# MASTER SERVICES AGREEMENT
# MSA-881673

This master services agreement ("**Agreement**") between **AETNA LIFE INSURANCE COMPANY**, a Connecticut corporation located at 151 Farmington Avenue, Hartford, Connecticut ("**Aetna**"), and **Lee County Board of County Commissioners**, located at 2115 2nd St., Fort Myers, FL 33901("**Customer**") is effective as of January 1, 2025("**Effective Date**").

The Customer has established one or more self-funded employee benefits plans, described in Exhibit 1, (the "**Plan(s)**"), for certain covered persons, as defined in the Plan(s) (the "**Plan Participants**").

The Customer wants to make available to Plan Participants one or more products and administrative services ("**Services**") offered by Aetna, as specified in the attached schedules, and Aetna wants to provide those Services to the Customer for the compensation described herein.

The parties therefore agree as follows:

## 1. TERM

The initial term of this Agreement will be three years beginning on the Effective Date. The County reserves the right to renew the contract for up to three additional one-year periods. The initial term and each successive one year renewal shall be considered an "**Agreement Period**". The schedules may provide for different start and end dates for certain Services.

## 2. SERVICES

Aetna shall provide the Services described in the attached schedules.

## 3. STANDARD OF CARE

Aetna and the Customer will discharge their obligations under this Agreement with that level of reasonable care which a similarly situated services provider or plan administrator, respectively, would exercise under similar circumstances. If the Customer delegates claim fiduciary duties to Aetna pursuant to the applicable schedule, Aetna shall observe the standard of care and diligence required of a fiduciary under applicable state law.

## 4. SERVICE FEES

The Customer shall pay Aetna the fees according to the Service and Fee Schedule(s) ("**Service Fees**"). Aetna may change the Services and the Service Fees annually by giving the Customer 30 days' notice before the changes take effect. Changes will take effect on the anniversary of the Effective Date unless otherwise indicated in the applicable Service and Fee Schedule(s).

Aetna shall provide the Customer with a monthly statement indicating the Service Fees owed for that month. The Customer shall pay Aetna the Service Fees no later than 45 calendar days after the first calendar day of the month in which the Services are provided (the "**Payment Due Date**"). The Customer shall provide with their payment either a copy of the Aetna invoice, modified to reflect current eligibility, or a copy of a pre-approved invoice which meets Aetna's billing requirements. The Customer shall also reimburse Aetna for certain additional expenses, as stated in the Service and Fee Schedule(s).

All overdue amounts are subject to the late charges outlined in the Service and Fee Schedule(s).

Aetna shall prepare and submit to the Customer an annual report showing the Service Fees paid.

## 5. BENEFIT FUNDING

The Customer shall choose one of the banking facilities offered by Aetna through which Plan benefit payments, Service Fees and Plan benefit related charges will be made. All such amounts will be paid through the banking facility by check, electronic funds transfer or other reasonable transfer methods. The Customer shall reimburse the banking facility for all such payments on the day of the request. All such reimbursements will be made by wire transfer in federal funds using the instructions provided by Aetna, or by another transfer method agreed upon by both parties.

Since funding is provided on a checks cleared basis, Aetna is not required to act on outstanding benefit checks (checks which have not been presented for payment) unless directed to do so by the Customer. The Customer may elect escheat or stop pay services under a separate contract, to which additional fees may apply. In the absence of an escheat or stop pay contract, checks will be voided when they age five years, which does not eliminate the Customer's potential escheat liability.

After termination of the Agreement, in the absence of an escheat or stop pay contract, Aetna may place stop payment orders on all of the Customer's outstanding benefit checks after either:

(i) One year has elapsed since Aetna completed its runoff obligations; or

(ii) Aetna has exercised its right to suspend claim payments or terminate this Agreement as stated in section 16(B) (Termination)

At the end of any run off service period, the Customer may also request Aetna to perform escheat

## 6. FIDUCIARY DUTY

It is understood and agreed that the Customer, as plan administrator, retains complete authority and responsibility for the Plan, its operation, and the benefits provided there under, and that Aetna is empowered to act on behalf of the Customer in connection with the Plan only to the extent expressly stated in this Agreement or as agreed to in writing by Aetna and the Customer.

The Customer has the sole and complete authority to determine eligibility of persons to participate in the Plan.

Claim fiduciary responsibility is identified in the applicable Schedule.

## 7. CUSTOMER'S RESPONSIBILITIES

**(A) Eligibility** – The Customer shall supply Aetna, by electronic medium acceptable to Aetna, with all relevant information identifying Plan Participants and shall notify Aetna by the tenth day of the month following any changes in Plan participation. Aetna is not required to honor a notification of termination of a Plan Participant's eligibility which Aetna receives more than 60 days after termination of such Plan Participant. Aetna has no responsibility for determining whether an individual meets the eligibility requirements of the Plan.

**(B) Plan Document Review** – The Customer shall provide Aetna with all Plan documents at least 30 days prior to the Effective Date. Aetna will review the Plan documents to determine any potential differences that may exist among such Plan documents and Aetna's claim processing systems and internal policies and procedures. Aetna does NOT review the Customer's Summary of Benefits and Coverage ("**SBC**"), Summary Plan Description ("**SPD**") or other Plan documents for compliance with applicable law. The Customer also agrees that it is responsible for satisfying any and all Plan reporting and disclosure requirements imposed by law, including updating the SBC or SPD and other Plan documents and issuing any necessary summaries of material modifications to reflect any changes in benefits.

**(C) Notice of Plan or Benefit Change** – The Customer shall notify Aetna in writing of any changes in Plan documents or Plan benefits (including changes in eligibility requirements) at least 30 days prior to the effective date of such changes. Aetna will have 30 days following receipt of such notice to inform the Customer whether Aetna will agree to administer the proposed changes. If the proposed changes increase Aetna's costs, alter Aetna's ability to meet any performance standards or otherwise impose substantial operational challenges, Aetna may require an adjustment to the Service Fees or other financial terms.

**(D) Employee Notices** – The Customer shall furnish each employee covered by the Plan written notice that the Customer has complete financial liability for the payment of Plan benefits. The Customer shall inform its Plan Participants, in a manner that satisfies applicable law, that confidential information relating to their benefit claims may be disclosed to third parties in connection with Plan administration.

**(E) Third Party Consents** – The Customer shall obtain any consents, authorizations or other permissions from Employees or relevant third parties, which may be required under law or otherwise necessary in order for Aetna to access, use or disclose information and data for the purposes of providing Services under this Agreement.

**(F) Miscellaneous** – The Customer shall promptly provide Aetna with such information regarding administration of the Plan as required by Aetna to perform its obligations and as Aetna may otherwise reasonably request from time to time. Such information shall include, at no cost to Aetna, all relevant medical records, lab and pharmacy data, claim and other information pertaining to Plan Participants and/or Employees. Aetna is entitled to rely on the information most recently supplied by the Customer in connection with the Services and Aetna's other obligations under the Agreement. Aetna is not responsible for any delay or error caused by the Customer's failure to furnish correct information in a timely manner. Aetna is not responsible for responding to Plan Participant requests for copies of Plan documents. The Customer shall be liable for all Plan benefit payments made by Aetna, including those payments made following the termination date or which are outstanding on the termination date.

## 8. RECORDS

Aetna, its affiliates and authorized agents shall use all Plan-related documents, records and reports received or created by Aetna in the course of delivering the Services ("**Plan Records**") in compliance with applicable privacy laws and regulations. Aetna may de-identify Plan Records and use them for quality improvement, statistical analyses, product development and other lawful, non-Plan related purposes. Such Plan Records will be kept by Aetna for a minimum of seven years, unless Aetna turns such documentation over to the Customer or a designee of the Customer.

In accordance with Florida Statute Section 119.0701, Aetna agrees to comply with public records laws including the following:

a. Keep and maintain public records required by the Customer in order to perform the Scope of Services identified herein.
b. Upon request from the Customer provide the Customer with any requested public records or allow the requested records to be inspected or copied within a reasonable time by the Customer.
c. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the Agreement term and thereafter if the Aetna does not transfer all records to the Customer.
d. Transfer, at no cost, to Customer all public records in possession of the Aetna upon termination of this Agreement and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. All records stored electronically must be provided to the Customer, upon request from the Customer, in a format that is compatible with the information technology systems of the Customer. If the Aetna keeps and maintains public records upon the conclusion of this Agreement, the Aetna shall meet all applicable requirements for retaining public records that would apply to the Customer.

2. If Aetna does not comply with a public records request, the Customer shall treat that omission as a breach of this Agreement and enforce the Contract provisions accordingly. Additionally, if the Aetna fails to provide records when requested, the Aetna may be subject to penalties under Section 119.10, Florida Statutes, and reasonable costs of enforcement, including attorney fees.

**3. IF AETNA HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO AETNA'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE CUSTOMER'S CUSTODIAN OF PUBLIC RECORDS AT 239- 533-2221, 2115 SECOND STREET, FORT MYERS, FL 33901, publicrecords@leegov.com; http://www.leegov.com/publicrecords.**

## 9. CONFIDENTIALITY

(A) **Business Confidential Information** - Neither party may use "Business Confidential Information" (as defined below) of the other party for its own purpose, nor disclose any Business Confidential Information to any third party. However, a party may disclose Business Confidential Information to that party's representatives who have a need to know such information in relation to the administration of the Plan, but only if such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them. The Customer shall not disclose Aetna's provider discount or payment information to any third party, including the Customer's representatives, without Aetna's prior written consent and until each recipient has executed a confidentiality agreement reasonably satisfactory to Aetna.

The term "**Business Confidential Information**" as it relates to the Customer means the Customer identifiable business proprietary data, procedures, materials, lists and systems, but does not include Protected Health Information ("PHI") as defined by HIPAA or other claims-related information.

The term "**Business Confidential Information**" as it relates to Aetna means the Aetna identifiable business proprietary data, rates, fees, provider discount or payment information, procedures, materials, lists and systems.

(B) **Plan Participant Information** - Each party will maintain the confidentiality of Plan Participant-identifiable information, in accordance with applicable law and, as appropriate, the terms of the HIPAA business associate agreement associated with this Agreement. The Customer may identify, in writing, certain Customer employees or third parties, who the Plan has authorized to receive Plan Participant-identifiable information from Aetna in connection with Plan administration. Subject to more restrictive state and federal law, Aetna will disclose Plan Participant-identifiable information to the Customer designated employees or third parties. In the case of a third party, Aetna may require execution by the third party of a non-disclosure agreement reasonably acceptable to Aetna. The Customer agrees that it will only request disclosure of PHI to a third party or to designated employees if: (i) it has amended its Plan documents, in accordance with 45 CFR 164.314(b) and 164.504(f)(2), so as to allow the Customer designated employees or third parties to receive PHI, has certified such to the Plan in accordance with 45 CFR 164.504(f)(2)(ii), and will provide a copy of such certification to Aetna upon request; and (ii) the Plan has determined, through its own policies and procedures and in compliance with HIPAA, that the PHI that it requests from Aetna is the minimum information necessary for the purpose for which it was requested.

(C) **Upon Termination** - Upon termination of the Agreement, each party, upon the request of the other, will return or destroy all copies of all of the other's Business Confidential Information in its possession or control except to the extent such Business Confidential Information must be retained pursuant to applicable law or cannot be disaggregated from Aetna's databases. Aetna may retain copies of any such Business Confidential Information it deems necessary for the defense of litigation concerning the Services it provided under this Agreement, for use in the processing of runoff claims for Plan benefits, and for regulatory purposes.

## 10. AUDIT RIGHTS

The Customer may, at its own expense, audit Plan claim transactions upon reasonable notice to Aetna. The Customer may conduct one audit per year and the audit must be completed within two years of the end of the time period being audited. Audits of any performance guarantees, if applicable, must be completed in the year following the period to which the performance guarantee results apply. Audits must be performed at the location where the Customer's claims are processed.

The Customer may select its own representative to conduct an audit, provided that the representative must be qualified by appropriate training and experience for such work and must perform the audit in accordance with published administrative safeguards or procedures and applicable law. In addition, the representative must not be subject to an Auditor Conflict of Interest which would prevent the representative from performing an independent audit. An "Auditor Conflict of Interest" means any situation in which the designated representative (i) is employed by an entity which is a competitor of Aetna, (ii) has terminated from Aetna or any of its affiliates within the past 12 months, or (iii) is affiliated with a vendor subcontracted by Aetna to adjudicate claims. If the audit firm is not licensed or a member of a national professional group, or if the audit firm has a financial interest in audit findings or results, the audit agent must agree to meet Aetna's standards for professionalism by signing Aetna's Agent Code of Conduct prior to performing the audit. Neither the Customer nor its representative may make or retain any record of provider negotiated rates or information concerning treatment of drug or alcohol abuse, mental/nervous, HIV/AIDs or genetic markers.

The Customer shall provide reasonable advance notice of its intent to audit and shall complete an Audit Request Form providing information reasonably requested by Aetna. No audit may commence until the Audit Request Form is completed and executed by the Customer, the auditor and Aetna. Further, the Customer or its representative shall provide Aetna with a complete listing of the claims chosen for audit at least four weeks prior to the on-site portion of the audit.

The Customer's auditors shall provide their draft audit findings to Aetna, prior to issuing the final report. This draft will provide the basis for discussions between Aetna and the auditors to resolve and finalize any open issues. Aetna shall have a right to review the auditor's final audit report, and include a supplementary statement containing information and material that Aetna considers pertinent to the audit.

Additional guidelines related to the scope of the audit are included in the applicable schedules.

## 11. RECOVERY OF OVERPAYMENTS

Aetna shall reprocess any identified errors in Plan benefit payments (other than errors Aetna reasonably determines to be *de minimis*) and seek to recover any resulting overpayment by attempting to contact the party receiving the overpayment twice by letter, phone, or email. The Customer may direct Aetna not to seek recovery of overpayments from Plan Participants, in which event Aetna will have no further responsibility with respect to those overpayments. The Customer shall reasonably cooperate with Aetna in recovering all overpayments of Plan benefits.

**If Aetna elects to use a third party recovery vendor, collection agency, or attorney to pursue the recovery, the overpayment recoveries will be credited to the Customer net of fees charged by Aetna or those entities.**

Any requested payment from Aetna relating to an overpayment must be based upon documented findings or direct proof of specific claims, agreed to by both parties, and must be due to Aetna's actions or inactions.

Indirect or inferential methods of proof – such as statistical sampling, extrapolation of error rate to the population, etc. – may not be used to determine overpayments. In addition, use of software or other review processes that analyze a claim in a manner different from the claim determination and payment procedures and standards used by Aetna shall not be used to determine overpayments.

When seeking recovery of overpayments from a provider, Aetna has established the following process: if it is unable to recover the overpayment through other means, Aetna may offset one or more future payments to that provider for services rendered to Plan Participants by an amount equal to the prior overpayment. Aetna may reduce future payments to the provider (including payments made to that provider involving the same or other health and welfare plans that are administered by Aetna) by the amount of the overpayment, and Aetna will credit the recovered amount to the plan that overpaid the provider. By entering into this Agreement, the Customer is agreeing that its right to recover overpayments shall be governed by this process and that it has no right to recover any specific overpayment unless otherwise provided for in this Agreement.

The Customer may not seek recovery of overpayments from network providers, but the Customer may seek recovery of overpayments from other third parties once the Customer has provided Aetna notice that it will seek such recovery and Aetna has been afforded a reasonable opportunity to recover such amounts. Aetna has no duty to initiate litigation to pursue any overpayment recovery.

## 12. INDEMNIFICATION

**(A)** Aetna shall indemnify the Customer, its affiliates and their respective directors, officers, and employees (only as employees, not as Plan Participants) for that portion of any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees) ("**Losses**") caused directly by (i) any material breach of this Agreement by Aetna, including a failure to comply with the standard of care in section 3; (ii) Aetna's negligence, willful misconduct, fraud, or breach of fiduciary responsibility; or (iii) Aetna's infringement of any U.S. intellectual property right of a third party, arising out of the Services provided under this Agreement.

**(B)** Subject to any applicable limitations of Florida Statutes section 768.28, the Customer shall indemnify Aetna, its affiliates and their respective directors, officers, and employees for that portion of any Losses caused directly by (i) any material breach of this Agreement by the Customer including a failure to comply with the standard of care in section 3; (ii) the Customer's negligence, willful misconduct, fraud, or breach of fiduciary responsibility; (iii) the release or transfer of Plan Participant-identifiable information to the Customer or its designee, or the use or further disclosure of such information by the Customer or such designee; or (iv) in connection with the design or administration of the Plan by the Customer or any acts or omissions of the Customer as an employer or Plan Sponsor. Any indemnification or liability of Customer will be subject to the monetary limits in Section 768.28, Florida Statutes, as amended from time to time and shall not be construed as a waiver of any sovereign immunity rights.

**(C)** The party seeking indemnification under this Agreement must notify the indemnifying party within 20 days in writing of any actual or threatened action, to which it claims such indemnification applies. Failure to so notify the indemnifying party will not be deemed a waiver of the right to seek indemnification, unless the actions of the indemnifying party have been prejudiced by the failure of the other party to provide notice as indicated above.

The indemnifying party may join the party seeking indemnification as a party to such proceeding; however the indemnifying party shall provide and control the defense and settlement with respect to claims to which this section applies.

**(D)** The Customer and Aetna agree that: (i) health care providers are not the agents or employees of the Customer or Aetna and neither party renders medical services or treatments to Plan Participants; (ii) health care providers are solely responsible for the health care they deliver to Plan Participants, and neither the Customer nor Aetna is responsible for the health care that is delivered by health care providers; and (iii) the indemnification obligations of (A) or (B) above do not apply to any portion of any loss relating to the acts or omissions of health care providers with respect to Plan Participants.

**(E)** These indemnification obligations above shall not apply to any claims caused by (i) an act, or failure to act, by one party at the direction of the other, or (ii) with respect to intellectual property infringement, the Customer's modification or use of the Services or materials that are not contemplated by this Agreement, unless directed by Aetna, including the combination of such Services or materials with services, materials or processes not provided by Aetna where the combination is the basis for the claim of infringement. For purposes of the exclusions in this paragraph, the term "Customer" includes any person or entity acting on the Customer's behalf or at the Customer's direction. For purposes of (A) and (B) above, the standard of care to be applied in determining whether either party is "negligent" in performing any duties or obligations under this Agreement shall be the standard of care set forth in section 3.

## 13. DEFENSE OF CLAIM LITIGATION

In the event of a legal, administrative or other action arising out of the administration, processing or determination of a claim for Plan benefits, the party designated in this document as the fiduciary which rendered the decision in the appeal last exercised by the Plan Participant which is being appealed to the court ("appropriate named fiduciary") shall undertake the defense of such action at its expense and settle such action when in its reasonable judgment it appears expedient to do so. If the other party is also named as a party to such action, the appropriate named fiduciary will defend the other party PROVIDED the action relates solely and directly to actions or failure to act by the appropriate named fiduciary and there is no conflict of interest between the parties. The Customer agrees to pay the amount of Plan benefits included in any judgment or settlement in such action. The other party shall not be liable for any other part of such judgment or settlement, including but not limited to legal expenses and punitive damages, except to the extent provided in section 12 (Indemnification).

