County of El Paso **January 1, 2023 through December 31, 2023**

Effective Date
The rates and benefit plan designs provided in this renewal are effective January 1, 2023 through December 31, 2023.

Definitions
For the purpose of this document: (1) "MA" means a group Medicare Advantage MA HMO and/or PPO plan without Medicare prescription drug coverage; (2) "MAPD" means a group MA HMO and/or PPO plan with Medicare prescription drug coverage; (3) "PDP" means a group standalone Medicare prescription drug plan; and (4) "ESA" means an MA PPO plan that uses a CMS-established waiver of service area requirements to offer coverage to eligible retirees/dependents who reside in an extended service area that does not offer a provider network that meets CMS network adequacy requirements.

Automatic renewal of your plan if we don't hear from you by October 1, 2022
If you plan to change or terminate your Aetna Group Medicare Plan you need to notify us in writing as soon as possible. We must hear from you by October 1, 2022. Otherwise, we will assume you consider the information in this renewal to be accurate and you have chosen to renew your Aetna Group Medicare Plan for 2023.

If you do not respond to this renewal, we will automatically renew your plan with the benefits, cost sharing, premium rates and terms and conditions described in this renewal and enclosed materials, and in your agreement with Aetna.

The following conditions allow us to assess the potential financial impact and adjust premium rates, subject to applicable state and federal mandates:

- **Enrollment Assumptions** – We reserve the right to rerate or restructure our rating if: a) the total enrollment varies by more than 10 percent from the enrollment assumption used in the enclosed rating or, b) if any site's enrolled membership expressed as a percent of total enrolled membership varies by more than +/- 10 percent from that assumed when rating the case. Aetna group retiree coverage does not extend to additional employer groups unless we are able to review supplemental census information and other underwriting information for appropriate financial review.

- **Full replacement** - This renewal assumes Aetna group retiree benefits will be a full replacement and the only plan for all current and future retirees from any source or other entity. If at any point in time during the period of the coverage, Aetna is not the full replacement plan, we reserve the right to revise, modify or terminate this renewal.

- **Legislative, Regulatory or Enforcement action** – Aetna reserves the right to rerate or restructure our rating for any legislative, regulatory or CMS changes or enforcement actions that cause a material change to taxes, fees, and assessments, required benefits, funding levels, or the manner and/or cost of providing Medicare Advantage with Part D Benefits.

- **Plan eligibility for MA and MAPD** -This renewal assumes all members are retired and enrolled in Medicare Part A and Part B. If you have retirees that are not eligible for premium free Part A they must be enrolled in an Aetna Medicare Part B only plan and separate rates will be provided to cover these members. Additionally, you represent that actively working employees and their dependents are not permitted to enroll in your group Medicare Advantage and/or Medicare Advantage with prescription drug plan(s) ("Plan(s)"), and that by offering the Plan(s) you intend to create and maintain a retiree plan that is separate from your active plan.

- **Employer contribution requirements** - This renewal assumes your average employer contribution level is 50% of the group premium for the Medical/Pharmacy plan. If the actual employer contribution differs from this assumed percentage, the medical and/or pharmacy rates and/or the plan offering are subject to revision.

- **Medicare Part D** - Aetna reserves the right to change the Medicare Part D premium, including the Medicare Part D component of the MAPD rate, or restructure the Part D plan design or formulary for the quoted plan year(s) if any changes are made to the laws, rules and/or regulations applicable to the Medicare Part D program.

  The premium developed in this proposal excludes any additional income-related Medicare Part D premium payments required of Medicare-eligible members in order for the member to be eligible for the Part D product.

  Aetna reserves the right to communicate with enrolled members regarding opportunities to reduce out of pocket prescription drug costs.

- **Medicare Part D Formulary** - The 2023 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 2023 premium if the formulary changes, per CMS review/approval of our 2023 formulary filing.

- **Rate and benefit approval** -This renewal 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 January 1, 2023 through December 31, 2023.

- **Blended MA PPO and PPO-ESA rates** - For billing purposes and administrative ease, we have blended our Medicare Advantage PPO and Medicare Advantage PPO with ESA rates. Due to the anti-selection concerns inherent in this billing arrangement, this must be a sole offering to these members.

- **Timely premium payments** - If a premium payment is not paid in full on or before the premium due date, a late payment charge of one and one-half percent of the total amount due per month may be added to the amount due, beginning with the premium due date. We also have the right to assess late premium payment and costs of collection of any unpaid premiums or fees, including reasonable attorney's fees and cost of suit.

