 or more employees must offer Federal COBRA coverage. Federal COBRA applies to employers with 20 or more employees on more than 50% of its typical business days in the previous calendar year.
    - Both full- and part-time employees are counted to determine whether a plan is subject to COBRA.
    - Each part-time employee counts as a fraction of a full-time employee, with the fraction equal to the number of hours worked divided by the hours an employee must work to be considered full time.
- Employers with 19 and fewer employees (refer to same calculation as Federal COBRA) may choose whether to offer 18 months of Continuation to Mini-COBRA/Spousal Continuation beneficiaries under CICI's Fixed Funding Solutions product. Employers are responsible for complying with any specific laws regarding continuation coverage and may make other arrangements for longer periods of continuation coverage. ConnectiCare is not a COBRA administrator. Claims under any such other arrangements will not be administered by CICI and will be excluded from stop loss coverage.

No Practice of Medicine – Providers are Independent Contractors

Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Providers are independent contractors

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and not agents of CICI. Provider participation may change without notice. CICI does not provide care or guarantee access to health services.

Billing

For all self-funded plan options, contract and plan effective dates are 1st of the month. Effective dates on the 15th of the month are not currently offered for self-funded plans.

Broker Compensation and CBIA Fees

Broker compensation of $40.00 PEPM is included in the Total Amount as part of the administrative fees and in not included in the stop loss premium. The Total Amount also includes fees for CBIA's administration.

Enrollment

This Final Renewal Proposal is based on the employees listed above, including any dependents shown on the attached Employee Enrollment report.

Employer eligibility, final enrollment, rates, and fees are subject to underwriting, and approval by CICI. Individual Medical Questionnaires may be required.

Banking

CICI or its banking partner shall be authorized to debit the employer's bank account monthly for an amount consisting of the sum of the Administrative Fees, Stop Loss Premium, Claims Funding, and Terminal Reserve Obligation (TRO).

Patient Protection and Affordable Care Act (PPACA) and State Taxes and Fees

- Quote is intended to be compliant with PPACA.
- Quote assumes the plan is not grandfathered.
- Any taxes or fees applied to self-funded benefits plans related to PPACA are the obligation of the employer and are not included in the Total Amount and will not be administered by CICI.
- Although CICI will indicate whether plans meet or do not meet the minimum value standards of PPACA if applicable to your plan on an SBC, we do not assume any responsibility or liability regarding minimum value evaluation as it is the responsibility of the employer to make this

determination. We do not provide legal or tax advice and recommend that the employer consult with their own legal and tax counselors when making minimum essential coverage and minimum value calculations.

- Employer is responsible for all applicable state taxes and fees that apply directly to their plan unless expressly stated otherwise in the plan documents.

Massachusetts Creditable Coverage

If the group has any Massachusetts employees, the plan will need to meet minimum coverage requirements according to Massachusetts Creditable Coverage. If the employee/group proceeds with a plan that does not, the MA employee(s) could be subject to fines/penalties. The Employer is responsible for the attestation process and will receive an attestation form to complete and return to verify that the plan meets Massachusetts Creditable Coverage. Although CICI will indicate whether plans meet or do not meet creditable status according to the rules of Massachusetts Creditable Coverage, if applicable to your plan, we do not assume any responsibility as it is the responsibility of the employer to make this determination. For more information or questions/concerns on Massachusetts Credibility, please contact your CPA of Financial Advisor.

The benefits and fees within this quote are subject to change pending any required approvals from state or federal regulatory agencies.

CICI reserves the right to modify its products, services, rates and fees, in response to legislation, regulation or requests of government authorities resulting in changes to plan benefits and to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

Reporting

- State all payer claims database laws mandate that insurance carriers and TPAs for self-funded plans supply data to that state's all payers claims database (APCD). As a result, we are required to submit health care claims data to those states. In some states, the law makes reporting for self-funded plans voluntary. We will provide your self-funded plan data to these states unless you inform us in writing not to.

SBCs

If requested, we will assist with the preparation of draft Summary of Benefits and Coverage (SBCs), subject to your direction, review and final approval. Draft SBCs will be based on the benefits

information you provide and existing plan information from our benefit source system. We will include plan design information in the draft SBC relating to products or services administered under the system. We will include plan design information in the draft SBC relating to products or services administered under the Administrative Services Agreement as well as any additional pharmacy or behavioral health carve out information provided by the plan sponsor or its delegate.

You have the responsibility to review and approve any SBCs and revisions hereto and to consult with your legal counsel, at your discretion, in connection with the review and approval, and to disseminate the final SBC to Plan participants. We have no responsibility or liability for the content or distribution of any of the SBCs, regardless of the role we may have played in the preparation of the documents.

We will provide the SBC in editable format so plan sponsors for self-funded plans can update MV and MEC statements within the document to appropriately reflect their determination for each respective plan. We do not provide legal or tax advice and recommend that plan sponsors consult with their own legal and tax counselors when making MEC and MV determinations.

We will review the minimum value standard for the plans based on the minimum value calculator criteria provided by the Department of Health and Humans Services (HHS).

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.

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. Self-funded employers are responsible for collecting and reporting the information to both the IRS and its employees pursuant to their obligations under both Sections 6055 and 6056. For the collection they may use a combined form for their 6055 and 6056 reporting. Entities must file returns under the 6055 and 6056 requirements with the no later than February 28 of the year following coverage (if filing on paper) or March 31 if filing electronically. A statement must be furnished to individuals by January

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31 of the year succeeding the calendar year to which the return relates.

Grandfathered Plans

For your company's plans that are currently certified as grandfathered, in order to retain grandfathered status, the plan must meet all grandfathering criteria and must have done nothing to cause the loss of grandfathered status in relation to the benefits in place on March 23, 2010. It is your responsibility to inform us whether changes to your plan have resulted in a loss of grandfathered status. We recommend that you seek the advice of legal counsel in making this determination and/or before making changes to your medical plan or your business that might defeat grandfathered status.

You are also required to notify us if your contribution rate changes for a grandfathered plan at any point during the plan year. By accepting your renewal, you represent that your contribution rate towards the cost of coverage for the upcoming plan year has not decreased by more than 5 percentage points below the contribution rate that was in effect on March 23, 2010.

Except for specific and limited scenarios described as transitional rules in the health care reform legislation, if a plan's grandfathered status has been lost, it cannot be regained. If, after reviewing the grandfathering rules with your benefit consultant or counsel, you determine that your coverage could be or is grandfathered, and you want to retain grandfathered status, you should contact your Account Executive for further instructions.

Federal Mental Health Parity

For self-funded plans, it is the plan sponsor's responsibility to ensure its plan complies with Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), including any and all regulations, amendments, and regulatory guidance. We cannot provide a self-funded plan sponsor legal advice on the application of MHPAEA (or any other law) to its plan. The plan sponsor should consult with its legal counsel to determine compliance with MHPAEA.

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Approved and agreed upon by employer and agent:

Owner/Officer of Company:

Employer/Company ________________________________

Print Name _______________________________________

Title ____

Signature ____

Date ____

Writing Agent:

Agency ___________________________________

Print Name ________________________________

Title_______________________________________

Signature __________________________________

Date _______________________________________

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