Notwithstanding anything to the contrary in this section 13, in any multi-claim litigation (including arbitration) disputing reimbursement for benefits for more than one Plan Sponsor, the Customer authorizes Aetna to defend and reasonably settle the Customer's benefit claims in such litigation.

## 14. REMEDIES

Other than in an action between the parties for third party indemnification, neither party shall be liable to the other for any consequential, incidental or punitive damages whatsoever.

## 15. COMPLIANCE WITH LAWS

Aetna shall comply with all applicable federal and state laws including, without limitation, the Patient Protection and Affordable Care Act of 2010 ("**PPACA**"), and the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**").

**16. TERMINATION**

This Agreement may be terminated by Aetna or the Customer as follows:

**(A) Termination by the Customer** – The Customer may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving Aetna at least 30 days' prior written notice of when such termination will become effective.

**(B) Termination by Aetna and Suspension of Claim Payments-**

(1) Aetna may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving the Customer at least 30 days' prior written notice of when such termination will become effective.

(2) If the Customer fails to fund claim wire requests from Aetna, or fails to pay Service Fees by the Payment Due Date, Aetna has the right to cease paying claims and suspend Services until the requested funds or Service Fees have been provided. Aetna may terminate the Agreement immediately upon notice to the Customer if the Customer fails to fund claim wire requests or pay the applicable Service Fees in full within five business days of written notice by Aetna.

**(C) Legal Prohibition** - If any jurisdiction enacts a law or Aetna reasonably interprets an existing law to prohibit the continuance of the Agreement or some portion thereof, the Agreement or that portion shall terminate automatically as to such jurisdiction on the effective date of such law or interpretation; provided, however, if only a portion of the Agreement is impacted, the Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

**(D) Responsibilities on Termination** –

Upon termination of the Agreement, for any reason other than default of payment by the Customer, Aetna will continue to process runoff claims for Plan benefits that were incurred prior to the termination date, which are received by Aetna within 12 months following the termination date. The Service Fee for such activity is included in the Service Fees described in the Service and Fee Schedule(s). Runoff claims will be processed and paid in accordance with the terms of this Agreement. New requests for benefit payments received after the 12 month runoff period will be returned to the Customer or to a successor administrator at the Customer's expense. Claims which were pended or disputed prior to the start of the runoff period will be handled to their conclusion by Aetna, as well as provider performance or incentive payments paid for prior period performance pay outs, and Customer agrees to fund such claims or payments when requested by Aetna.

The Customer shall continue to fund Plan benefit payments and agrees to instruct its bank to continue to make funds available until all outstanding Plan benefit payments have been paid or until such time as mutually agreed upon by Aetna and the Customer. The Customer's wire line and bank account from which funds are requested must remain open for one year after runoff processing ends, or two years after termination.

Upon termination of the Agreement and provided all Service Fees have been paid, Aetna will release to the Customer, or its successor administrator, all claim data in Aetna's standard format, within a reasonable time

period following the termination date. All costs associated with the release of such data shall be paid by the Customer.

**17. GENERAL**

**(A) Relationship of the Parties -** The parties to this Agreement are independent contractors. This Agreement is not intended and shall not be interpreted or construed to create an association, agency, joint venture or partnership between the parties or to impose any liability attributable to such a relationship. Each party shall be solely responsible for all wages, taxes, withholding, workers compensation, insurance and any other obligation on behalf of any of its employees, and shall indemnify the other party with respect to any claims by such persons.

**(B) Intellectual Property -** Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under this Agreement (the "**Aetna IP**"). Aetna has granted the Customer a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in this Agreement. Customer agrees not to modify, create derivative product from, copy, duplicate, decompile, disassemble, 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 this 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 the Customer.

**(C) Communications -** Aetna and the Customer may rely upon any communication believed by them to be genuine and to have been signed or presented by the proper party or parties. For a notice or other communication under this Agreement to be valid, it must be in writing and delivered (i) by hand, (ii) by e-mail or (iii) by fax to a representative of each party as mutually agreed upon. Notices or communications may also be sent by U.S. mail to the address below.

| If to Aetna: | If to the Customer: |
|---|---|
| Scott Weber | Lee County Board of County Commissioners |
| 4630 Woodlands Corporate Blvd. | 2115 2nd St |
| Tampa, FL 33614 | Fort Myers, FL 33901 |

**(D) Force Majeure –** With the exception of the Customer's obligation to fund benefit payments and Service Fees, neither party shall be deemed to have breached this Agreement, or be held liable for any failure or delay in the performance of any portion of its obligations under this Agreement, including performance guarantees if applicable, if prevented from doing so by a cause or causes beyond the reasonable control of the party. Such causes include, but are not limited to: acts of God; acts of terrorism; pandemic; fires; wars; floods; storms; earthquakes; riots; labor disputes or shortages; and governmental laws, ordinances, rules, regulations, or the opinions rendered by any court, whether valid or invalid.

**(E) Governing Law -** The Agreement shall be governed by and interpreted in accordance with applicable federal law. To the extent such federal law does not govern, the Agreement shall be governed by Florida law.

**(F) Financial Sanctions –** If Plan benefits or reimbursements provided under this Agreement violate or will violate any economic or trade sanctions, such Plan benefits or reimbursements are immediately considered invalid. Aetna cannot make payments for claims or Services if it violates a financial sanction regulation. This

includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written office of Foreign Assets Control (OFAC) license.

**(G) Waiver** - No delay or failure of either party in exercising any right under this Agreement shall be deemed to constitute a waiver of that right.

**(H) Third Party Beneficiaries** - There are no intended third party beneficiaries of this Agreement.

**(I) Severability** – If any provision of this Agreement or the application of any such provision to any person or circumstance shall be held invalid, illegal or unenforceable in any respect by a court of competent jurisdiction, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement and all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect.

**(J) Entire Agreement; Order of Priority** - This Agreement, and the accompanying HIPAA business associate agreement, constitutes the entire understanding between the parties with respect to the subject matter of this Agreement, and supersedes all other agreements, whether oral or written, between the Parties.

**(K) Amendment** – Except as provided for in the Customer's renewal package, no modification or amendment of this Agreement will be effective unless it is in writing and signed by both Parties, except that a change to a party's address of record as set forth in section 18(C) (Communications) may be made without being countersigned by the other party.

**(L) Taxes –** The Customer shall be responsible for any sales, use, or other similarly assessed and administered tax (and related penalties) incurred by Aetna by reason of Plan benefit payments made or Services performed hereunder, and any interest thereon. Additionally, if Aetna makes a payment to a third party vendor at the request of the Customer, Aetna will assume the tax reporting obligation, such as Form 1099-MISC or other applicable forms.

**(M) Assignment** - This Agreement may not be assigned by either party without the written approval of the other party. The duties and obligations of the parties will be binding upon, and inure to the benefit of, successors, assigns, or merged or consolidated entities of the parties.

**(N) Survival** - Sections 5, 8 through 13 and 17(D) shall survive termination of the Agreement.

**(0) Scope of Services** - Aetna agrees to provide all products and services for the Purchase in accordance with Section 3, Standard of Care, and the project Scope of Services made part of this Agreement as Exhibit 1, attached hereto and incorporated herein. Aetna shall comply strictly with all the terms and conditions of Solicitation No. RFP230580CJV, a copy of which is on file with the County's Department of Procurement Management and is deemed incorporated into this Agreement. Aetna's response to Solicitation No. RFP230580CJV is also deemed incorporated into this Agreement. The order of precedence shall be: 1) this Agreement; 2) Solicitation No. RFP230580CJV; 3) Aetna's response to Solicitation No. RFP230580CJV.

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

**WITNESS:**

Signed By: _____

Name: _____

**AETNA LIFE INSURANCE COMPANY:**

Signed By: Natalie Gonder Jones

Name: Natalie Gonder Jones

Title: Director, Sales/Service - Southea

Date: July 12, 2024

LEE COUNTY BOARD OF COUNTY COMMISSIONERS OF LEE COUNTY, FLORIDA

ATTEST:
CLERK OF THE CIRCUIT COURT

BY: Signed by: Latasha Seth
77C37938E6744EA...

**DEPUTY CLERK**

BY: DocuSigned by: Mike Greenwell
55F586F7224445A...

**CHAIR**

DATE: 9/24/2024 | 11:19 AM EDT

DS

BOARD OF COUNTY COMMISSIONERS SEAL LEE COUNTY, FLORIDA

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

BY: Signed by: Andrea Fraser
D7B0A432435E448...

**OFFICE OF THE COUNTY ATTORNEY**

# GENERAL ADMINISTRATION SCHEDULE
# MASTER SERVICES AGREEMENT MSA- 881673
# EFFECTIVE January 1, 2025

This General Administration Schedule describes certain of the Services to be performed by Aetna for the Customer pursuant to the Agreement. The Services described in this schedule apply generally to any medical, dental, pharmacy and behavioral health Plans that are subject to the Agreement. Terms used but not otherwise defined in this schedule shall have the meaning assigned to them in the Agreement.

## 1. CLAIM SERVICES:

(A) Aetna shall process claims for Plan benefits incurred on or after the Effective Date using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the Plan(s), any applicable provider contract, and the Agreement. Aetna shall issue a payment of benefits and related charges on behalf of the Customer in accordance with section 5 of the Agreement, for such benefits and related charges that are determined to be payable under the Plan(s). With respect to any claims that are denied on behalf of the Customer, Aetna shall notify the Plan Participant of the denial and of the Plan Participant's right of review of the denial in accordance with applicable law.

(B) Where the Plan contains a coordination of benefits clause or anti duplication clause, Aetna shall administer all claims consistent with such provisions and any information concurrently in its possession regarding duplicate or primary coverage. Aetna shall have no obligation to recover sums owed to the Plan by virtue of the Plan's rights to coordinate where the claim was incurred prior to the Effective Date. Aetna has no obligation to bring actions based on subrogation or lien rights, unless the Customer has elected Aetna's subrogation services as indicated in the Service and Fee Schedule.

(C) In circumstances where Aetna may have a contractual, claim or payment dispute with a provider, the settlement of that dispute with the provider may include a one-time payment in settlement to the provider or to Aetna, or may otherwise impact future payments to providers. Aetna, in its discretion, may apportion the settlement to self-funded customers, either as an additional service fee from, or as a credit to, the Customer, as may be the case, based upon specific applicable claims, proportional membership or some other allocation methodology, after taking into account Aetna's cost of recovery. The Customer shall remain liable after termination of the Agreement, for their portion of any settlement payments arising from claims paid while an active customer.

## 2. MEMBER SERVICES:

Aetna shall establish and maintain one or more service centers, responsible for handling calls and other correspondence from Plan Participants with respect to questions relating to the Plan and Services under the Agreement.

## 3. PLAN SPONSOR SERVICES:

(A) Aetna shall assign an experienced Account Management Team to the Customer's account. This team will be available to assist the Customer in connection with the Services provided under the Agreement.

(B) Aetna shall design and install a benefit-account structure separately by class of employees, division, subsidiary, associated company, or other classification reasonably requested by the Customer.

**(C)** Aetna shall assist the Customer in connection with the design of the Customer's Plan, including actuarial and underwriting support reasonably requested by the Customer, provided that the Customer shall have ultimate responsibility for the content of the Plan and compliance with law in connection therewith.

**(D)** Aetna shall make employee identification cards available to Plan Participants. Upon request, Aetna will arrange for the custom printing of identification cards, with all costs borne by the Customer.

**(E)** Upon request of the Customer, Aetna shall provide the Customer with information reasonably available to Aetna relating to the administration of the Plans which is necessary for the Customer to prepare reports that are required to be filed with the United States Internal Revenue Service and Department of Labor.

**(F)** Aetna shall provide the following reports to the Customer for no additional charge:

(1) Monthly/Quarterly/Annual Reports - Aetna shall prepare the following reports in accordance with the benefit-account structure for use by the Customer in the financial management and administrative control of the Plan benefits:

(a) a monthly listing of funds requested and received for payment of Plan benefits;

(b) a monthly reconciliation of funds requested to claims paid within the benefit-account structure;

(c) a monthly listing of paid benefits;

(d) online access to monthly, quarterly and annual standard claim analysis reports; and

(e) if applicable, monthly, quarterly, or annual HealthFund product reports for customers with at least 100 enrolled lives in each HealthFund to be used for the financial evaluation and management of each HealthFund plan.

(2) Annual Accounting Reports - Aetna shall prepare standard annual accounting reports detailing product specific financial and plan information including enrollment fees and/or rates for each Agreement Period.

(3) Annual Renewal Reports – Aetna shall prepare standard annual renewal reports detailing product specific financial and plan information, including enrollment fees and/or rates for each Agreement Period.

Any additional reporting formats and the price for any such reports shall be mutually agreed upon by the Customer and Aetna.

**(G)** Upon request of the Customer, for no additional charge, Aetna shall provide either of the following services in support of the preparation of Plan descriptions:

(1) Prepare an Aetna standard Plan description, including descriptions of benefit revisions; or

(2) Review the Customer-prepared employee Plan descriptions, subject to the Customer's final and sole authority regarding benefits and provisions in the self-insured portion of the Plan.

Upon request of the Customer, Aetna shall prepare a non-standard Plan description, provided the Customer must agree in advance to reimburse Aetna for the costs of that work. If the Customer requires both preparation (1) and review (2), Aetna may require an additional charge.

**(H)** Upon request of the Customer, Aetna will arrange for the printing of Plan descriptions, with all costs borne by the Customer.

**(I)** Upon request of the Customer, if applicable, Aetna will provide assistance in connection with the preparation of the Customer's draft Summaries of Benefits and Coverage (SBCs). Aetna may charge an additional fee for such request.

**(J)** The Customer acknowledges that it has the responsibility to review and approve all Plan documents and SBCs, if applicable, and shall have the final and sole authority regarding the benefits and provisions of the Plan(s), as outlined in the Customer's Plan document. Aetna shall have no responsibility or liability for the content of any of the Customer's Plan documents, or SBC's, if applicable, regardless of the role Aetna may have played in the preparation of such documents.

## 4. NETWORK ACCESS SERVICES

**(A)** Aetna shall provide Plan Participants with access to Aetna's network hospitals, physicians and other health care providers (**"Network Providers"**) who have agreed to provide services at agreed upon rates and who are participating in the applicable Aetna network covering the Plan Participants.

**(B)** Aetna has value-based contracting ("VBC") arrangements with Network Providers. These arrangements reward providers based on indicators of value, such as, effective population health management, efficiency and quality care. Contracted rates with Network Providers may be based on fee-for-service rates, case rates, per diems, performance-based contract arrangements, risk-adjustment mechanisms, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. These mechanisms may include payments to physicians, physician groups, health systems and other provider organizations, including but not limited to organizations that may refer to themselves as accountable care organizations and patient-centered medical homes, in the form of periodic payments and incentive arrangements based on performance. Aetna will process any incentive payments attributable to the Plan in accordance with the terms of each VBC arrangement. Each Customer's results will vary. It is possible that incentives paid to a particular provider or health system may be required even if the Customer's own population did not experience the same financial or qualitative improvements. It is also possible that incentives will not be paid to a provider even if the Customer's own population did experience financial and quality improvements. Upon request, Aetna will provide additional information regarding our VBC arrangements.

**(C)** Retroactive adjustments are occasionally made to Aetna's contract rates. Retroactive adjustments may occur, for example, when the federal government does not issue cost of living data in sufficient time for an adjustment to be made on a timely basis, or because contract negotiations were not completed by the end of the prior price period or due to contract dispute settlements. In all cases, Aetna shall adjust the Customer's payments accordingly. The Customer's liability for all such adjustments shall survive the termination of the Agreement.

**(D)** Aetna may contract with vendors who in turn are responsible for contracting with the providers who perform the health care services, and potentially for certain other services related to those providers such as claims processing, credentialing, and utilization management. Under some of these arrangements, the vendor bills Aetna directly for those services by its network of providers at the vendor's contracted rate with Aetna, and Aetna pays the vendor for those services. In certain cases, the amount billed by the vendor to Aetna, paid pursuant to the plan, includes an administrative fee for delegated services by the vendor. As a result, the amount the vendor pays to the health care provider through the vendor's contract with the provider may be different than the amount paid pursuant to the Plan because the allowed amount under the Plan will be Aetna's contracted rate with the vendor, and not the contracted amount between the vendor and the health care provider.

**(E)** Aetna reserves the right to set a minimum plan benefit design structure for in-area network claims to which the Customer must comply in order to access a particular Aetna network.

**(F)** Aetna shall maintain an online directory containing information regarding Network Providers. Upon request and for an additional charge, Aetna shall provide the Customer with paper copies of physician directories.

**(G)** Aetna makes no guarantee and disclaims any obligation to make any specific health care providers or any particular number of health care providers available for use by Plan Participants or that any level of discounts or savings will be afforded to or realized by the Customer, the Plan or Plan Participants.

**(H)** Customer agrees to comply with all of the applicable terms of Aetna's network provider contracts.

**5. NON-DIRECT NETWORKS**

If Aetna is requested by the Customer, or otherwise arranges for network services to be provided for Plan Participants in a geographic area where Aetna does not have a directly contracted network of providers (or additional access is requested or advisable), Aetna may contract with another network and or additional providers ("**non-Aetna network**") to provide the network services. With respect to the services provided by providers in the non-Aetna network ("**non-Aetna network providers**"), the Customer acknowledges and agrees that, any other provisions of the agreement notwithstanding:

**(A)** Aetna may not credential, monitor or oversee the providers or the administrative procedures or practices of any non-Aetna network;

**(B)** No particular discounts may, in fact, be provided or made available by any particular providers;

**(C)** Performance guarantees appearing in the agreement may not apply to Services delivered by non-Aetna providers or networks; and

**(D)** Non-Aetna network providers are not employees or agents of Aetna and may not be contractors or subcontractors of Aetna.

The Customer further agrees that, if Aetna subsequently establishes or expands its own contracted provider network in a geographic area where services are being provided by a non-Aetna network, Aetna may terminate the non-Aetna network contract, and begin providing services through a network that is subject to the terms and provisions of the agreement. The Customer acknowledges that such conversion may cause disruption, including the possibility that a particular provider in a non-Aetna network may not be included in the replacement network.