- **End stage renal disease** - This section applies to Aetna's group MA, MAPD 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 renewal.

- **Medical deductible credits** - This quote excludes medical deductible credits from our proposed medical plan.

- **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.

- **Additional products and services-** We will bill you for the cost of special services that are not included or assumed in the pricing. For example, you'll be subject to additional charges for customized communication materials. Costs will depend on the actual services performed and are determined at the time the service is requested.

Inaccurate or incomplete information – We're relying on information from you and your representatives in establishing the rates and terms of this renewal. If any of this information is inaccurate or incomplete and has a material impact on the cost of the programs, we reserve the right to adjust our rates and terms.

Proprietary and Confidential – This renewal contains trade secrets and commercial and financial information that Aetna deems proprietary and confidential and cannot be further released to any third party by County of El Paso without Aetna's prior written consent.

Aetna Intellectual Property
Under your Agreement with Aetna for the group Medicare Plans ("Agreement"), you may have access to certain of Aetna's Customer reporting systems. Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing services under the Agreement ("Aetna IP"). Aetna will grant you, as the Customer, a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in the Agreement. You agree not to modify, create derivative product from, copy, duplicate, decompile, dissemble, reverse-engineer or otherwise attempt to perceive the source code from which any software component

of the Aetna IP is compiled or interpreted. Nothing in the Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent or otherwise transfer or convey, the Aetna IP to you.

Conclusion

We present this renewal on the condition that it will be accepted in its entirety. Furthermore, we've assumed that you'll continue to offer all other coverages, products, and services that you purchased previously. If there is a material change in this regard, we reserve the right to review and reprice this renewal. If you're interested in a subset of our renewal, then we will gladly review and reprice, if necessary. Before accepting the rates in this renewal, you must disclose any material deviation, current or expected, from these assumptions.

The most recent version of this document issued by Aetna to you, including any attachments to this document (collectively, "Financial Documents") are part of your agreement with Aetna to offer Medicare Advantage plans and/or standalone Medicare prescription drug plans ("Group Agreement"). In the event of a conflict between the terms of the Financial Documents and your Group Agreement and the documents incorporated into the Group Agreement, the order of priority shall be as described in your Group Agreement. Any riders, amendments, inserts and attachments shall have the same priority as the document to which they are attached.

County of El Paso **January 1, 2023 through December 31, 2023**

Broker commissions – The enclosed rates exclude broker commissions.

We honor 'Agent of Record' or 'Broker of Record' letters when an agent, broker, or consultant sells new business or takes over an Aetna case from another agent, broker, or consultant. Please have an appropriate representative from your organization sign the letter using your organization's letterhead. The change will become effective on the first day of the month after our payment unit receives the 'Agent of Record' or 'Broker of Record' letter unless another future date is designated in the letter.

County of El Paso **January 1, 2023 through December 31, 2023**

The following plan benefit information is being provided to notify County of El Paso of some important information related to Aetna's Medicare Advantage and Part D plans.

Medicare Advantage – Medical Plan Information

CMS Changes

Each year, CMS sets cost sharing threshold amounts on specific MA plan benefits to ensure access to care and prevent discrimination against certain classes of Medicare beneficiaries. CMS has made the following changes to these thresholds for 2023.

Changes to maximum-out-of-pocket (MOOP) limit for some MA PPO plans

CMS has moved from two MOOP thresholds in 2022 (Voluntary and Mandatory) to three MOOP thresholds for 2023 (Lower, Intermediate and Mandatory) for the in-network and plan level (or combined) MOOP on a MA PPO plan. CMS provides you with the ability to establish different values for your plan. Plans offering an in-network MOOP in the Lower, Intermediate or Mandatory range must also offer a plan level MOOP in the same range. The chart below helps to define the 2023 thresholds for MA PPO.

Lower MOOP	Intermediate MOOP	Mandatory MOOP
$0 - $3,650 In-network $0 -$5,450 Plan Level (combined)	$3,651 - $6,000 In-network $3,651 - $8,950 Plan Level (combined)	$6,001 - $8,300 In-network $6,001 - $12,450 Plan Level (combined)

To encourage members to receive the most effective health care CMS has adjusted the cost share thresholds for specific service categories. These changes have been implemented with respect to the Aetna standard plan portfolio. It is important that you review each service category in your Summary of Benefits for any year-over-year changes.