# MEDICAL
# SERVICE AND FEE SCHEDULE
# MSA – 881673

The Service Fees and Services effective for the period beginning January 1, 2025, and ending December 31, 2030, are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

For purposes of this document, Aetna may be referred to using 'we', 'our' or 'us' and Customer may be referred to using 'you' or 'your'.

| Administrative Fees Per-Employee, Per-Month (PEPM) | | |
|---|---|---|
| **Initial Contract Period**<br>**January 1, 2025, through December 31, 2027** | Choice POS II | Open Access Aetna Select |
| Assumed Enrollment | 1,688 | 2,647 |
| Total Per-Employee, Per Month | **$38.40** | **$38.40** |
| | | |
| **Three 1-Year Renewal Periods** | Choice POS II | Open Access Aetna Select |
| January 1, 2028, Total Per-Employee, Per-Month | **$39.55** | **$39.55** |
| January 1, 2029, Total Per-Employee, Per-Month | **$40.74** | **$40.74** |
| January 1, 2030, Total Per-Employee, Per-Month | **$41.96** | **$41.96** |
| | | |
| Our fees are based on the total number of employees enrolled in Aetna medical products.<br>Aetna also provided a "fee holiday" of $550,000 for year 2025 and $100,000 for years 2026, 2027, 2028, 2029, and 2030. | | |
| | | |
| Please refer to the Financial Assumptions for a detailed description of the services, terms, and conditions associated with our self-funded proposal. | | |
| | | |
| We have provided a three year fee guarantee from January 1, 2025 through December 31, 2027 for the self-insured coverages included in this proposal. The first three year fees are guarantee according to the per employee, per month fees as illustrated on the fee exhibit. The fourth-year fee will increase over the third-year fee by 3 percent, the fifth-year fee will increase over the fourth-year fee by 3 percent and the sixth-year fee will increase over the fifth-year fee by 3 percent. | | |

| Program Summary<br>(Included Services/Programs in Administrative Fee) | Choice POS II | Open Access Aetna Select |
|---|---|---|
| **General Administration** | | |
| Experienced Account Management Team | Included | Included |
| Designated billing, eligibility, plan set up, underwriting | Included | Included |
| Onsite Open Enrollment Meeting Preparation | Included | Included |
| Open Enrollment Marketing Material (non-customized) | Included | Included |
| ID Cards* | Included | Included |
| Review or draft plan documents | Included | Included |
| Summary of Benefits and Coverage (SBC) | Included | Included |
| Claim Fiduciary Option 1 | Included | Included |
| External Review | Included | Included |
| Non-ERISA | Included | Included |
| Claim Administration | Included | Included |
| Onsite Claims Associate and Onsite Wellness Consultant | Included | Included |
| Special Investigations / Zero Tolerance Fraud Unit | Included | Included |
| **Network Services** | | |
| Full National Reciprocity (excludes some Stand Alone ACOs and Joint Ventures)* | Included | Included |
| Institutes of Excellence™ * | Included | Included |
| Institutes of Quality® (IOQ) Broad Network | Included | Included |
| No Cost/Low Cost Designated Walk In Clinic (MinuteClinic®)* | Included | Included |
| National Medical Excellence Program® | Included | Included |
| Network access | Included | Included |
| Teladoc Health (Custom) General Medical* | Included | Included |
| **Care Management** | | |
| Aetna Compassionate Care℠ | Included | Included |
| Aetna Advice | Included | Included |
| Aetna Enhanced Maternity Program | Included | Included |
| Utilization Management (Inpatient Precertification, Concurrent Review, Discharge Planning, Retrospective Review) | Included | Included |
| **Member Resources** | | |
| Designated Service Center | Included | Included |
| Aetna Concierge (includes First Impression Treatment) | Included | Included |
| Provider search (online provider directory) | Included | Included |
| Health Decision Support - Basic | Included | Included |
| Member Website and Mobile Experience | Included | Included |
| MindCheck℠ | Included | Included |
| Online Programs | Included | Included |
| **Wellness** | | |
| 24-Hour Nurse Line: 1-800# Only | Included | Included |
| Aetna Health Your Way™ Health Assessment and Digital Support | Included | Included |
| Aetna Health Your Way™ Plus (includes MedQuery and Personal Health Record) | Included | Included |
| **Allowances** | | |
| Implementation/Communication Allowance | Included | Included |
| Wellness Allowance | Included | Included |
| Audit Allowance | Included | Included |
| Technology Allowance | Included | Included |
| Warehouse Credit Allowance | Included | Included |

| Reporting and Integration | | |
|---|---|---|
| Analytic Consultation from Plan Sponsor Insights | 10 Hours | 10 Hours |
| ART Reports - New analytic reporting platform | Included | Included |
| Aetna Health Information Advantage™ (AHIA) | Included | Included |
| Monthly Financial Claim Detail Reports | Included | Included |
| Monthly Banking Reports | Included | Included |
| **Behavioral Health** | | |
| Managed Behavioral Health | Included | Included |
| Applied Behavior Analysis (ABA) | Included | Included |
| AbleTo Network - member cost share may apply | Included | Included |
| **Aetna Discount Program** | | |
| At home products, fitness, hearing, LifeMart® shopping website, natural products and services, oral health care, vision, weight management | Included | Included |
| **Program & Services Included in the Claim Wire*** | **Choice POS II** | **Open Access Aetna Select** |
| **No Surprises Act - Fees*** | | |
| No Surprises Act (NSA) claim administration fee (per NSA eligible claim) | $50 | $50 |
| No Surprises Act (NSA) Independent Dispute Resolution (IDR) initial fee (per arbitration case) | $50 | $50 |
| No Surprises Act (NSA) Independent Dispute Resolution (IDR) arbitration expenses (per arbitration case) | ~ $200 to $900+ | ~ $200 to $900+ |
| **Network Services** | | |
| Subrogation* | 37.5% of savings | 37.5% of savings |
| Contracted Services* (Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, Workers Compensation, DRG and Implant Audits) | 37.5% of savings | 37.5% of savings |
| Claim and Code Review Program* | 30% of savings | 30% of savings |
| National Advantage™ Program – includes Facility Charge Review* | We will retain 40% of savings | We will retain 40% of savings |
| National Advantage™ Program Cap – includes Facility Charge Review | Cap of $100,000 per individual claim | Cap of $100,000 per individual claim |
| **Care Management** | | |
| Aetna One® Flex (per engaged member, per month)* | $735 | $735 |
| Enhanced Clinical Review Program – High Tech Imaging (PMPM)* | $0.35 | $0.35 |
| Enhanced Clinical Review Program – Diagnostic Cardiac (PMPM)* | $0.10 | $0.10 |
| Enhanced Clinical Review Program – Sleep Management (PMPM)* | $0.05 | $0.05 |
| Enhanced Clinical Review Program – Cardiac Implantable Devices (PMPM)* | $0.05 | $0.05 |
| Enhanced Clinical Review Program – Interventional Pain (PMPM)* | $0.10 | $0.10 |
| Enhanced Clinical Review Program – Hip and Knee Arthroplasties (PMPM)* | $0.05 | $0.05 |
| Transform Diabetes Care® 2.0 (per diabetic, per month)* | $14.15 | $14.15 |

***Additional Program Details**

**Claim Wire Billing, ID Cards, Subrogation, Contracted Services, Claim and Code Review**

Details can be found in our UW Disclosure document located at the following URL:

https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/Large%20Group%20Self-Funded%20Medical%20Underwriting%20(UW)%20Disclosures%20as%20of%2005-02-2023.pdf

**Claim and Code Review Program**

This financial proposal includes enhancements that have been made to our claim and code review programs. Some of these capabilities were previously a component of our base fees, but this proposal assumes they will now instead be part of our standard shared savings arrangement.

**No Surprises Act - Fees**

Refer to the NSA Payment Practices in our Caveats for information on our payment practices for NSA eligible claims.

IDR fees are required by the NSA rules and are payable to the IDR entity. There is an initial fee to begin an arbitration, which applies to each case. There is also an additional fee for the arbitration expenses; the losing party within the dispute is liable for this fee. For batch cases, the NSA permits IDR entities to charge a different arbitration fee based on a set fee range and/or percentage of the batch fee. The fees are passed through (with no mark up by Aetna) to a customer based on the number of line items for their plan that were included in the batch case. The above are the current NSA fees as set by federal agencies. These fees are subject to future adjustments by the agencies (and any such adjustments shall be applied to your plan).

**Aetna One® Flex**

Engagement begins upon a two-way interaction (i.e. telephonic, email, secured messaging, etc.) with a member of the multi-disciplinary care team (i.e. nurse, registered social worker, pharmacist, health coach, or behavioral health specialist). After one month without a two-way interaction a member is no longer considered engaged.

**Enhanced Clinical Review**

This fee will only be charged based upon those members who fall into service areas where the program is available.

**Full National Reciprocity**

Banner, Emory and Memorial Hermann have full national reciprocity. All other Joint Ventures and ACOs exclude full national reciprocity.

**Institutes of Excellence™ (IOE)**

This program includes a steerage component by educating members on the benefits of using an IOE designated facility. However, benefit differential steerage is not supported for IOE Infertility network.

**National Advantage™ Program (including the Contracted Rates, Facility Charge Review and Itemized Bill Review Components)**

NAP includes a Contracted Rates component and two optional components: Facility Charge Review (FCR) and Itemized Bill Review (IBR). In addition, some plans also elect Data iSight (DiS) as their out-of-network plan rate for professional services. NAP's Contracted Rates component offers access to contracted rates for many medical claims from non- network providers (including claims for emergency services and claims by hospital-

based specialists such as anesthesiologists and radiologists who do not contract with insurers) and ad hoc negotiations (when a contracted rate is not available). We retain a percentage of savings achieved through NAP, including savings achieved through FCR, IBR, and DiS, if elected. This NAP Fee is in addition to the per employee, per month administrative service fees.

**No Cost/Low Cost Designated Walk In Clinic (MinuteClinic®)**

Access to no/low cost MinuteClinic is included with APCN or Aetna Whole Health networks, where available. A list of included networks will be provided upon request.

**Teladoc Health**

In addition to the administrative fees as outlined above, there is a per consultation charge which will be shared by the member and plan sponsor based on type of service provided and member's benefit plan. Specific charges are available upon request.

**Transform Diabetes Care ® 2.0**

Members are identified for the program based on diabetes diagnosis codes and at least one other identifier which corroborates diabetes. Additional identifiers may include but are not limited to pharmacy claims for antidiabetic medication, and/or laboratory test results.

**Allowances - Self-Funded** **Effective Date: January 01, 2025**

We are including allowance(s) for your Aetna plans applicable to each year of the Guarantee Period as outlined in the chart below. Allowance dollars are intended to be used for your Aetna medical plans and Aetna medical members.

| Annual Allowance Type | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 | Year 6 |
|---|---|---|---|---|---|---|
| Plan Year Effective Date | 01/01/2025 | 01/01/2026 | 01/01/2027 | 01/01/2028 | 01/01/2029 | 1/1/2030 |
| Implementation /Communication | $20,000 | $20,000 | $20,000 | $20,000 | $20,000 | $20,000 |
| Wellness | $250,000 | $200,000 | $200,000 | $200,000 | $200,000 | $200,000 |
| Audit | $100,000 | $50,000 | $50,000 | $50,000 | $50,000 | $50,000 |
| Warehouse Credit | $65,000 | $65,000 | $65,000 | $65,000 | $65,000 | $65,000 |
| **Total** | **$385,000** | **$335,000** | **$335,000** | **$335,000** | **$335,000** | **$335,000** |

Annual allowance amounts may be adjusted if actual enrollment changes by 15 percent or more from our enrollment assumptions.

**Implementation/Communication Allowance**

- You can use the **implementation/communication** allowance to offset expenses applicable to the Guarantee Period(s) for which it is offered. Your allowance can be used for implementing your contract with us, promoting our products, our programs or services, communicating with our members, and our system front-end charges.
- Allowance dollars are for the exclusive benefit of your Aetna medical plan(s) and Aetna medical members.
- Should you terminate your contract with us, the allowance(s) cannot be used to fund implementation/communication expenses related to the new carrier's contract.

**Wellness, Audit, Technology and Warehouse Credit Allowances**

- You can use the **wellness** allowance to pay for reasonable wellness-related programs or activities you received from third-party vendors incurred during the Guarantee Period(s) for which it is offered. Wellness allowance expenses must be for wellness-related programs or activities that are designed to promote the health and well-being of members, or to educate participants about healthy lifestyles and choices. Any wellness-related allowance amounts we pay you directly to offset or reimburse you for any expense or costs you reimbursed a vendor for directly, must comply with these conditions. Examples of reimbursable wellness related activities include programs or activities such as onsite biometric screening and flu vaccination clinics or wellness fairs.
- You can use the **technology** allowance to pay for reasonable technology-related programs or activities you received from third-party vendors incurred during the Guarantee Period(s) for which it is offered. Your allowance must be used for system enhancements to facilitate your Aetna medical plan benefit administration or Aetna member eligibility.
- Your **audit** allowance can be used to offset expenses incurred from third-party vendors for auditing our medical claim adjudication and member eligibility. Expenses must be incurred during the Guarantee Period(s) for which it is offered.
- You can use the Warehouse Credit allowance to offset expenses incurred during the Guarantee Period(s) for which it is offered.

**Your allowance can be used for**

- Allowance dollars are for the exclusive benefit of your Aetna medical plan(s) and Aetna medical members.

The above referenced fund(s) will be available after the effective date of each plan year. Only those expenses performed and billed by a third party are payable; reimbursement for time and materials incurred directly by

the plan sponsor (e.g. hours worked by the plan sponsor's own employees) are not eligible. Our preferred method of payment is directly to the vendor. We will pay allowance related expenses directly to the vendor only after you send us proper documentation outlining the expenses you have incurred. On an exception basis, we can reimburse you directly. In the event the exception is granted, we'll require you to submit detailed paid receipts from the vendor. To facilitate allowance processing, documentation should be submitted within 60 days of the invoice date, whenever possible. All documentation must be submitted no later than 60 days following the end of the plan year for which expenses were incurred. Acceptable documentation includes, but is not limited to:

- Vendor invoice(s) summarizing level of work completed, hourly rate and hours spent
- Invoices or other documentation summarizing any other miscellaneous expenses incurred

The allowance amounts indicated above for the following Allowance Type(s) are available for the years indicated in the chart. Each allowance is forfeited at the end of each plan year if not fully utilized (it does not get rolled over to the following plan year for a cumulative amount). If you have elected to offer wellness incentives through a product reward site, unredeemed vouchers are forfeited at the end of each plan year.

- Implementation/Communication
- Wellness
- Audit
- Technology
- Warehouse Credit

We assume the funding of any allowance dollars is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. You are responsible for determining that your use of allowance dollars is appropriate and legally compliant. With respect to allowance dollars that are used in connection with a wellness program, you are responsible for ensuring that the program and any incentives/rewards comply with applicable laws, including limitations on maximum allowable incentives/rewards. We will pay any allowances in accordance with applicable law. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and laws.

If you terminate your medical plan with us in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal prior to the end of the multi-year Guarantee Period, you'll be responsible for remitting payment for any allowance amounts used. Payment is due to us within 31 days of the invoice.

**Caveats - Self-Funded** **Effective Date: January 01, 2025**

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". If fees are adjusted, the caveats below will apply and be based on the new assumptions.

## Underwriting Caveats

Your pricing considers all the products, programs and services you have with us and will be in effect for the full 12 months of the plan year. Pricing for some programs and services are amortized over a 12-month period. Therefore, fees will not be reduced if termination occurs prior to the end of the plan year. We also assume the proposal assumptions below remain consistent throughout the plan year. We require notice to properly terminate before the plan year ends in accordance with the Termination provision in your Agreement. Otherwise, you may be charged for the cost until that notice is met.
If any of the changes outlined below occur, we may adjust your Guaranteed Fees. If this happens, you'll have to pay any difference between the fees collected and the new fees calculated back to the start of the Guarantee Period. If you are not notified of the change in advance, such difference will be reconciled in the annual accounting for the Guarantee Period.
If fees are adjusted, the caveats below will be based on the new assumptions. During the Guarantee Period we may adjust your Guaranteed Fees if:

*Enrollment*

There is a 15 percent change in the total number of enrolled employees for all commercial medical products combined. Our proposal assumes coverage will not be extended to additional employee groups without review of supplemental census information and other underwriting information for appropriate financial review.

*Member-to-Employee Ratio*

The member-to-employee ratio changes by more than 15 percent from the 2.2 ratio assumed in this quote.

*Projected Processed Claim Transactions (PCT) Per Employee*

The actual PCT ratio changes by more than 15 percent from the 45.10 ratio assumed in this quote.

*Age 65 and Over Enrollment*

The number of enrolled employees age 65 and over (excluding those enrolled on Medicare Direct plans) exceeds 6 percent of the total enrolled group or changes by more than 15 percent from the 540 enrollees assumed in this quote. Patient Management programs are excluded for Medicare primary members.

*Quoted Benefits and Administration*

A material change is initiated by you or by legislative or regulatory action which materially affects the cost of the plan. This includes, but is not limited to, changes impacting standard contract provisions, claim settlement practices, plan administration, plan benefits or changes to the programs and services we offer you.

*National Advantage™ Program*

You change or terminate the National Advantage™ Program (NAP), Facility Charge Review (FCR), Itemized Bill Review (IBR), or Data iSight™ (DiS) programs.

*Multi-Year Provision*

You place the products, programs and services included in this multi-year fee guarantee out to bid with an effective date prior to December 31, 2030, then this guarantee is no longer valid.

*Total Replacement*

We're the sole carrier for the quoted lines of coverage.

*Performance Guarantees*

If any of the conditions outlined above occur, then any performance guarantees may be changed or terminated based on the caveats outlined in those guarantee documents.

## Underwriting Assumptions

*Agreement Provisions*

Our quotation assumes our standard Agreement provisions and claim settlement practices apply unless otherwise stated.

*Participation*

A minimum of 150 enrolled employees is required to administer the proposed products on a self-funded basis.

*Plan Design*

This proposal is based on the current benefit plan designs, plus any noted deviations, subject to the terms of our Benefit Review document.

*Claim Fiduciary - Option 1*

Our proposal assumes we've been delegated claim fiduciary responsibilities. As claim fiduciary, we'll be responsible for final claim determination and the legal defense of disputed benefit payments. Our appeal administrative services are automatically included when we've been delegated claim fiduciary responsibilities.

*External Review*

We've included external review in our proposal. External review uses outside vendors who coordinate medical review through their network of outside physician reviewers.

*Non-ERISA*

For non-ERISA plan, the risk and responsibilities are different from those under ERISA plans, since the ERISA preemption and ERISA standard of performance do not apply. Our charge for non-ERISA plans must account for the additional liability risk as compared to known risks under an ERISA plan.

*Member Communications*

Pricing assumptions include direct communications access to Aetna membership through both ongoing Aetna Health communications and relevant ongoing included product/program specific communications. These communications can reduce member and plan costs by guiding in care navigation, managing chronic conditions, promoting preventive services, and more.

**Wellness Incentives and Rewards**

We offer several different wellness incentives and rewards programs that you may choose from to offer to your members. We, or our third-party vendors, will administer and distribute to your members any wellness incentives or rewards earned based on the programs selected under the direction and control of your plan. The wellness incentives and rewards earned through these programs may be taxable for your members. We will provide you with reporting which will identify members who have earned such wellness incentives or rewards. These reports will provide the data needed for any tax information reporting requirements that you determine are necessary.

With regard to these wellness incentives and rewards, you, as the Plan Sponsor have the following responsibilities:

- Ensure any incentives or rewards offered to your members comply with applicable law and any

limitations imposed thereunder. This includes but is not limited to, the Health Insurance Portability Act (HIPAA), the Americans With Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA).

- Distribute notices and/or obtain any authorizations required by law.
- Comply with all tax information reporting requirements regarding any wellness incentives or rewards earned through these programs (cash, cash equivalent, or other tangible property) and provided by us or our third-party vendor to your members.
- Assume any and all liability for your noncompliance with any tax withholding or information reporting requirements.

You may wish to consult with your legal counsel or other advisors as to the proper tax treatment of such wellness incentives or rewards and to ensure that the incentives or rewards offered under your program comply with applicable law.

***Mental Health/Substance Abuse Benefits***

Our quotation assumes that mental health/substance abuse benefits are included.

***Prescription Drug Benefits***

Our quotation assumes that prescription drug benefits are included and will be provided by Aetna.
If you terminate your Aetna prescription drug benefits with us, we will increase your ASC medical fees and the medical trend assumption used for any applicable claim projections or guarantees. You may also be subject to additional charges to integrate data with external Pharmacy vendors. Refer to the reporting charges outlined in the Programs and Services exhibit for more information. In addition to an increase to your ASC medical fees, the Fee Credit will not apply.

***Stop Loss Reporting***

Our quotation assumes stop loss coverage is provided by Aetna and therefore reporting to an external vendor is not required. If we are no longer the stop loss carrier, external reporting charges will apply.

***Medical Pharmacy Rebates***

Rebates for pharmacy products administered and paid through the medical benefit rather than the pharmacy benefit will be retained by Aetna as compensation for our efforts in administering this program.

***Additional Products, Programs and Services***

Costs for special services rendered that are not included or assumed in the pricing guarantee will be billed through the claim wire, on a single claim account, when applicable, to separately identify charges. Additional charges that are not collected through the claim wire during the year will either be direct-billed or reconciled in conjunction with the year-end accounting and may result in an adjustment to the final administration charge. For example, you will be subject to additional charges for customized communication materials, as well as costs associated with custom reporting, booklet and SPD printing, etc. The costs for these types of services will depend upon the actual services performed and will be determined at the time the service is requested.

## Billing Information

*Advanced Notification of Fee Change*

We'll notify you of any off-anniversary fee change within 31 days of the fee change.

*Late Payment*

We'll assess a late payment charge at a 12 percent interest rates as follows:

- if you fail to pay plan benefit payments within 1 business day of the request
- if you fail to pay administrative service fees within 31 days of the due date

We'll notify you of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to us under the Agreement or at law or in equity for failure to pay.

*Extended Grace Period*

As we agreed, we'll accept payment of service fees within 45 days. If you fail to pay service fees within 45 days, we'll assess a late payment charge. We reserve the right to change this extended period for paying Service Fees at any time. We'll provide you
with 30 days written prior notice in the event we decide to change the arrangement. Any Service Fees due after the end of the 30 day notice period will be subject to the new arrangement. We reserve all rights to enforce Agreement remedies as to any Service Fees overdue.

*Producer Compensation*

The quoted fees don't include producer compensation.

## Claim and Member Services

*Runoff Claims Processing*

Your administrative service fees are mature. The expenses associated with processing runoff claims following termination are covered for one year.

*Medical Service Center*

We've assumed that claim administration and member services for the quoted plans will be managed centrally by the Tampa, FL Service Center. Members will be able to reach the Member Service representatives Monday through Friday, from 8 a.m. to 6 p.m., local time (based on where the member resides).

## Reporting and Data Transfer

*Aetna Intellectual Property*

Under the Agreement, you may have access to certain of Aetna's Plan Sponsor 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 the Services under the Agreement ("Aetna IP"). Aetna will grant you, as the Plan Sponsor, 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.

*Data Integration (Historical)*

Our proposal assumes one historical medical and one historical pharmacy data integration feed. Additional fees will apply if feeds from more than one historical vendor are required.

*Data Integration (Ongoing)*

Options and pricing for integrating claims data from an external vendor into one or more of our systems will vary depending on the scale of your integration needs.

*Data Transfer at Termination*

Upon Agreement termination, we agree to cooperate with succeeding administrators in producing and transferring required claim and enrollment data. Data will be transferred within 30 days after determination of specific format and content requirements, subject to a charge that is based on direct labor cost and data processing time.

## Banking

We've assumed that you provide funds through a bank initiated ACH wire transfer for drafts clearing the bank under the self-funded arrangement assumed in this proposal.

When claims have accumulated to more than $20,000, a request will be sent to you and/or your bank requesting funds for the total claims from the previous day(s). For most customers, this will mean daily claim wire transfers. In addition, there will be a month end close out request on the first banking day of each subsequent month.

The proposed banking arrangement is subject to change based on results of a credit risk evaluation. We will complete an evaluation upon notification of sale.

We've assumed you'll use no more than three primary banking lines which are shared across all self-funded products, excluding Flexible Spending Account (FSAs). Additional wire lines and customized banking arrangements will result in an adjustment to the proposed pricing.

## Additional

Please review the additional important information found at the following URL. This information is incorporated by reference into this package and considered part of your Agreement. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriting Disclosure Document, the information in your package prevails.

https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/Large%20Group%20Self-Funded%20Medical%20Underwriting%20(UW)%20Disclosures%20as%20of%2005-02-2023.pdf

## Legislative and Regulatory Requirements

*Affordable Care Act (ACA) Taxes and Fees - Notice to Self-Funded Group Health Plan's Financial Liability*

The Affordable Care Act (ACA) imposed Patient-Centered Outcome Research Trust Fund fee (PCORI) on the issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans. The fee was set to end in 2019, but it was extended for 10 years through 2029. The fee applies to policy or plan years ending on or after October 1, 2012, and before October 1, 2029.

Any taxes or fees (assessments) related to the Affordable Care Act that apply to the self-insured health plans are your obligation. The Administrative Service Fee does not include any such liability or the remittance of the fees on your behalf.

*NSA Payment Practices*

The No Surprises Act (NSA) applies to certain out of network claims at participating facilities when the member doesn't have a choice or is unaware the provider is out of network. The law protects plan participants by limiting cost sharing to the preferred benefit level and prohibits balance billing by out of network providers. For NSA eligible claims, we will pay the out of network provider an initial payment amount. In most cases, the initial payment will be an amount equal to the qualifying payment amount as defined in NSA regulations (generally, the median contracted rate for a specific service in a geographic area). A provider may choose to go to independent dispute resolution (IDR) if the provider does not accept our payment as payment in full. During the IDR process, you authorize us to pay more than the qualified payment amount in order to reasonably settle the matter when it appears expedient to do so.

*Recovery of Overpayments*

Our process of recovering overpayments attempts to recoup money in the most accurate, effective, and cost-efficient manner.

When seeking recovery of overpayments from a provider, we have established the following process: If unable to recover the overpayment through other means, we may offset one or more future payments to that provider for services rendered to Plan Participants by an amount equal to the prior overpayment. We may reduce future payments to the provider (including payments made to that provider involving your or other health and welfare plans that are administered by us) by the amount of the overpayment, and we will credit the recovered amount to the plan that overpaid the provider. By entering into an agreement with us, you are agreeing that its right to recover overpayments shall be governed by this process and that it has no right to recover any specific overpayment unless otherwise provided for in the Agreement.

**Late Payment Charges**

We will assess a late payment charge if you do not provide funds on a timely basis to cover benefit payments and/or fail to pay service fees on a timely basis as outlined in the Agreement.

The current charges are outlined below:

1. Late funds to cover benefit payments (e.g., late wire transfers): 12 percent annual rate
2. Late payments of Service Fees: [xx] percent annual rate

We reserve the right to collect any incurred late payment charges through the claim wire on a monthly basis provided there is no other special payment arrangements in-force to fund any incurred late payment charges. You will be notified by us in writing to obtain approval prior to billing any late payment charges through the claim wire.

In addition, we'll charge to recover costs of collection including reasonable attorney's fees.

We will notify you of any changes in late payment interest rates.

The late payment charges described in this section are without limitation to any other rights or remedies available to us under the Agreement or at law or in equity for failure to pay.

# MEDICAL SERVICES SCHEDULE
# MASTER SERVICES AGREEMENT MSA- 881673
# EFFECTIVE January 1, 2025

Subject to the terms and conditions of the Agreement, the medical Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by the Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to section 4, Service Fees, of the Agreement) will be provided by Aetna. Additional Services may be provided at the Customer's written request under the terms of the Agreement. This Schedule shall supersede any previous document(s) describing the Services.

Some programs are available to Plan Participants and other eligible employees as determined by Customer not otherwise covered under products provided under this Agreement ("**Employee**").

## I. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to applicable state law, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of fiduciary duties under applicable state law necessarily involves the exercise of discretion on Aetna's part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, the Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between the Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

## II. EXTERNAL REVIEW

The external review process will be conducted by an independent clinical reviewer with appropriate expertise in the area in question. External Review shall be available for certain "Adverse Benefit Determinations" as defined in 29 CFR 2560.503-1 as amended by 26 CFR 54.9815-2719. It shall also be available for eligible "Final Internal Adverse Benefit Determinations", which is an eligible Adverse Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal review process or an Adverse Benefit Determination for which the appeal process has been exhausted. The External Review process shall meet the standards of the Federal Affordable Care Act and utilize a minimum of three accredited Independent Review Organizations. Independent reviewers conduct a de novo review of the information provided to them as part of the External Review process. Both Aetna and Customer acknowledge that neither Plan Participants nor providers will be penalized for exercising their right to an External Review.

The Customer delegates the sole discretionary authority to make the determination regarding the eligibility for external review, under the Plan, to Aetna. If an appeal is denied through the final level of internal appeal, Aetna will determine if it is eligible for ERO. Then Aetna will inform the Plan Participant of the right to appeal through ERO. If the appeal is upheld, Aetna will inform the Plan Participant the reason for the denial. If the appeal is not eligible for ERO, Aetna will inform the Plan Participant of the reasons for the ineligibility.

The Customer acknowledges that the Independent Review Organizations that make the external review decisions are independent contractors and not agents or employees of Aetna, and that Aetna is not responsible for the decision of the Independent Review Organization.

To assist in conducting such external reviews, the Customer agrees to provide Aetna with the current Plan documents, and any revised, amended, or updated versions no later than the date of any revisions, amendments, or updates.

## III. ADDITIONAL AUDIT GUIDELINES

Aetna is not responsible for paying customers' audit fees or the costs associated with an audit. Aetna will bear its own expenses associated with an audit; provided (i) the on-site portion of the audit is completed within five days, and (ii) the sample size is no more than 250 claims. Aetna will notify the Customer prior to the audit, if an audit request would require an additional payment from the Customer for any audits in excess of the aforementioned thresholds.

## IV. CARE MANAGEMENT SERVICES

1. **Utilization Management:**
   a. **Inpatient and Outpatient Precertification:**
   A process for collecting information prior to an inpatient confinement (Inpatient Precertification) or selected ambulatory procedures, surgeries, diagnostic tests, home health care and durable medical equipment (Outpatient Precertification). The precertification process permits eligibility verification/confirmation, initial determination of coverage, and communication with the physician and/or Plan Participant in advance of the provision of the procedure, service or supply at issue. Outpatient precertification is not applicable to Indemnity or PPO Products.

   b. **Concurrent Review:**
   Concurrent review encompasses those aspects of patient management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment. The concurrent review process includes obtaining information regarding the care being delivered; assessing the clinical condition, providing benefit determination, identifying continuing care needs to facilitate appropriate discharge plans, and identifying Plan Participants for other specialty programs such as Case Management or Disease Management.

   c. **Discharge Planning:**
   This is an interdisciplinary process that assists Plan Participants as their medical condition changes and they transition from the inpatient setting. Discharge planning may be initiated at any stage of the patient management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences upon identification of post discharge needs during precertification or concurrent review. This program may include evaluation of alternate care settings and identification of care needed after discharge. The goal is to provide continuing quality of care and to avoid delay in discharge due to lack of outpatient support.

   d. **Retrospective Review:**
   Retrospective review is the process of reviewing coverage requests for initial certification after the service has been provided or when the Plan Participant is no longer in-patient or receiving the service. Retrospective review includes making coverage determinations for the appropriate level of service consistent with the Plan Participant's needs at the time the service was provided after confirming eligibility and the availability of benefits within the Plan Participant's benefit plan.

   Not all services are subject to utilization management. Aetna maintains the discretion as to the particular level and intensity of these utilization management programs. The services subject to utilization review may vary from time to time.

2. **Case Management Programs:**

The Aetna Case Management program is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs in accordance with the Plan through communication and available resources to promote quality, cost-effective outcomes.

Those Plan Participants with diagnoses and clinical situations for which a specialized nurse, working with the Plan Participant and their physician, can make a material impact to the course or outcome of care and/or reduce medical costs will be accepted into the program at Aetna's discretion. Case management staff strives to enhance the Plan Participant's quality of life, support continuity of care, facilitate provision of services in the appropriate setting and manage cost and resource allocation to promote quality, cost-effective outcomes in accordance with the Plan. Case Managers collaborate with the Plan Participant, family, caregiver, physician and healthcare provider community to coordinate care, with a focus on closing gaps in the Plan Participant's care.

Aetna targets two types of case management opportunities:

- Complex Case Management targets Plan Participants who have already experienced a health event and are likely to have care and benefit coordination needs after the event. The objective for Case Managers is to identify care or benefit coordination needs which lead to faster or more favorable clinical outcomes and/or reduced medical costs.
- Proactive Case Management targets Plan Participants, from Aetna's perspective, who are misusing, over-using or under-utilizing the health care system, leading them towards avoidable and costly health events. This program's objective is to confirm gaps in Plan Participants' care leading to their over-use, misuse, or under-use, and to work with the Plan Participant and their physician to close those gaps.

Case management programs can vary based on the level of advocacy and overall intensity of the programs. The variation is determined by the changing the thresholds by which Plan Participants are identified for outreach. The various case management program options include:

- **Aetna Flexible Medical Model[SM]** - This program provides the Customer with the option to purchase more clinical resources devoted specifically to their Plan Participants. The Flex Model provides a Single Point of Contact Nurse (SPOC Nurse) and designated team to handle all case management activities for three levels of Flex Model Options, as elected. This team will engage in outbound Plan Participant outreach calls to provide case management support based on specific criteria. Each Flexible Medical Management option provides an increase in member engagement and outreach.

- **Dedicated Units, Designated Units and Care Advocate Teams** - These services were created to help coordinate care, support and resources for Plan Participants under one Care Unit.
  - Aetna's Dedicated Unit provides centralized care management services for pre-certification, utilization management and Case Management.
  - Aetna's Designated Unit is a unit team that provides centralized care management services for pre-certification, utilization management, and Case Management for a specific set of Customers, and
  - Aetna's Care Advocate Team has customized workflows based on the Customer's needs, vendor integration, specialized outreach, and program integration. The Care Advocate Team will:
    - Help the Plan Participant understand their doctor's diagnosis and treatment plan
    - Coordinate care across all Aetna programs to help the Plan Participant to optimize use of Aetna programs,
    - Help the Plan Participant decide what questions to ask the doctor or health care provider,

- Introduce the Plan Participant to a disability specialist if they need to file a disability claim, and
- Support the Plan Participant throughout their treatment and recovery by making follow-up calls and helping them get the support they need.

These services are the basis for National Accounts Targeted Care Solutions and Custom Case Management Solutions

3. **Specialty Case Management Programs:**
   - **Aetna Compassionate Care℠ Program ("ACCP")** - The Aetna Compassionate Care program provides additional support to terminally ill Plan Participants and their families. It removes barriers to hospice and provides more choices for end-of-life care so that the Plan Participant is able to spend time with family and friends outside a hospital setting.

     **ACCP Enhanced Hospice Benefits Package** - The enhanced hospice benefits package includes the following:
     - The option for a Plan Participant to continue to seek curative care while in hospice
     - The ability to enroll in a hospice program with a 12-month terminal prognosis
     - The elimination of the current hospice day and dollar maximum plan limits
     - Respite and bereavement services are included as part of the enhanced hospice benefits. The hospice services provided through a hospice regularly include these services and are coordinated by the hospice agency providing care and the Aetna nurse case manager who precertifies care for the Plan Participant. In addition, bereavement services are available through the Aetna Employee Assistance Program ("**EAP**") for Customers without an EAP vendor.

     Bereavement counseling shall be available to Plan Participants upon loss of a loved one, and to family and caregivers of a Plan Participant enrolled in ACCP following the death of such Plan Participant.

4. **National Medical Excellence Program®/Institutes of Excellence™ /Institutes of Quality®:**
   The National Medical Excellence Program was created to help arrange for access to effective care for Plan Participants with particularly difficult conditions requiring transplants or complex cardiac, neurosurgical or other procedures, when the needed care is not available in a Plan Participant's service area. The program utilizes a national network of experienced providers and facilities selected based on their volume of cases and clinical outcomes. The National Medical Excellence Program Unit provides specialized case management through the use of nurse case managers, each with procedure and/or disease-specific training. There are two networks:

   - **The Aetna Institutes of Excellence (IOE)** transplant network was established to enhance quality standards and lower the cost of transplant care for Plan Participants. It is made up of a select group of hospitals and transplant centers that meet quality standards for the number of transplants performed and their outcomes, as well as access criteria for Plan Participants.

   - **The Aetna Institutes of Quality (IOQ)** are a national network of health care facilities that are designated based on measures of clinical performance, access and efficiency for orthopedic, cardiac, and bariatric surgery. Bariatric surgery, also known as weight loss surgery, refers to various surgical procedures to treat people living with morbid or extreme obesity.

5. **MedQuery®:**
   The MedQuery program is a data-mining initiative, aimed at turning Aetna's data into information that physicians can use to improve clinical quality and patient safety. Through the program, Aetna's data is analyzed and the resulting information gives physicians access to a broader view of the Plan Participant's clinical profile. The data which fuels this program includes claim history, current medical claims, pharmacy, physician encounter reports, and patient demographics. Data is mined on a weekly basis and compared with evidence-based treatment recommendations to find possible errors, gaps, omissions (meaning, for example, that a certain accepted treatment regimens may be absent) or co-missions in care (meaning, for example, drug-to-drug or drug-to disease interactions). When MedQuery identifies a Plan Participant whose data indicates that there may be an opportunity to improve care, outreach is made to the treating physician based on the apparent urgency of the situation. For customers who have elected to purchase MedQuery with member messaging feature, in certain situations outreach will be made directly to the Plan Participant by MedQuery, requesting that the Plan Participant discuss with their physician, specific opportunities to improve their care.

   When available information reveals lack of compliance with a clinical risk, condition, or demographic-related recommendation for preventive care, a Preventive Care Consideration ("**PCC**") is generated. The PCC is a preventive/wellness alert sent to the Plan Participant electronically via the Plan Participant's Personal Health Record. Paper copies of a PCC, delivered via U.S. Mail, are also available as an additional purchase option.