Your Aetna account representative can assist you with understanding these year-over-year changes and any additional adjustments you may want to make to your plan.

Network

Changes in Aetna Medicare Advantage network-based service areas for 2023

- **PPO:** We worked hard during 2022 to meet CMS network adequacy rules and add to our MA PPO network. We have successfully completed this effort and will be adding **32** counties to our MA PPO network service area in 2023. Please see the 2023 Aetna Medicare Advantage PPO network-based expansion counties exhibit in the Index to this renewal.

Our network providers go through a comprehensive credentialing process before they're included in our Medicare network.

MA PPO plan with an extended service area
The Aetna PPO Plan network-based service areas will expand in 2023. We have established contracts with additional providers and now meet CMS network access requirements in new counties.

Any retirees/dependents that live in network-based service areas in 2023 will be enrolled in the Aetna MA plan (PPO). The MA PPO plan encourages members to use participating providers who are engaged in more robust medical management programs. This helps to manage health plan costs and reduce plan premium increases. Members will have higher cost sharing when accessing care from out-of-network providers.

We will work with you to update any electronic eligibility files with the new MA PPO plan designation.

In addition, any member that resides in an MA PPO plan service area where we no longer meet CMS network adequacy requirements will be transitioned to a new plan. We will offer these members our MA PPO with extended service areas (ESA). The MA PPO ESA plan offers members the same level of coverage for benefits received both in-network and out-of-network, so members can still access covered services consistent with CMS requirements.

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 in an ESA plan may not have access to the Aetna network of providers that meets CMS network adequacy requirements.
- Providers that are not contracted with Aetna are not required to accept the Aetna ESA PPO plan except for emergency and urgently needed care.

We will monitor the network adequacy throughout the year to confirm that 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 May 2022, 97.42% of your members reside in service areas that meet CMS network adequacy requirements. If the total percentage of members 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.

US Territories
Aetna offers Medicare Advantage PPO plans to retirees throughout the 50 states, Washington, DC, and the US Territories through use of a CMS service area waiver ("MA PPO ESA plans"). Please be advised that coverage under the MA PPO ESA plan in the US Territories is limited to medical coverage. Aetna MA PPO ESA plans do not offer fully insured Medicare prescription drug coverage in the US Territories. Therefore, if one of your MA PPO ESA plan members moves to a US Territory and Medicare prescription drug coverage is offered under that plan, the member will no longer be eligible for the plan. By mutual agreement, Aetna may offer a MA PPO ESA plan with medical coverage only for your members who reside in the US Territories, and we will discuss with you available pharmacy coverage options.

We are making you aware of these rules because of the potential impact to your account structure and eligibility files in this scenario. Please reach out to your Account Management Team for more information.

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.

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.

CMS changes

The CMS Part D benefit parameters will change for 2023. For plan details, you should refer to the plan design document, included with this renewal. These changes, which are listed below, may or may not impact your current plan design.

Deductible cannot exceed:	$505
Initial Coverage Limit (ICL) has increased from $4,430 to:	$4,660
True out-of-pocket limit (TrOOP) has increased from $7,050 to:	$7,400
Catastrophic copayments have increased from $3.95 and $9.85 to:	$4.15 for covered generic drugs and $10.35 for other drugs (or 5%, whichever is greater)

For 2023, member cost sharing during the coverage gap phase for covered Part D drugs is to be no more than 25 percent for both generic drugs and brand-name drugs.

The Medicare Coverage Gap Discount Program provides a 70 percent manufacturer discounts on covered brand-name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." This discount is applied before any supplemental benefits included in the plan.

Aetna prescription drug plan changes for 2023

Part D formulary changes

Formularies change on an annual basis. Members should review the updated formulary that aligns with their plan to determine the tier of coverage and what they will pay for their drugs

in 2023. Updated plan year formularies are made available online during the 'Annual Notice of Change' member communications which occurs 15 days prior to the designated open enrollment or, if there is no designated open enrollment period, no later than 15 days before December 31st. Members may also request a printed copy of this formulary to be mailed to them by contacting customer service.

Aetna is changing the names of our formularies for 2023.