6. **Personal Health Record:**
   Personal Health Record ("**PHR**") is a collection of personal health information about an individual Plan Participant that is stored electronically. The PHR is designed so that the Plan Participant can maintain his or her own comprehensive health record. In a PHR developed by a health plan, health information is commonly derived from claims data collected during plan administration activities. Health information may be supplemented with information entered by the Plan Participant.

   Aetna offers the Aetna CareEngine®-Powered PHR (for Customers who have elected this additional purchase option). The CareEngine-Powered PHR combines the basic functions of a PHR with a personalized, proactive, evidence-based messaging platform. The Plan Participant's PHR is pre-populated with health information from Aetna's claims system. Plan Participants can also input personal health information themselves. An online health assessment is available to facilitate the self-reporting process. The Aetna CareEngine-Powered PHR also offers personalized messaging and alerts based on medical claims, pharmacy claims, and demographic information, and lab reports.

7. **Aetna Enhanced Maternity Program:**
   Provides best-in-class member support for all members regardless of risk level throughout maternity journey. It starts with family-planning and fertility support and uses predictive analytics to help you keep your members and their families healthy throughout the entire maternity experience. This comprehensive solution helps identify opportunities to manage costs for one of the largest claim spend categories while improving clinical outcomes.

8. **Informed Health® Line:**
   Informed Health Line provides Employees with toll-free 24-hour/7 day telephonic access to registered nurses experienced in providing information on a variety of health topics. The nurses can contribute to informed health care decision-making and optimal patient/provider relationships through coaching and support. Informed Health Line has added the Healthwise® Video Library to enhance the Employees access to health information. The Employee can be sent links to health education videos from the Healthwise Video Library, via email.

The range of available service components options include:

- **Nurse Information line 1-800# Only**. This includes toll-free telephone access to the Informed Health Line.
- **Service Plus**. (optional additional purchase) Includes toll-free access to the Informed Health Line; introductory program announcement letter, reminder postcards mailed directly to Employee's homes; and semi-annual activity utilization report.
- **Service Green** (optional additional purchase) IHL Service Green is an environmentally friendly version of the Service Plus option. It provides the same level of service and availability as Service Plus but instead of mailing postcards and reminders, email is used.
- **Optional Service Features**. (optional additional purchase) These features may be purchased in conjunction with the Service Plus or Service Green package and includes an additional introductory kit; and annual Plan Participant or Employee survey and comprehensive results report.

9. **Simple Steps To A Healthier Life®:**
Aetna has developed an internet-based comprehensive management information resource, known as "Simple Steps To A Healthier Life" (the "**Simple Steps**"). Employees can access Simple Steps at www.aetna.com, an online support tool which provides advice relating to disease prevention, condition education, behavior modification, and health promotion programs that may contribute to the health and productivity of Employees.

   Simple Steps allows users to create a health assessment profile that generates personalized health reports. In addition to generating a health profile/assessment, Employees also have access to an action plan with links to personalized online health programs called Journeys®, offered through a relationship with RedBrick Health®. Through RedBrick Health, there is also an alternative health assessment option called RedBrick Compass™.

10. **Enhanced Clinical Review:**
This radiology program is designed, through a clinical prior authorization process, to promote appropriate and effective use of outpatient diagnostic imaging services and procedures. Aetna will provide these services nationally and/or regionally, and interact with, free-standing radiology and/or outpatient network facilities that provide the following services: Computed Tomography/Coronary Computed Tomography Angiograph (CT/CTA), Magnetic Resonance Tomography, Magnetic Resonance Angiography (MRIs/MRAs), Nuclear Medicine and Positron Emission Tomography (PET) and/or PET/CT Fusion, Stress Echocardiography (Stress Echo), and Diagnostic Cardiac Catherization, Sleep Studies and Cardiac Rhythm Implantable procedures (Pacemakers, Implantable Cardioverter-Defibrillators, and Cardiac Resynchronization Therapy). The Enhanced Clinical Review program will typically be administered through relationships with third parties.

11. **Aetna One® Care Management Programs:**
Aetna One Care Management programs addresses chronic and acute conditions holistically, instead of through separate case management and disease management programs. This program supports Plan Participants with an integrated program experience for the Plan Participant. Aetna's One Care program is condition agnostic, provides a more holistic approach to care, and a higher level of engagement supporting Plan Participants with the most risk and the greatest opportunity for health impacts.

    Aetna One Care Management identifies Plan Participants based on assessing their clinical urgency, financial impact, and clinical impact. Based on this assessment, Plan Participants are then assigned to one of three program tracks: high, moderate, or low. Plan Participants would then be targeted for either one-on-one nurse support or through virtual support, providing the appropriate level of support when needed. Plan Participants targeted for one-on-one support will be assigned a single nurse point of contact providing a holistic approach to care. This single nurse model also assigns the same nurse to the

other family members for support if needed. Management interactions are tailored to match the Plan Participant's engagement preferences, such as online contact.

These services are the basis for National Accounts Aetna One™ Flex and Aetna One™ Choice offerings.

12. **Healing Better:**
Healing Better is a coordinated program for everything members need across provider and facility selection, medication guidance, home care expectations, covered Durable Medical Equipment (DME), and support services in order to recover quickly and without complications. Eligible members will receive an initial care package that includes information related to their condition and support to order supplies on a curated CVS site specific to their recovery needs.
This program includes:
    - Predictive modeling to identify members early in their journey
    - Care Package and Product Bundle to surprise and delight our members
    - Digital Support Center with stories from peers that have had the procedures
    - Pain management support materials
    - Concierge Service to support higher risk members

13. **Aetna Enhance**
The version of Advice included with Aetna One Essentials does not include the option to add incentives. This is an incentive buy-up, offered to plan sponsors who have elected the Aetna One Flex or Aetna One Choice care management tiers. The incentive product enables customers to "enhance" their medical cost savings opportunity from Aetna's care management program by adding incentives to existing Advice preventive and site-of-care campaigns. Incentives will be redeemable for gift cards and will range in value (up to $300 in total per targeted member per calendar year) depending on the medical cost savings generated for each campaign.

14. **Transform Diabetes Care (TDC) Program**
Most of today's diabetes solutions take a one-size-fits-all approach and do not effectively address the complexity of managing diabetes. Based on our breadth of clinical assets and member engagement data, we know that providing more personalized, actionable solutions for all members with diabetes is the best approach. Leveraging our care management assets and integrating medical and pharmacy data for advanced targeting and interventions, we now have a comprehensive model that addresses diabetes across 5 major treatment categories. By addressing all 5 key categories critical to complete diabetes management: taking the right medication, adherence to medication, preventative screenings, lifestyle & comorbidity management and monitoring blood glucose, this program offers the best chance to lower A1C for members and reduce overall medical and pharmacy costs for clients. Complete condition management increases the depth and breadth of care management for a single condition. Complete diabetes care offers the member individualized support inclusive of local, direct care delivered by an integrated team of pharmacists, Aetna care managers, Minute Clinic providers, and Health Hub specialists.

## V. BEHAVIORAL HEALTH SERVICES

1. **Managed Behavioral Health:**

A set of services that includes both inpatient and outpatient care management.

- Inpatient Care Management provides phone-based utilization review of inpatient behavioral health (mental health and chemical dependency) admissions intended to contain confinements to

appropriate lengths, assure medical necessity and appropriateness of care, and control costs. Inpatient Care Management provides precertification, concurrent review and discharge planning of inpatient behavioral health admissions. These services also include identification of Plan Participants for referral to a Behavioral Health Condition Management program.

- Outpatient Care Management includes precertification on a limited number of selected services. Where precertification is required, the request for services is reviewed against a set of criteria established by clinical experts and administered by trained staff, in order to determine coverage of the proposed treatment. Where precertification is not required, cases are identified for Outpatient Case Management through the application of clinical algorithms.

2. **Behavioral Health Condition Management**
The Aetna Behavioral Health Condition Management program identifies and engages Employees diagnosed with high-risk acute and chronic behavioral health conditions. Employees enrolled in the program get support with behavior change to improve overall functioning and wellness, which keeps them involved in and compliant with their treatment. The program promotes active collaboration and coordination of everyone involved in the Employee's medical and behavioral health care, including providers, family, friends and other Aetna clinical programs.

   Base Level Program (Embedded) - Triggers include: high cost claimants, re-admissions, and multiple diagnoses/co-morbidities.

   High Level Program (Optional)
   This option includes quarterly utilization reports. Triggers include: base embedded triggers plus, medical or behavioral health diagnosed conditions, inpatient admission, ER visits for behavioral health.

3. **AbleTo**
AbleTo performs outreach, on behalf of Aetna, to offer Plan Participants, with certain medical conditions or those going through certain life changes, an alternative treatment setting. Outreach is made to offer behavioral health support to Plan Participants using web-based videoconferencing, online interface or telephone support, instead of a face-to-face office visit. AbleTo provides condition-specific, structured, fixed duration support. AbleTo is an in-network provider and its clinical team consists of therapists and behavioral health coaches. Each web-based videoconferencing session, online interface or telephone support session, is subject to Plan terms applicable to a behavioral health office visit, including cost share, deductible, etc.

## VI. TECHNOLOGY/WEB TOOLS

1. **Online Provider Directory:**
Aetna's online participating provider directory--updated daily -- that anyone can use to locate network physicians and other health care providers such as dentists, optometrists, hospitals and pharmacies.

2. **Secure Member Portal:**
The secure member portal is a Plan Participant website that can be used as an online resource for personalized health and financial information.

3. **Health Decision Support:**
Health Decision Support provides educational support so Employees can better understand their conditions and treatment options, including tests, procedures and surgery. This helps Employees make more informed decisions for their health care.

Health Decision Support has two options for customers. Both options offer programs for treatment, procedure and surgery decision support.

- **Basic** -- Offers 30 programs. It is available to all secure member portal registered users at no additional cost to customers or employees.
- **Premium** – (optional additional purchase) Offers over 200 programs and plan sponsor-specific engagement reporting. Aetna Healthy Actions℠ incentive tracking is available for program completion in the premium option.

## VII. OTHER SERVICES

1. **Teladoc:**
   Teladoc is a vendor that provides access to physicians who are under contract with Teladoc, to provide consultations for non-urgent care needs by telephone. The physicians made available through the Teladoc program are independent contractors and are neither employees nor agents of Teladoc or Aetna.

2. **Onsite Health Screening Services:**
   Aetna's Onsite Health Screening Services help employers engage and educate their Employees about wellness at the workplace. These offerings provide turnkey solutions to support employers' overall wellness strategies, increase consumerism and promote informed-decision making. Offerings include Onsite Health Screenings, Workshops, Special Awareness Campaigns; and Educational Resources. Aetna may contract with nationally recognized vendors to administer Onsite Health Screening Services, and such vendors may be subject to change.

3. **ID Cards:**
   Upon the Customer's request, Aetna will include third party vendor information on Plan Participant identification cards. In such event, the Customer shall indemnify Aetna, its affiliates and their respective directors, officers, and employees from that portion of any actual third party loss (including reasonable attorney's fees) resulting from the inclusion of such third party vendor information on identification cards.

4. **Subrogation Services:**
   Aetna will provide subrogation/reimbursement services when the Customer's summary plan description (SPD) is finalized, available to the Customer's employees, and includes subrogation/reimbursement language.

   Aetna does not delay processing or deny claims for subrogation/reimbursement purposes.

   Aetna has the exclusive discretion to: (a) decide whether to pursue potential recoveries on subrogation/reimbursement claims; (b) determine the reasonable methods used to pursue recoveries on such claims, except with respect to initiation of formal litigation; and (c) decide whether to accept any settlement offer relating to a subrogation/reimbursement claim. Aetna shall advise the Customer if the pursuit of recovery requires initiation of formal litigation. In such event, the Customer shall have the option to approve or disapprove the initiation of litigation. Subrogation /reimbursement services will be delegated to an organization of Aetna's choosing.

   The subrogation/reimbursement fee is outlined in the Service and Fee Schedule and includes reasonable expenses such as (a) collection agency fees, (b) police and fire reports, (c) asset checks, (d) locate reports and (e) attorneys' fees. If no monies are recovered as a result of the subrogation/reimbursement service, no fee will be charged to the Customer.

Subrogation/reimbursement recoveries will be credited to the Customer net of fees charged by Aetna. Aetna does not credit individual Plan Participant claims for subrogation/reimbursement recoveries.

The Customer must notify Aetna should the Customer pursue, recover by settlement or otherwise waive any subrogation/ reimbursement claim, or instruct Aetna to cease pursuit of a potential subrogation claim. Aetna will be entitled to the subrogation/reimbursement fee, which will be calculated based on the full amount of claims paid at the time the Customer settles the file or instructs Aetna to cease pursuit.

The Customer must notify Aetna of its election to terminate the subrogation/reimbursement services provided by Aetna. All claims identified for potential subrogation/reimbursement recovery prior to the date notification of such election is received, including both open subrogation files and matters under investigation, shall be handled to conclusion by Aetna and shall be governed by the terms of this provision. Aetna does not handle new subrogation/reimbursement cases on matters identified after the Customer's termination date.

## 5. NATIONAL ADVANTAGE PROGRAM (NAP)

There are three components to NAP: Contracted Rates (with or without Professional Claims Repricing), Facility Charge Review and Itemized Bill Review. Plans enrolled in NAP automatically have access to NAP's Contracted Rates component. The Contracted Rates component also includes Professional Claims Repricing, if warranted, based on the plan's out-of-network rate structure. Plans enrolled in the Contracted Rates component have two optional components that are available: Facility Charge Review and Itemized Bill Review. Unless otherwise agreed in writing, only the NAP components selected by the Customer in the Service and Fee Schedule will be provided by Aetna.

### A. Contracted Rates Component (with or without Professional Claims Repricing)

Through the Contracted Rates component of NAP, Aetna either contracts with third-party vendors to access their contracted rates with providers (a "**Vendor Accessed Rate**"), or directly contracts with providers (a "**Directly Contracted Rate**") (collectively, a "**Pre-Negotiated Contracted Rate**") for (i) medical claims paid under non-network indemnity plans, (ii) claims covered under the out-of-network portion of network-based plans ("**Voluntary Out-of-Network Claims**"), and (iii) claims from out-of-network providers covered as in-network benefits under the Plan because the claims are for emergency services, because the services are provided by out-of-network providers at in-network facilities, or because Aetna otherwise determines that the Plan Participant received the services out-of-network because of circumstances outside the Plan Participant's control ("**Involuntary Out-of-Network Claims**"). An Aetna Directly Contracted Rate is applied to a claim first, if available (for example, a Directly Contracted Rate is typically applicable for indemnity plans and narrow-network arrangements). If a Directly Contracted Rate is not available, an external vendor looks for a Vendor Accessed Rate, based on a preset hierarchy of vendor contracted networks. Providers with Pre-Negotiated Rates are collectively referred to as "**NAP Providers.**"

When a Pre-Negotiated Contracted Rate is applied to a claim, the provider is contractually bound not to balance bill Plan Participants. To limit balance billing for Plan Participants, the Pre-Negotiated Contracted Rate will apply even if that rate exceeds the amount determined by the benefit level under the Plan.

In the absence of a Pre-Negotiated Contracted Rate, Aetna or a third-party vendor will attempt to negotiate a claim specific rate/discount (**"Ad-Hoc Rate"**).

B. **Facility Charge Review ("FCR") Component**

FCR applies to inpatient and outpatient facility claims for which a Pre-Negotiated Contracted Rate is not available and for which the claim amount exceeds a certain threshold as determined by Aetna. Through the FCR component, Aetna establishes a charge for a Plan benefit in the geographic area where such benefit was provided to the Plan Participant ("**Recognized Charge**"). The Recognized Charge is based on the provider's estimated cost, including an anticipated profit margin. The claim will be priced based on the Recognized Charge. Even with FCR, if a provider refuses to agree to a negotiated rate, claims may be priced at billed charges in certain circumstances.

C. **Itemized Bill Review ("IBR") Component**

IBR applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology. Aetna refers to these as "**IBR Claims**."

Aetna will forward IBR Claims to a vendor to review and identify any billing inconsistencies and errors. The vendor reports back the amount of eligible charges after adjusting for any identified inconsistencies and errors. Aetna then pays the claim based on the adjusted bill.

D. **Terms and Conditions**

(i) NAP Fees

(a) The Customer's fees for the NAP program are charged as a percentage of the Savings achieved for a claim paid under NAP ("**NAP Fee**"), as described in the Service and Fee Schedule. For purposes of calculating the NAP Fee, the following definitions shall apply:

- "**Savings**" means the difference between (i) the Reference Price, and (ii) the NAP priced amount.

- "**Reference Price**" means (i) for Involuntary Out-of-Network Claims and facility Voluntary Out-of-Network Claims, the amount billed by the provider for the covered service; (ii) for Professional Voluntary Out-of-Network Claims, the benefit level set forth under the plan; and (iii) for in-network facility services where Itemized Bill Review applies, the rate for the facility service prior to removal of any non-payable charges identified as part of the claim review.

(b) The Customer will not owe any NAP Fees with respect to amounts that are the financial responsibility of Aetna, such as when Aetna writes stop loss insurance and the individual or aggregate limit, as applicable, is reached.

(c) If Aetna pays more than the Reference Price, the Savings will be defined as zero.

(d) NAP Fees will be credited back to the Customer for any Savings subsequently reduced or eliminated for which the Customer has already paid a NAP Fee.

(e) Aetna will provide a quarterly report of Savings and NAP Fees. NAP Fees may be included with claims in other reports.

(ii) Plan Participant Information Regarding NAP

The Customer shall inform Plan Participants of the availability of NAP Providers. Further, the Customer's Summary Plan Description specifying coverage for out-of-network health services must conform to Aetna requirements. Aetna shall provide information regarding NAP Providers on DocFind®, Aetna's online provider listing, on our website at www.Aetna.com or by other comparable means.

(iii) Customer Acknowledgements

Customer acknowledges that:

(a). Aetna does not credential, monitor or oversee those providers who participate through Vendor Accessed Rates. NAP Providers participating in the Contracted Rates component may not necessarily be available or convenient.

(b). The following claim situations may not be eligible for NAP:

- Claims involving Medicare when Aetna is the secondary payer
- Claims involving coordination of benefits (COB) when Aetna is the secondary payer
- Claims that have already been paid directly by the Plan Participant.

(iv) General Provisions

(a) Aetna's only liability to the Customer for any loss of access to a discount arising under or related to NAP, regardless of the form of action, shall be limited to the NAP Fee actually paid to Aetna by the Customer for services rendered. Any performance standards agreed to by Aetna and set forth in the Agreement are not affected by this provision and shall remain in effect.

(b) The terms and conditions of NAP shall remain in effect for any claims incurred prior to the termination date that are administered by Aetna after the termination date.

# PRESCRIPTION DRUG
# SERVICE AND FEE SCHEDULE
# TO THE MASTER SERVICES AGREEMENT
# EFFECTIVE January 1, 2025

The Service Fees and Services effective for the period beginning January 1, 2025 and ending December 31, 2029 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement.

Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

This Exhibit outlines the fees for the Comprehensive Prescription Drug Benefit Plan Administration Services contract between Lee County Board of County Commissioners and Aetna Life Insurance Company (hereinafter "Aetna"). The fees are for services performed by Aetna under the Administrative Services Agreement (hereinafter "Agreement") for the period January 1, 2025 through December 31, 2029.

## Pharmacy Discounts & Fees

Management or administration of prescription drug benefits selected by the Customer will be performed by CaremarkPCS Health, L.L.C. and/or its affiliates (CVS Caremark), each of which is an affiliated, licensed pharmacy benefit manager.

| | |
|---|---|
| Pricing Arrangement | Pass Through at Retail |
| Network | Aetna National Network |
| Employees | 4,334 |

| RETAIL | | | | | |
|---|---|---|---|---|---|
| | 01/01/2025 | 01/01/2026 | 01/01/2027 | 01/01/2028 | 01/01/2029 |
| Brand Discount | AWP - 19.60% | AWP - 19.70% | AWP - 19.80% | AWP - 19.90% | AWP – 20.00% |
| Generic Discount | AWP - 85.00% | AWP - 85.20% | AWP - 85.40% | AWP - 85.60% | AWP - 85.80% |
| Dispensing Fee | $0.55 per script | $0.55 per script | $0.55 per script | $0.55 per script | $0.55 per script |

| MAIL ORDER PHARMACY/MAINTENANCE CHOICE | | | | | |
|---|---|---|---|---|---|
| Mail Benefit Type | Voluntary Maintenance Choice | | | | |
| | 01/01/2025 | 01/01/2026 | 01/01/2027 | 01/01/2028 | 01/01/2029 |
| Brand Discount | AWP - 25.10% | AWP - 25.20% | AWP - 25.30% | AWP - 25.40% | AWP - 25.50% |
| Generic Discount | AWP - 89.25% | AWP - 89.45% | AWP - 89.65% | AWP - 89.85% | AWP – 90.05% |
| Dispensing Fee | $0.00 per script | $0.00 per script | $0.00 per script | $0.00 per script | $0.00 per script |

| SPECIALTY PHARMACY | | | | | |
|---|---|---|---|---|---|
| Network | Specialty Network | | | | |
| Product List | Aetna Specialty Product List | | | | |
| | 01/01/2025 | 01/01/2026 | 01/01/2027 | 01/01/2028 | 01/01/2029 |
| Discount | AWP - 22.00% | AWP - 22.10% | AWP - 22.20% | AWP - 22.30% | AWP - 22.40% |

| ADMINISTRATIVE FEES | | | | | |
|---|---|---|---|---|---|
| | 01/01/2025 | 01/01/2026 | 01/01/2027 | 01/01/2028 | 01/01/2029 |
| PEPM | $2.00 | $2.00 | $2.00 | $2.00 | 2.00 |

| ALLOWANCES | | | | | |
|---|---|---|---|---|---|
| | 01/01/2025 | 01/01/2026 | 01/01/2027 | 01/01/2028 | 01/01/2029 |
| Audit Allowances | $150,000 | $150,000 | $150,000 | $150,000 | $150,000 |
| General Allowance | $100,000 | $50,000 | $50,000 | $50,000 | $50,000 |

Rebates

| REBATES | | | | | |
|---|---|---|---|---|---|
| Formulary | Aetna Standard Formulary | | | | |
| Plan Design | 3 Tier Qualifying | | | | |
| Rebate Terms | Customer will receive the following minimum rebate guarantees: | | | | |
| | 01/01/2025 | 01/01/2026 | 01/01/2027 | 01/01/2028 | 01/01/2029 |
| Retail | Greater of 100% or $378.88 Per Brand Script | Greater of 100% or $411.54 Per Brand Script | Greater of 100% or $446.66 Per Brand Script | TBD | TBD |
| Mail Order/Maintenance Choice | Greater of 100% or $949.08 Per Brand Script | Greater of 100% or $1,002.13 Per Brand Script | Greater of 100% or $1,061.11 Per Brand Script | TBD | TBD |
| Specialty | Greater of 100% or $3,144.01 Per Brand Script | Greater of 100% or $3,574.18 Per Brand Script | Greater of 100% or $3,970.23 Per Brand Script | TBD | TBD |

Capitalized terms in the pricing charts above are not intended to reflect defined terms except where specifically noted in the Prescription Drug Services Schedule.

Standard core as well as additional and third-party service options are described in the Aetna Pharmacy Program Summary incorporated herein by reference.

In the event of any inconsistencies between the terms and conditions set forth in this Pharmacy Service and Fee Schedule and the terms and conditions set forth in the Prescription Drug Services Schedule, the term and conditions of this Pharmacy Service and Fee Schedule shall prevail.

**"Brand Drug"** shall mean drugs or devices for which the Medi-Span Multisource Code field contains "M" (co-branded product), or "N" (single source brand), or "O" (originator) unless the Claim processes with MAC pricing, in which case, for purposes of reconciling financial guarantees, the Claim shall be classified as a Generic Drug Claim. For purposes of adjudication, in limited circumstances, Aetna may override the M, N, or O indicators and deem the drug to be a Generic Drug after a review of additional information including other Medi-Span data, FDA application data (NDA/ANDA) and price.

**"Generic Drug"** shall mean drugs or devices for which the Medi-Span Multisource Code field contains a "Y" (generic). Claims with DAW 5 code ("House Generics") shall also be classified as Generic Drug Claims. In addition, for purposes of reconciling financial guarantees, Authorized Generics shall be classified as Generic Drug Claims. For purposes of reconciling financial guarantees, all other Claims with Medi-Span Multisource Code of "O" that process with MAC pricing, including DAW 3, 4, and 6, shall be classified as Generic Drug Claims. For purposes of adjudication, in limited circumstances, Aetna may override the M, N, or O indicators and deem the drug to be a Generic Drug after a review of additional information including other Medi-Span data, FDA application data (NDA/ANDA) and price.

**"Authorized Generics"** shall mean drugs that are produced by an innovator (i.e., the brand manufacturer) under a New Drug Application (NDA), or licensed to be produced by a generic company under the New Drug Application (NDA), and are marketed, sold and/or distributed as generics under private label and as published by the FDA.

**Terms & Conditions**

The pricing and services set forth herein are subject to the following Terms & Conditions:

- To the extent the pricing and services outlined in this document are part of a renewal to the Customer, the pricing set forth herein is valid for 90 days from the date of such offer.
- This pricing has an effective date of January 1, 2025. In order for Aetna to implement the pricing as set forth above by the effective date, a notification of award must be given 90 days prior to effective date.
- Our renewal assumes that Aetna administers both the medical and pharmacy benefits for Customer on an integrated basis. If Customer elects to use a different vendor to provide medical benefits, then Aetna reserves the right to adjust the pricing contained in this proposal.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Participating Pharmacy shall give the Plan Participant the benefit of the lesser of (i) the Participating Pharmacy's Usual and Customary Charge, (ii) MAC (where applicable) or (iii) discounted AWP cost. Participating Pharmacy shall collect and retain from the Plan Participant at the time of dispensing the lesser of (i) the Cost Share; (ii) the Participating Pharmacy's Usual and Customary Charge, (iii) MAC (where applicable) or (iv) discounted AWP cost.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.

- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
    - Discount and Dispensing Fee guarantees are measured and reconciled individually; surpluses in one or more component guarantees may not be used to offset shortages in other component guarantees.
    - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within ninety (90) days following the guarantee period.
    - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant Cost Share and include zero balance due claims.
    - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein:
        - Compound Prescription claims
        - Limited distribution drug (LDD) claims
        - Direct Plan Participant reimbursement / out-of-network claims
        - Coordination of Benefits (COB) or secondary payor claims
        - In-house pharmacy claims
        - Vaccines (including for COVID) and other COVID testing-related claims
        - 340B claims
    - Retail pricing guarantees exclude claims that reflect the Usual & Customary Retail Price.
    - Single Source Generic Drugs are included in the Generic Discount guarantees.
    - Only Specialty Products dispensed by a Specialty Pharmacy are included in the Specialty Pharmacy Discount guarantee listed above. Specialty Products dispensed by Participating Retail Pharmacies are not included in any Discount guarantee listed above.
    - Aetna has assumed 0.00% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.
- Pricing and terms in this proposal assume the Customer has elected Aetna Standard Formulary.
- The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members
- Specialty Network means that Plan Participants are required to use participating Specialty Pharmacies (no fills at retail allowed) ,with the exception of the HIV class which is not required to be dispensed at Specialty Pharmacies.
- The Overall Effective Discount (OED) offer is conditioned on Aetna being the exclusive provider of Specialty Products through CVS Specialty Pharmacies with the exception of the HIV class and Client implementing and maintaining a generics first plan design for specialty. Aetna may amend the individual Specialty Drug discounts from time to time to manage the financial guarantee. The financial guarantee is measured and reconciled annually across all Specialty Drugs dispensed by Aetna Specialty pharmacy, including through the Specialty Connect program, with the exception of the following exclusions (in addition to the standard exclusions).

- New to market Specialty Products

For the items noted here, the following quoted rates shall apply:

- New to market Specialty Products: AWP - 15%
- New to market limited distribution drugs: AWP - 10%

MAC: Certain dosage forms and strengths may not be included on the MAC list and shall be priced at the Specialty Product default rate.

In the event retail leakage increases by a percentage change of 10%, or more, from the effective date of the agreement, Aetna reserves the right to amend pricing.

- Our financial offer does not assume any adoption of the Transform Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.
- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein.
- Rebate guarantees may be subject to:
  - The adoption of Specialty Guideline Management (SGM) program
  - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
- The above rebate guarantees exclude:
  - Any other Claim identified as having received 340B program wholesale pricing
  - Compound Drug Claims
  - Paper or Member Submitted Claims
  - Coordination of Benefits (COB) or secondary payor Claims
  - Vaccine and vaccine administration Claims
  - COVID treatment Claims
  - Claims approved by Formulary Exception
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty rebate guarantees apply to Specialty Product claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:
  - Two-tier qualifying plan designs - will consist of an open plan design, with the first tier comprised of Generic Drugs and the second tier comprised of Brand Drugs. There are no requirements for a minimum Cost Share differential between these tiers. The plan design may need to implement formulary interventions recommended by Aetna.
  - Three-tier non-qualifying plan designs – maintain a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs.

- Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a $15.00 co-payment differential between preferred and non-preferred Brand Drugs, at least a $15.00 differential in the minimum co- payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).

- Rebate guarantees are measured individually by component and reconciled in the aggregate on an annual basis within 12 months following the end of the Plan year; a surplus in one or more component Rebate guarantees may be used to offset shortages in other component Rebate guarantees.

## Allowances

Allowances which are based on the information available to Aetna during this process will be available as of the Effective Date of the Pharmacy Services and Fee Schedule. Aetna will pay related expenses directly to a third-party vendor once the Customer sends the invoice(s) outlining the expenses incurred to Aetna. Invoices must be submitted before the end of each Plan year otherwise the Customer forfeits the funds. Any unused allowance monies at the end of each Plan year will be forfeited. It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, this credit shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. §1320a- 7b(b)(3)(A). The parties acknowledge and agree that the allowances provided by Aetna are commercially reasonable and necessary services related to this Agreement, including without limitation, implementation, audit, communication and/or external data file/feeds, and represent fair market value for the services provided.

### Audit Allowance

Aetna is including an audit allowance of up to $150,000.00 on a Annual basis. The Customer can use this allowance to pay for the costs associated with an audit performed to review claim transactions for the purpose of assessing the accuracy of the benefit determination.

### General Allowance

Aetna is including a Year 1 (1/1/2025) general allowance up to $100,000 and $50,000 on a Annual basis for Years 2 through 5 (1/1/2026-1/1/2029). The Customer can use this allowance to pay for implementation, audit or communication related expenses along with external data files or feeds.

## Market Check

Once during the second quarter of the second contract year, and at Customer's reasonable request, Aetna and Customer or a mutually agreed upon third party with a signed non-disclosure agreement may review the financial terms of Customer compared to financial offering presented to similar employers in

the marketplace as deemed appropriate. The parties agree for the purpose of this market check that Aetna or Customer's representative will compare, among other things, the following factors to determine whether Customer is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable customers of comparable size, inclusive of the program savings, the retail pricing for brand and generic drugs, pricing for specialty drugs, administrative fees, rebates and guarantees;(ii) the services provided by Aetna to such customers; and (iii) the plan design of such customers, which may include plan formulary, brand/generic utilization information and mail and retail utilization information, available to Aetna. Customer, or its representative, shall provide Aetna with a report to substantiate its findings. Should the comparison demonstrate that the current market conditions would yield a savings of 2% or more in net costs (i.e. gross costs net of administration fees and rebate guarantees), then the parties will discuss in good faith a revision to the current pricing terms and other applicable contract provisions. If Customer and Aetna agree to any revisions to the financial terms as a result of this review (i) the agreement shall be amended and (ii) shall be effective January 1 of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the contract year as to which the revisions are to apply.

## Additional Disclosures

The Customer acknowledges that the Discounts and Dispensing Fees contained in this agreement reflect a Transparent or Pass Through pricing arrangement at Retail. Transparent or Pass Through Pricing means the amount charged to the Customer and Plan Participants for network claims shall equal the amount paid to Participating Retail Pharmacy. Maintenance Choice claims dispensed at CVS/pharmacy, if applicable, are exempt from the Transparent Pricing requirements under this Agreement. The amount billed to the Customer will be equal to the amount paid to the participating pharmacies.

The financial provisions in this Agreement are based upon Claims data and membership information provided by Customer (or Customer's authorized representative) during the pricing request process, which shall serve as the baseline. Aetna reserves the right to make an equitable adjustment to modify or amend the financial provisions set forth herein in a manner designed to account for the impact of specific triggering events identified below ("Equitable Adjustment").

1. Greater than 15% change in total membership or Claims volume as compared to the baseline
2. Customer-initiated change to the Benefit Plan Design, or Formulary alignment. To the extent applicable, Aetna will notify Customer in advance of any proposed Equitable Adjustment
3. Product offering decisions by drug manufacturers that result in a reduction of rebates, including the introduction of a lower cost alternative product which may replace an existing rebatable brand product; an unexpected launch of an interchangeable version of a brand product; or a branded product converted to OTC status, recalled or withdrawn from the market; or a material reduction in the Wholesale Acquisition Cost (WAC);or
4. Other events triggering an Equitable Adjustment as detailed below:
   - Legal and/or regulatory changes specific to customers which negatively affects the economic value of the Agreement to a party or the parties under the Agreement, for example restrictions on preferred or limited network arrangements; policy changes

impacting drug manufacturers which negatively affect the economic value of the Agreement including the ability to provide or maintain discounts or Rebates; and/or

- An inability to access, or changes to, industry pricing information (e.g. AWP) required to support the current economic structure of the Agreement.

If one or more of such triggering events occurs, Aetna may initiate a review to determine if an Equitable Adjustment to any of the financial provisions is warranted as a direct result of the triggering event(s). Aetna will conduct an analysis based upon Customer-specific Claims, utilization, and membership data demonstrating how the triggering event(s) result in the proposed Equitable Adjustment. Any such Equitable Adjustment based upon events #1 or #2 described above shall be effective on the first day that the triggering event occurred. Any such Equitable Adjustment based upon events #3 or #4 described above shall be effective 30 days after notification to Customer. Aetna will provide documentation of the reason for the proposed Equitable Adjustment in addition to a summary analysis demonstrating that the Equitable Adjustment is solely related to the impact of the specific triggering event. Aetna will disclose necessary facts and data to an independent auditor for validation.

Aetna reserves the right to modify its products, services, and fees, and to recoup any costs, taxes, fees, or assessments, in response to legislation, regulation or requests of government authorities. Any taxes or fees (assessments) applied to self-funded benefit Plans related to The Patient Protection and Affordable Care Act (PPACA) will be solely the obligation of the Customer. The pharmacy pricing contained herein does not include any such Customer liability.

**Rebate Payment Terms**

Rebates will be distributed on a quarterly basis by claim wire credit.

Rebate collections are paid quarterly one hundred and eighty (180) days after the quarter ends. Rebates are calculated and paid in accordance with the terms and conditions of this Agreement.

Earned Rebates are distributed in March, June, September and December each contract year.

Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

When remitting and reconciling minimum Rebate guarantees, Aetna may add Rebate Credit value to the total Rebates remitted to Customer for each respective Rebate component. Rebate Credits shall consist of (i) the differential between the Wholesale Acquisition Cost (WAC) of a lower net cost Brand Covered Product, including but not limited to a Biosimilar (Low Cost Brand) Claim processed and the WAC of the reference Brand Drug, subject to the below cap; and/or (ii) the value of price reductions for rebateable

products that have experienced a WAC decrease, measured as the differential between the Baseline WAC of the product and the WAC of the product when the Claim is processed, subject to the below cap. The Baseline WAC will be the WAC of the product prior to a reduction in WAC or, as applicable, for Low Cost Brands, the Baseline WAC will be the WAC of the reference Brand Drug at the time of Claim processing.

In no way will the Rebate Credit exceed the Baseline Rebate less the earned Rebates on either the Low Cost Brand or the rebateable product that has experienced a WAC decrease. Baseline Rebate is calculated as follows: in the year the price reduction occurred, Baseline Rebate will be the Rebate available for coverage of the product prior to the WAC reduction or, as applicable, for Low Cost Brands the Baseline Rebate will be the Rebate available for coverage of the reference Brand Drug on the date of claim processing. For a product experiencing a WAC reduction in subsequent years, the Baseline Rebate will increase over the prior year Baseline Rebate at the WAC inflation rate of the GPI subclass (GPI-6) of the applicable product. The following products will be eligible for the Rebate Credit: (1) Any Biosimilar product processed where Humira or Stelara are the reference Brand Drug; (2) any Insulin product that experienced a WAC decrease; and (3) any other products as mutually agreed in writing by Customer and Aetna. Aetna will provide 60 days advance notice of any applicable Covered Product that qualifies for Rebate Credits and that will be added to list of products eligible for the Rebate Credit. Aetna shall provide Customer specific reporting upon Customer request demonstrating the net-cost impact in the therapeutic category. Additional 340B reconciliation and true-up may occur post annual minimum Rebate guarantee reconciliation.

If this Agreement is terminated by Aetna for the Customer's failure to meet our obligations to fund benefits or pay administrative fees (medical or pharmacy) under the Agreement, Aetna shall be entitled to deduct deferred administrative fees or other plan expenses from any future rebate payments due to the Customer following the termination date.