2022 Formulary Name	2023 Formulary Name	Description
Open 2 Plus	Comprehensive+	• Richest option, open, covers all Part D drugs • Generic drugs reside on defined generic tier(s)
B2 Plus	Classic+	• Closed, covering a subset of Part D drugs, medium coverage • Generic drugs reside on defined generic tier(s)
B2	Classic	• Closed, covering a subset of Part D drugs, medium coverage • Commingled, generics reside on all tiers
A1 Plus	Core+	• Closed, lean coverage • Generic drugs reside on defined generic tier(s)
A1	Core	• Closed, lean coverage • Commingled, generics reside on all tiers

We have discontinued the Open 1 formulary for 2023. We have recommended a similar formulary alternative; your account manager can address your formulary questions.

Members will see the new formulary name in the Annual Notice of Change mailing.

Your formulary includes generic drugs on all tiers
The formulary included with your 2023 plan includes generic drugs on all tiers. This tier structure allows for the grouping of drugs with similar price points in the same tier, regardless of drug type. This allows members to make decisions based upon the drug cost as opposed to the drug type. The resulting savings help to offset annual cost increase trend.

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.

CMS Notifications

We will notify members of plan changes as required by CMS
CMS requires that Aetna provide each member enrolled in our group Medicare Advantage plan or standalone Medicare prescription drug plans an Annual Notice of Change (ANOC) letter along with the new plan year Schedule of Member Cost Sharing (SOC) which provides a detailed description of the benefits and coverage provisions of the plan. The Evidence of Coverage (EOC) provides Medicare-specific information about the health plan and is available to members online or by calling customer service to request a written copy. Medicare members must receive detailed benefit information for their current plan no later than 15 days before the start of your annual open enrollment period. If you don't have an open enrollment period, Medicare members must receive this benefit information no later than 15 days before the start of the new plan year.
If you wish to receive a copy of these plan documents for your records, please reach out to your Aetna account representative.

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")** - County of El Paso will comply with the following conditions with respect to any subsidization of that portion of premiums paid by County of El Paso for

the Medicare Prescription Drug benefit ("PD Premium") and any required PD Premium contribution by members enrolled in MAPDs or PDPs ("Members"):

- County of El Paso 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.

County of El Paso 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 an LIS-eligible Member shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of the County of El Paso's PD Premium contribution. However, if the sum of the Member Contribution and County of El Paso'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), County of El Paso shall communicate with the LIS-eligible Member about the cost of remaining enrolled in County of El Paso'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 County of El Paso, 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 County of El Paso and County of El Paso chooses to receive group list invoices, Aetna will apply LIS

subsidy credits and LEP debits to the group invoice. County of El Paso must apply the LIS subsidy and collect the LEP consistent with applicable law.

Direct Billed - If County of El Paso 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 and access to community assistance programs

We're pleased to provide plan sponsors with a Medicaid outreach program through BeneLynk. This program provides continuous monitoring of social program eligibility and enrollment status to ensure appropriate access to benefits for which members are entitled.

This program includes:

- Community Programs to help members overcome food insecurity, transportation, social isolation, and lower the cost of utilities
- Initial Outreach and enrollment assistance with Medicaid or Medicare Savings Programs and the Low Income Subsidy
- Annual Recertification to maintain enrollment in these programs

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 BeneLynk, your organization may "opt-out" of our Medicaid outreach program. To do so, please contact your Aetna representative no later than October 1, 2022.

Please Note: If we don't receive your "opt-out" notification by October 1, 2022, 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, 2024 for the 2023 calendar year).

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

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2023 Aetna Medicare Advantage PPO network-based expansion counties

We worked hard during 2022 to meet CMS network adequacy rules and add to our MA PPO network. As of January 1, 2023, we will add **32** new network-based counties to our MA PPO service area.

State	County
AZ	Mohave
CO	Weld
FL	Flagler
GA	Floyd
GA	Gordon
IN	Wayne
IA	Black Hawk
KS	Douglas
LA	Iberia
MD	Allegany
MI	Berrien

State	County
MI	Cass
MI	Jackson
MS	Benton
MS	Calhoun
MS	Chickasaw
MS	Clay
MS	Panola
MS	Pontotoc
MS	Prentiss
MS	Tippah
MS	Tunica

State	County
MS	Webster
NC	Edgecombe
NC	Lenoir
NC	Moore
NC	Wayne
SC	Lancaster
SC	Oconee
VA	Frederick
WV	Berkeley
WV	Jefferson