**Formulary Management**

Aetna offers several versions of formulary options for Customer to consider and adopt as Customer's Formulary. The formulary options made available to Customer will be determined and communicated by Aetna prior to the implementation date. Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted Customer the right to use one of our Formulary options during the term of the Agreement solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. As such, Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the Plan. Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a result of factors, including but not limited to, market conditions, clinical information, cost, rebates and other factors.
Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

**Other Payments**

The term Rebates as defined in the Prescription Drug Services Schedule does not mean or include any manufacturer administrative fees that may be paid by pharmaceutical manufacturers to cover the costs related to the reporting and administration of the pharmaceutical manufacturer agreements. Such manufacturer administrative fees are not shared with Customer hereunder.

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with Customers.

Aetna may also receive network transmission fees from our network pharmacies for services we provide for them. These amounts are not considered Rebates and are not shared with Customers. These amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees, if applicable.

Customer agrees that the amounts described above are not compensation for services provided under this Agreement by either Aetna or CVS Caremark and instead are received by Aetna in connection with network contracting, provider education and other activities Aetna conducts across our book of business. Customer further agrees that the amounts described above belong exclusively to Aetna or it's affiliate, CVS Caremark, and Customer has no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or CVS Caremark.

Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the preferred Specialty Products program. Payments or rebates from drug manufacturers that compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder also will be retained by Aetna.

**Early Termination**

In the event Customer terminates Aetna's arrangement of prescription drug benefit services as described in the Prescription Drug Services Schedule and Pharmacy Service and Fee Schedule to the Agreement prior to December 31, 2029 (an "Early Termination") Aetna shall retain any earned but unpaid rebates as of the Early Termination date subject to any exception thereto provided herein.

In the event of an Early Termination, the pharmacy guarantees described hereunder, if any, shall be considered null and void for the Plan year and, therefore, not subject to reconciliation.

In addition, in the event Customer terminates the Agreement prior to the expiration of the initial term for any reason other than for Aetna's material breach, Customer shall refund, prior to the termination

date, to Aetna all allowances described herein and received by Customer for the unfulfilled term on a prorated basis.

Aetna's remedies as described immediately above are liquidated damages and shall not be characterized as a penalty (collectively, the "Early Termination Fee"). Unless otherwise agreed in writing by the parties, such Early Termination Fee will be due and paid in full within sixty (60) days after the termination effective date.

**Late Payment Charges**

If the Customer fails to provide funds on a timely basis to cover benefit payments and/or fails to pay service fees on a timely basis as required in the Agreement, Aetna will assess a late payment charge. The current charges are outlined below:

i. Late funds to cover benefit payments (e.g., late wire transfers): 12.0% annual rate
ii. Late payments of Service Fees: 12.0%, annual rate

In addition, Aetna will make a charge to recover our costs of collection including reasonable attorney's fees. We will notify the Customer of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Agreement or at law or in equity for failure to pay.

**Pharmacy Audit Rights and Limitations**

Customer is entitled to one annual Rebate audit, subject to the audit terms and conditions outlined in the Prescription Drug Services Schedule.

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the Prescription Drug Services Schedule.

Pharmacy audits shall be conducted at the Customer's own expense unless otherwise agreed to between the Customer and Aetna.

# PRESCRIPTION DRUG SERVICES SCHEDULE
# MASTER SERVICES AGREEMENT MSA- 881673
# EFFECTIVE January 1, 2025 ("Schedule Effective Date")

Subject to the terms and conditions of the Agreement, management or administration of prescription drug benefits selected by the Customer in the Pharmacy Service and Fee Schedule (as modified by Aetna from time to time pursuant to section 4, Service Fees, of the Agreement) will be performed by CaremarkPCS Health, L.L.C. and/or its affiliates (CVS Caremark), each of which is an affiliated, licensed pharmacy benefit manager. This Schedule shall supersede any previous document(s) describing the Services.

## I. SCHEDULE TERM

The initial term of this Schedule shall be three years beginning on the Schedule Effective Date (referred to as an "Agreement Period"). This Schedule will automatically renew for additional Agreement Periods (successive one-year terms) unless otherwise terminated pursuant to the Agreement.

## II. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of fiduciary duties under ERISA necessarily involves the exercise of discretion on Aetna's part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, the Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between the Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

## III. EXTERNAL REVIEW

The external review process will be conducted by an independent clinical reviewer with appropriate expertise in the area in question. External Review shall be available for certain "Adverse Benefit Determinations" as defined in 29 CFR 2560.503-1 as amended by 26 CFR 54.9815-2719. It shall also be available for eligible "Final Internal Adverse Benefit Determinations", which is an eligible Adverse Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal review process or an Adverse Benefit Determination for which the appeal process has been exhausted. The External Review process shall meet the standards of the Federal Affordable Care Act and utilize a minimum of three accredited Independent Review Organizations. Independent reviewers conduct a de novo review of the information provided to them as part of the External Review process. Both Aetna and Customer acknowledge that neither Plan Participants nor providers will be penalized for exercising their right to an External Review.

The Customer delegates the sole discretionary authority to make the determination regarding the eligibility for external review, under the Plan, to Aetna. If an appeal is denied through the final level of internal appeal, Aetna will determine if it is eligible for ERO. Then Aetna will inform the Plan Participant of the right to appeal through ERO. If the appeal is upheld, Aetna will inform the Plan Participant the reason for the denial. If the appeal is not eligible for ERO, Aetna will inform the Plan Participant of the reasons for the ineligibility.

The Customer acknowledges that the Independent Review Organizations that make the external review decisions are independent contractors and not agents or employees of Aetna, and that Aetna is not responsible for the decision of the Independent Review Organization.

To assist in conducting such external reviews, the Customer agrees to provide Aetna with the current Plan documents, and any revised, amended, or updated versions no later than the date of any revisions, amendments, or updates.

## IV. DEFINITIONS

When used in this Schedule and/or the Pharmacy Service and Fee Schedule, all capitalized terms shall have the following meanings if not already defined in the Agreement:

**"AWP"** means the "average wholesale price" for a standard package size of a Prescription Drug from the most current pricing information provided to us by Medi-Span Master Drug Database (MDDB) (with supplements) or any other nationally available reporting service of pharmaceutical prices as selected by us. We use a single data reporting source for determining a Customer's AWP pricing. The standard package size applicable to a Mail Order Pharmacy shall mean the actual package size dispensed. The standard package size applicable to a Participating Retail Pharmacy shall be the actual package size dispensed as reported by the Participating Retail Pharmacy to CVS Caremark.

**"Benefit Cost(s)"** means the cost of providing Covered Services to Plan Participants and includes amounts paid to Participating Pharmacies and other providers. Benefit Costs do not include Cost Share amounts paid by Plan Participants. Benefit Costs do not include Service Fees. The Benefit Cost includes any Dispensing Fee paid to a Participating Pharmacy or other provider for dispensing covered medications to Plan Participants.

**"Benefit Plan Design"** means the terms, scope and conditions for Prescription Drug or device benefits under a Plan, including Formularies, exclusions, days or supply limitations, prior authorization or similar requirements, applicable Cost Share, benefit maximums and any other features or specifications as may be included in Plan documents, as communicated by the Customer to Aetna in accordance with any implementation procedures described herein. The Customer shall disclose to Plan Participants any and all matters relating to the Benefit Plan Design that are required by law to be disclosed, including information relating to the calculation of Cost Share or any other amounts that are payable by a Plan Participant in connection with the Benefit Plan Design. Customer acknowledges that it is responsible for determining whether products or services added by Customer to the Benefit Plan Design are compliant with the laws applicable to Customer's plan.

**"Biosimilar Drug"** means a biological product that is highly similar to a biological product already approved by the FDA (i.e. reference product) and is licensed and approved by the FDA as a biosimilar under Section 351(k) of the Public Health Service Act, as added by the Biologics Price Competition and Innovation Act of 2009, notwithstanding minor differences in clinically inactive components but otherwise no clinically meaningful differences between the biologic product and the reference products in terms of safety, purity and potency of the product.
**"Brand Drugs"** shall mean drugs or devices for which the Medi-Span Multisource Code field contains "M" (co-branded product), or "N" (single source brand), or "O" (originator). In limited circumstances, Aetna may override the M, N, or O indicators and deem the drug to be a Generic Drug through review of additional information including other Medi-Span data, FDA application data (NDA/ANDA) and price.

**"Calculated Ingredient Cost"** means the lesser of:

a) AWP less the applicable percentage Discount;
b) MAC; or

c) U&C Price.

The Calculated Ingredient Cost does not include the Dispensing Fee or sales tax, if any. The amount of the Calculated Ingredient Cost payable by the Customer is net of the applicable Cost Share.

**"Claim"** or **"Claims"** means any electronic or paper request for payment or reimbursement arising from a Participating Pharmacy providing Covered Services to a Plan Participant.

**"Compound Prescription"** means a Prescription Drug which would require the dispensing pharmacist to produce an extemporaneously produced mixture containing at least one Federal Legend drug, the end product of which is not available in an equivalent commercial form. For purposes of this Schedule, a prescription will not be considered a Compound Drug if it is reconstituted or if the only ingredient added to the prescription is water, alcohol, a sodium chloride solution or other common diluents.

**"Concurrent Drug Utilization Review"** or **"Concurrent DUR"** means the review of drug utilization when an On-Line Claim is processed by Aetna at the point of sale.

**"Cost Share"** means that portion of the charge for a Prescription Drug or device dispensed to a Plan Participant that is the responsibility of the Plan Participant as provided in the applicable Plan, including coinsurance, copayments, deductibles and penalties, and may be a fixed amount or a percentage of an applicable amount. Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services except as required by law to be otherwise.

**"Covered Services"** means Prescription Drugs, Specialty Products, over-the-counter medications or other services or supplies that are covered under the terms and conditions set forth in the description of the Plan.

**"Discount"** means the percentage deduction from AWP that is to be taken into account by Aetna in determining the Calculated Ingredient Cost.

**"Dispensing Fee"** means an amount agreed by the Customer and Aetna in consideration of the costs associated with a Participating Pharmacy dispensing medication to a Plan Participant.

**"DMR Claim"** means a direct member (Plan Participant) reimbursement claim.

**"Drug Classification"** means that CVS Caremark shall use Medi-Span Master Drug Database (Medi-Span) indicators, and their associated files, or indicators provided by another nationally available reporting service of pharmaceutical drug information, in helping to determine the classification of drugs (e.g., Prescription Drug vs. OTC, Brand Drug vs. Generic Drug, Single-Source vs. Multi-Source) for purposes of this Agreement.

**"Formulary"** or **"Formularies"** means the list(s) of Prescription Drugs and supplies approved by the U.S. Food and Drug Administration ("FDA") developed by Aetna which classifies drugs and supplies for purposes of benefit design and coverage decisions.

**"Generic Drugs"** shall mean drugs or devices for which the Medi-Span Multisource Code field contains a "Y" (generic). In addition, Claims with DAW 5 code ("House Generics") shall be classified as Generic Drug Claims. In limited circumstances, Aetna may override the M, N, or O indicators and deem the drug to be a Generic Drug after a review of additional information including other Medi-Span data, FDA application data (NDA/ANDA) and price.

**"Implementation Credit"** if applicable, is a credit provided to the Customer to cover specific costs related to the transition from another vendor to Aetna and further described in the Fee Schedule

**"Limited distribution drugs (LDDs) and exclusive distribution Specialty Products"** are only available through a limited number of pharmacy providers due to exclusive or preferred vendor arrangements with drug manufacturers.

**"Mail Order Pharmacy"** or **"Specialty Pharmacy"** means a licensed mail order and specialty pharmacy designated by Aetna to provide or arrange for Covered Services to Plan Participants.

**"Maximum Allowable Cost"** or **"MAC"** means the cost basis for reimbursement established by Aetna, as modified from time to time, for the same dose and form of Generic Drugs which are included on Aetna's applicable MAC List.

**"MAC List(s)"** means the lists of MAC payment schedules for Prescription Drugs, devices and supplies identified as readily available as a Generic Drug or generally equivalent to a Brand Drug (in which case the Brand Drug may also be on the MAC List) and developed and maintained or selected by Aetna and that, in each case, are deemed to require or are otherwise capable of pricing management due to the number of drug manufacturers, utilization and/or pricing volatility.

**"National Average Drug Acquisition Cost"** or **"NADAC"** means an average of the drug acquisition costs submitted by retail community pharmacies as published by the Centers for Medicare and Medicaid Services.

**"National Drug Code"** or **"NDC"** means a universal product identifier for human drugs. The National Drug Code Query (NDCQ) content is limited to Prescription Drugs and a few selected OTC products. The National Drug Code (NDC) Number is a unique, eleven-digit, three-segment number that identifies the labeler/vendor, product, and trade package size.

**"On-Line Claim"** means a claim that (i) meets all applicable requirements, is submitted in the proper timeframe and format, and contains all necessary information, and (ii) is submitted electronically for payment to Aetna by a Participating Pharmacy as a result of provision of Covered Services to a Plan Participant.

**"Participating Pharmacy"** means a Participating Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy.

**"Participating Retail Pharmacy"** means any licensed retail pharmacy that has entered into an arrangement with Aetna to provide Covered Services to Plan Participants.

**"Pharmacy Service and Fee Schedule"** means a document entitled same and incorporated herein by reference setting forth certain guarantees (if applicable), underlying conditions and other financial information relevant to Customer.

**"Precertification"** means a process under which certain drugs require precertification (prior approval) before Plan Participants can obtain them as a covered benefit. Aetna's Precertification unit must receive prior notification from physicians or their authorized agents requesting coverage for medications on the Precertification List.

**"Prescriber"** means an individual who is appropriately licensed and permitted by law to order drugs that legally require a prescription.

**"Prescription Drug"** means a legend drug that, by law, cannot be sold without a written prescription from an authorized Prescriber. For purposes of this Schedule, insulin, certain supplies, and devices shall be considered a Prescription Drug.

**"Prospective Drug Utilization Review"** or **"Prospective DUR"** means a review of drug utilization that is performed before a prescribed medication is covered under a Plan.

**"Rebates"** means the pharmaceutical manufacturer revenue shared with Aetna by CVS Caremark and/or any of their respective affiliates (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (ii) in consideration for the inclusion of such manufacturer's Prescription Drugs on Aetna's Formulary and (ii) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain Prescription Drugs by Plan Participants. Rebates shall not include any fees or other compensation paid, credited, or owing by a pharmaceutical manufacturer to Aetna or CVS Caremark or any of their respective affiliates, as applicable, in exchange for the performance or provision of front-end pharmacy or clinical services or activities, including any of the following services and activities: (i) Plan Participant adherence or compliance services, (ii) nursing or other Plan Participant support, (iii) physician or member communication services, (iv) Plan Participant assistance and referrals, (v) product launch and similar support, (vi) equipment replacement services, (vii) clinical and other research or studies, (viii) data and analytics, and (ix) services to ensure the appropriate distribution of high risk biopharmaceuticals.

**"Rebate Guarantee"** means the Rebate amount that Aetna guarantees the Customer will receive as set forth in the Pharmacy Service and Fee Schedule.

**"Retrospective Drug Utilization Review"** or **"Retrospective DUR"** means a review of drug utilization that is performed after a Claim for Covered Services is processed.

**"Single Source Generics"** means those generics having fewer than two FDA-approved Abbreviated New Drug Application (ANDA) manufacturers (not including any "authorized generics"), or alternatively generic drugs for which there is insufficient inventory and/or competition to supply market demand.

**"Specialty Products"** means those injectable and non-injectable Prescription Drugs, other medicines, agents, substances and other therapeutic products that are designated in the Pharmacy Service and Fee Schedule and modified by Aetna from time to time in its sole discretion as Specialty Products on account of their having particular characteristics, including one or more of the following: (i) they address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis), (ii) they require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste, (iii) they have limited pharmaceutical supply chain distribution as determined by the drug's manufacturer and/or (iv) their relative expense.

**"Step-Therapy"** means a type of Precertification under which certain medications will be excluded from coverage unless the Plan Participant tries one or more "prerequisite" drug(s) first, or unless a medical exception for coverage is obtained.

**"Tennessee Low Volume Pharmacy"** means a Participating Pharmacy qualifying as low-volume ambulatory pharmacies pursuant to Tennessee Code Annotated, Section 56-7-3206(f) and the regulations promulgated thereunder.

**"Tennessee Non-Low Volume Pharmacy"** means every other Participating Pharmacy falling outside of the definition of the Tennessee Low Volume Pharmacy.

**"Usual and Customary Retail Price"** or **"U&C Price"** means the cash price less all applicable Customer discounts which Participating Pharmacy usually charges customers for providing pharmaceutical services.

**"Wholesale Acquisition Cost"** or **"WAC"** means the wholesale acquisition cost of a prescription drug as listed in the Medispan weekly price updates (or any other similar publication designated by Aetna) received by Aetna.

**"340B Claim"** means a Claim identified by the submission of "20" in any of the submission clarification code fields and/or a Claim submitted by a Participating Pharmacy owned by a covered entity, as defined in Section 340B(a)(4) of the Public Health Services Act, whose 340B status is coded as "38" or "39" in the NCPDP DataQ database.

## V. ADMINISTRATIVE SERVICES

Subject to the terms and conditions of this Schedule, the Services to be provided by Aetna, as well as certain Customer obligations in connection thereto, are described below.

### 1. General Responsibilities and Obligations

#### a. Exclusivity

During the term of this Schedule, the Customer shall use Aetna as the exclusive provider of the Benefit Plan Design for Plan Participants covered thereby, including without limitation, for pharmacy claims processing, pharmacy network management, clinical programs, formulary management and rebate management. All terms under this Schedule and on the attached Pharmacy Service and Fee Schedule are conditioned on Aetna's status as the exclusive provider of the Benefit Plan Design. Any failure by the Customer to comply with this Section shall constitute a material breach of this Schedule and the Agreement. Without limiting Aetna's other rights or remedies, in the event the Customer fails to comply with this section, Aetna shall have the right to modify the terms and conditions of this Schedule, including without limitation, the financial terms set forth in the Pharmacy Service and Fee Schedule and any Performance Guarantees attached hereto.

### 2. Pharmacy Benefit Management Services

#### a. Pharmacy Claims Processing

(i) On-Line Claims Processing. Aetna will perform claims processing services for Covered Services that are provided by a Participating Pharmacy as of the Effective Date, and submitted electronically to Aetna's on-line claims processing system. On-Line Claims processing services shall include confirmation of coverage, performance of drug utilization review activities pursuant to this Schedule, determination of Covered Services, and adjudication of the On-Line Claims.

(ii) DMR Claims Processing. The Plan Participant shall be responsible for the submission of DMR Claims directly to Aetna on such form(s) provided by Aetna within the timeframe specified on the description of Plan benefits. DMR Claims shall be reimbursed by Aetna based on the lesser of: (i) the amount invoiced and indicated on such DMR Claim; or (ii) the amount the Plan Participant is entitled to be reimbursed for such claim pursuant to the description of Plan benefits.

#### b. Pharmacy Network Management

(i) Participating Retail Pharmacies. Any additions or deletions to the network of Participating Retail Pharmacies shall be made in Aetna's sole discretion. Aetna shall provide notice to the Customer of any deletions that have a material adverse impact on Plan Participants' access to Participating Retail Pharmacies. Aetna shall direct each Participating Retail Pharmacy to (a) verify the Plan Participant's eligibility using Aetna's on-line claims system, and (b) charge and collect the applicable Cost Share from Plan Participants for each Covered Service. Aetna will adjudicate On-

Line Claims for Covered Services from Participating Retail Pharmacies using the negotiated rates that Aetna has in place with the applicable Participating Retail Pharmacy.

- Aetna shall require each Participating Retail Pharmacy to comply with Aetna's applicable network participation requirements. Aetna does not direct or otherwise exercise any control over the professional judgment exercised by any pharmacist dispensing prescriptions or providing pharmacy services. Participating Retail Pharmacies are independent contractors of Aetna and Aetna shall have no liability to the Customer, any Plan Participant or any other person or entity for any act or omission of a Participating Retail Pharmacy or its agents, employees or representatives.

- Aetna shall adjudicate each On-Line Claim for services rendered by a Participating Retail Pharmacy at the applicable Discount and Dispensing Fee paid to the Participating Retail Pharmacy. For the avoidance of doubt, the Benefit Cost paid by the Customer in connection with On-Line Claims for services rendered by the Participating Retail Pharmacy will be equal to the Discount and Dispensing Fees paid to such pharmacy. This is considered "transparent" or "pass through" pricing.

(ii) Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Mail Order Pharmacy on its internet website and via its member services call center. The Mail Order Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Mail Order Pharmacy generally will require that medications and supplies be dispensed in quantities not to exceed a 90-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable law do not prohibit substitution of a Generic Drug equivalent, if any, for the prescribed drug, or if the Mail Order Pharmacy obtains consent of the Prescriber, the Mail Order Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. Certain Specialty Products, some acute drug products or certain compounds cannot be ordered through the Mail Order Pharmacy. The Mail Order Pharmacy shall make refill reminder and on-line ordering services available to Plan Participants. Aetna and/or the Mail Order Pharmacy may promote the use of the Mail Order Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Mail Order Pharmacy's cost, unless otherwise agreed upon by Aetna and the Customer.

(iii) Specialty Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Specialty Pharmacy on its internet website and via its member services call center. The Specialty Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Specialty Pharmacy generally will require that Specialty Products be dispensed in quantities not to exceed a 30-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable law do not prohibit substitution of a Generic Drug equivalent, if any, to the prescribed drug, or if the Specialty Pharmacy obtains consent of the Prescriber, the Specialty Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. The Specialty Pharmacy shall make refill reminder services available to Plan Participants. Aetna and/or the Specialty Pharmacy may promote the use of the Specialty Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Specialty Pharmacy's cost, unless otherwise agreed upon by Aetna and the Customer. Further information regarding Specialty Product pricing and limitations is provided in the Service and Fee Schedule.

c. **Clinical Programs**

(i) Formulary Management. Aetna offers several versions of formulary options ("Formulary") for the Customer to consider and adopt as its Formulary. The Formulary options made available to the Customer will be determined and communicated by Aetna prior to the implementation date. The Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted the Customer the right to use one of its Formulary options during the term of the Agreement solely in connection with the plan, and to distribute or make the Formulary available to members. As such, the Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the plan. The Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a result of factors, including but not limited to, market conditions, clinical information, cost, rebates and other factors. The Customer agrees that any proposed additions and/or deletions to the Formulary will be adopted by the plan sponsor as a matter of the plan sponsor's plan design, and that the Customer has the right to elect to not implement any such addition or deletion, which such election shall be considered a Customer change to the Formulary subject to Aetna's ability to operationally administer such election and, if so, Aetna's reservation of right to make appropriate and equitable financial changes resulting therefrom. The Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

(ii) Prospective Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan benefits the Prospective DUR program, which may include Precertification and Step-Therapy programs and other Aetna standard Prospective DUR programs, with respect to On-Line Claims. Under these programs, Plan Participants must meet standard Aetna clinical criteria before coverage of the Prescription Drugs included in the program will be authorized; provided, however, the Customer authorizes Aetna to approve coverage of drugs for uses that do not meet applicable clinical criteria in the event of complications, co-morbidities and other factors that are not specifically addressed in such criteria. Aetna shall perform exception reviews and authorize coverage overrides when appropriate for such programs, and other benefit exclusions and limitations. In performing such reviews, Aetna may rely solely on diagnosis and other information concerning the Plan Participant deemed credible and supplied to Aetna by the requesting provider, applicable clinical criteria and other information relevant or necessary to perform the review.

(iii) Concurrent Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan benefits its standard Concurrent DUR programs with respect to On-Line Claims. Aetna's Concurrent DUR programs help Participating Pharmacies to identify potential drug interactions, duplicate drug therapy and other circumstances where prescriptions may be clinically inappropriate for Plan Participants. Aetna's Concurrent DUR programs are educational programs that are based on available clinical literature. Aetna's Concurrent DUR programs are administered using information submitted to and available in Aetna's on-line claims system, as well as On-Line Claims information submitted by the Participating Pharmacy.

(iv) Retrospective Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan benefits its standard Retrospective DUR programs with respect to On-Line Claims. Aetna's Retrospective DUR programs are designed to help providers and Plan Participants identify circumstances where prescription drug therapy may be clinically inappropriate or other cost-effective drug alternatives may be available. Aetna's Retrospective DUR programs are educational programs and program results may be communicated to Plan Participants, providers and plan sponsors. Aetna's Retrospective DUR programs are

administered using information submitted to and available in Aetna's On-Line Claims system, as well as On-Line Claims information submitted by the Participating Pharmacy.

(v) Choose Generics Program. If purchased by the Customer as indicated on the Fee Schedule, the Choose Generics Program is an option that encourages Plan Participants to receive generic equivalent rather than the Brand Drug. Under this program, Plan Participants can choose to obtain the Brand Drug at a higher than normal cost (subject to the exceptions described in the paragraph immediately below). Such higher cost will be equal to the Cost Share for the Brand Drug plus the difference in the cost between the Brand Drug and its generic equivalent. The cost differential is not applied to the Plan Participant's deductible.

If no generic equivalent medication or corresponding MAC amount is available or the prescriber has written "dispense as written" on the prescription order, the cost differential described above is not applied to the higher cost. In some instances, a Brand Drug is not eligible for a corresponding MAC amount due to Formulary and/or Rebate contract requirements that prohibit application of "member pay the difference" logic or mandate minimum copay steerage levels. In other instances, a Brand Drug may not be eligible for a corresponding MAC amount due to supply and/or pricing considerations.

Disclaimer Regarding Clinical Programs. Aetna's clinical programs do not dictate or control providers' decisions regarding the treatment of care of Plan Participants. Aetna assumes no liability from the Customer or any other person in connection with these programs, including the failure of a program to identify or prevent the use of drugs that result in injury to a Plan Participant.

**d. Plan Participant Services and Programs**

**Internet services including the Secure Member Portal and Aetna Website.**
Through the Secure Member Portal, Plan Participants have access to the Aetna website and Aetna Health mobile app. Plan Participants have access to the following:

- Estimating the cost of Prescription Drugs (Price a Drug℠).
- Prescription Comparison Tool – Compares the estimated cost of filling prescriptions at a Participating Retail Pharmacy to the Mail Order Pharmacy mail-order prescription service.
- Aetna Formulary – Available for Plan Participants who wish to review prescribed medications to verify if any additional coverage requirements apply.
- View drug alternatives for medications not on the Preferred Drug List.
- Claim information and EOBs.

**e. Rebate Administration**

(i) CVS Caremark shares Rebates with Aetna based on the utilization by Plan Participants of covered Prescription Drugs administered and paid through the Plan Participant's pharmacy benefits. Aetna, in turn, may share Rebates with Customer subject to the terms and conditions set forth in the Pharmacy Service and Fee Schedule.

(ii) If the Customer is eligible to receive Rebates under this Schedule, the Customer acknowledges and agrees that Aetna shall retain the interest (if any) on, or the time value of, any Rebates received by Aetna prior to Aetna's payment of such Rebates to the Customer in accordance with this Schedule. Aetna may delay payment of Rebates to the Customer to allow for final adjustments or reconciliation of Service Fees or other amounts owed by the Customer upon termination of this Schedule.

(iii) If the Customer is eligible to receive a portion of Rebates under this Schedule, the Customer acknowledges and agrees that such eligibility under paragraphs a. and b. above shall be subject to the Customer's and its affiliates', representatives' and agents' compliance with the terms of this Schedule, including without limitation, the following requirements:

- Election of, and compliance with, Aetna's Formulary;
- Adoption of and conformance to certain benefit plan design requirements related to the Formulary as described in Pharmacy Service and Fee Schedule; and
- Compliance with other generally applicable requirements for participation in Aetna's rebate program, as communicated by Aetna to the Customer from time to time.

The Customer further acknowledges and agrees that if it is eligible to receive a portion of Rebates under this Schedule, such eligibility shall be subject to the condition that the Customer, its affiliates, representatives and agents do not contract directly or indirectly with any other person or entity for discounts, utilization limits, Rebates or other financial incentives on pharmaceutical products or formulary programs for Claims processed by Aetna pursuant to this Agreement, without the prior written consent of Aetna. Without limiting Aetna's right to other remedies, failure by the Customer to obtain Aetna's prior written consent in accordance with the immediately preceding sentence shall constitute a material breach of the Agreement, entitling Aetna to (a) suspend payment of Rebates hereunder and to renegotiate the terms and conditions of this Agreement, and/or (b) immediately withhold any Rebates earned by, but not yet paid to, the Customer as necessary to prevent duplicative Rebates on such drugs.

## VI. IMPORTANT INFORMATION ABOUT THE PHARMACY BENEFIT MANAGEMENT SERVICES

1. Rebate amounts vary based on several factors, including the volume of utilization, Benefit Plan Design, and Formulary or preferred coverage terms. Aetna may offer the Customer an amount of Rebates on Prescription Drugs that are administered through the Plan Participant's pharmacy benefit. These Rebates are earned when members use drugs listed on Aetna's Formulary and preferred Specialty Products. Aetna determines each customer's Rebates based on actual Plan Participant utilization of those Formulary and preferred Specialty Products for which Aetna receives Rebates from CVS Caremark. The amount of Rebates will be determined in accordance with the terms set forth in the Customer's Pharmacy Service and Fee Schedule.

   Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the preferred Specialty Products program. Pharmaceutical rebates earned on Prescription Drugs and Specialty Products administered and paid through the Plan Participant's pharmacy benefits represent the great majority of Rebates.

   A report indicating the Plan's Rebate payments, broken down by calendar quarter, is included with each remittance received under the program, and is also available upon request. Remittances are distributed as outlined in the Pharmacy Service and Fee Schedule. Interest (if any) received by Aetna prior to allocation to eligible self-funded customers is retained by Aetna.

2. The Customer acknowledges that from time to time, Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Rebates and which are paid separately to Aetna or designated third parties (e.g., mailing vendors, printers). These payments are to reimburse Aetna for the cost of various educational programs. These programs are designed to reinforce Aetna's

goals of maintaining access to quality, affordable health care for Plan Participants and the Customer. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Rebates. These payments are generally for one of three purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data, (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and Plan Participants about clinical guidelines, disease management and other effective therapies, or (iii) to compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder. These payments are not considered as Rebates and are not included in rebate sharing arrangements with plan sponsors, including without limitation, Customer.

CVS Caremark may also receive network transmission fees from its network pharmacies for services it provides for them. These amounts are not considered rebates and are not shared with plan sponsors. These amounts are also not considered part of the calculation of claims expense for purposes of discount guarantees.

Customer agrees that the amounts described above are not compensation for services provided under this Agreement by either Aetna or CVS Caremark, and instead are received by Aetna or CVS Caremark in connection with network contracting, provider education and other activities Aetna conducts across its book of business. Customer further agree that the amounts described above belong exclusively to Aetna or CVS Caremark, and Customer has no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or CVS Caremark.

These other payments are unrelated to the Prescription Drug Formulary Rebate arrangements and serve educational as well as other functions. Consequently, these payments are not considered Rebates, and are not included in the Rebates provided to the Customer, if any.

3. The Customer acknowledges that in evaluating clinically and therapeutically similar Prescription Drugs for selection for the Formulary, Aetna reviews the costs of Prescription Drugs and takes into account Rebates negotiated between CVS Caremark and Prescription Drug manufacturers. Consequently, a Prescription Drug may be included on the Formulary that is more expensive than a non-Formulary alternative before any Rebates Aetna may receive from CVS Caremark are taken into account. In addition, certain Prescription Drugs may be chosen for Formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-Formulary alternatives. The net cost to the Customer for Covered Services will vary based on: (i) the terms of CVS Caremark's arrangements with Participating Pharmacies; (ii) the amount of the Cost Share obligation under the terms of the Plan; and (iii) the amount, if any, of Rebates to which the Customer is entitled under this Schedule and Pharmacy Service and Fee Schedule. As a result, the Customer's actual claim expense per prescription for a particular Formulary Prescription Drug may in some circumstances be higher than for a non-Formulary alternative.

   In Plans with Cost Share tiers, use of Formulary Prescription Drugs generally will result in lower costs to Plan Participants. However, where the Plan utilizes a Cost Share calculated on a percentage basis, there could be some circumstances in which a Formulary Prescription Drug would cost the Plan Participant more than a non-Formulary Prescription Drug because: (i) the negotiated Participating Pharmacy payment rate for the Formulary Prescription Drug charged to Aetna by CVS Caremark may be more than the negotiated Participating Pharmacy payment rate charged to Aetna by CVS Caremark for the non-Formulary Prescription Drug; and (ii) Rebates received by Aetna from CVS Caremark are not reflected in the cost of a Prescription Drug obtained by a Plan Participant.

4. The Customer acknowledges that Aetna contracts with Participating Pharmacies through CVS Caremark to provide the Customer and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by Participating Pharmacies can vary from one pharmacy product, plan or network to another.

   Under this Schedule and Pharmacy Service and Fee Schedule, the Customer and Aetna have negotiated and agreed upon a uniform or "lock-in" price to be paid by the Customer for all claims for Covered Services dispensed by Participating Pharmacies. This uniform price may exceed or be less than the actual price negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by the Participating Pharmacy. Where the uniform price exceeds the actual price negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by the Participating Pharmacy, Aetna realizes a positive margin. In cases where the uniform price is lower than the actual price negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by the Participating Pharmacy, Aetna realizes a negative margin. Overall, lock-in pricing arrangements result in a positive margin for Aetna. Such margin is retained by Aetna in addition to any other fees, charges or other amounts agreed upon by Aetna and the Customer, as compensation for the pharmacy benefit management services Aetna provides to the Customer. Also, when Aetna receives payment from the Customer before payment to CVS Caremark, Aetna retains the benefit of the use of the funds between these payments.

5. The Customer acknowledges that Aetna generally pays CVS Caremark for Brand Drugs dispensed by Participating Pharmacies whose patents have expired and their Generic Drug equivalents at a single, fixed price established by Aetna (Maximum Allowable Cost or MAC). MAC pricing is designed to help promote appropriate, cost-effective dispensing by encouraging Participating Pharmacies to dispense equivalent Generic Drugs where clinically appropriate. When a Brand Drug patent expires and one or more generic alternatives first become available, the price for the Generic Drug(s) may not be significantly less than the price for the Brand Drug. Aetna reviews the drugs to determine whether to pay CVS Caremark based on MAC or on a discounted fee-for-service basis, typically a percentage discount off of the listed Average Wholesale Price of the drug (AWP Discount). This determination is based in part on a comparison under both the MAC and AWP Discount methodologies of the relative pricing of the Brand and Generic Drugs, taking into account any Rebates Aetna may receive from CVS Caremark in connection with the Brand Drug. If Aetna determines that under AWP Discount pricing the Brand Drug is less expensive (after taking into account manufacturer Rebates Aetna receives) than the generic alternative(s), Aetna may elect not to establish a MAC price for such Prescription Drugs and continue to pay CVS Caremark according to an AWP Discount.

   In some circumstances, a decision not to establish a MAC price for a Brand Drug and its generic equivalents dispensed by Participating Pharmacies could mean that the cost of such Prescription Drugs for the Customer is not reduced. In addition, there may be some circumstances where the Customer could incur higher costs for a specific Generic Drug ordered through the Mail Order Pharmacy than if such Generic Drug were dispensed by a Participating Retail Pharmacy. These situations may result from: (i) the terms of CVS Caremark's arrangements with Participating Pharmacies; (ii) the amount of the Cost Share; (iii) reduced retail prices and/or discounts offered by Participating Pharmacies to Plan Participants; and (iv) the amount, if any, of Rebates to which the Customer is entitled under the Schedule and the Pharmacy Fee Schedule.

## VII. AUDIT RIGHTS

### 1. General Pharmacy Audit Terms and Conditions

a. Subject to the terms and conditions set forth in this Schedule, the Agreement and the Pharmacy Service and Fee Schedule, the Customer shall be entitled to have audits performed on its behalf (hereinafter "**Pharmacy Audits**") to verify that Aetna has processed Claims submitted by CVS

Caremark for Covered Services dispensed by Participating Pharmacies in accordance with this Agreement. Pharmacy Audits (benefits and pricing) may be performed as desk audit "virtual".

b. Additional Terms and Conditions

(i) Auditor Qualifications and Requirements specific to Pharmacy Audits

All Pharmacy Audits shall be performed solely by third party auditors meeting the qualifications and requirements of the Agreement, this Schedule and the Pharmacy Service and Fee Schedule. In addition, the requirements set forth in section 11, Audit Rights of the Agreement, the auditor chosen by the Customer must be mutually agreeable to both the Customer and Aetna. Auditors may not be compensated on the basis of a contingency fee or a percentage of overpayments identified, in accordance with the provisions of Section 8.207 through 8.209 of the International Federation of Accountant's (IFAC) Code of Ethics for Professional Accountants (Revised 2004).

(ii) Closing Meeting

In the event that Aetna and the Customer's auditors are unable to resolve any such disagreement regarding draft Pharmacy Audit findings, either Aetna or the Customer shall have the right to refer such dispute to an independent third-party auditor meeting the requirements of the Agreement, this section VII, and the Pharmacy Service and Fee Schedule and selected by mutual agreement of Aetna and the Customer. The parties shall bear equally the fees and charges of any such independent third-party auditor, provided however that if such auditor determines that Aetna or the Customer's auditor is correct, the non-prevailing party shall bear all fees and charges of such auditor. The determination by any such independent third-party auditor shall be final and binding upon the parties, absent manifest error, and shall be reflected in the final Pharmacy Audit report.

**2. Additional Pharmacy Claim Audit Terms and Conditions**

In the case of electronic Claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of Claims is requested and processed off-site, the Customer may elect to audit 100% of the prior contract year claims. Aetna will review and respond to a maximum of 250 disputed Claims from the auditor's fall out within 30 business days. The Customer is entitled to only one annual Claim audit.