**MASTER SERVICES AGREEMENT**
**MSA-285620**

This master services agreement ("**Agreement**") between **AETNA LIFE INSURANCE COMPANY**, a Connecticut corporation located at 151 Farmington Avenue, Hartford, Connecticut ("**Aetna**"), and **Webb County**, a Texas corporation, located at 1000 Houston Street, 2nd Floor, Laredo, Texas ("**Customer**") is effective as of January 1, 2017 ("**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 one year beginning on the Effective Date. This Agreement will automatically renew annually unless otherwise terminated pursuant to section 16 (Termination). 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 General Administration Schedule, Medical Services Schedule, Dental Services Schedule, and Prescription Drug Services Schedule.

**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 Texas law.

**4. SERVICE FEES**

The Customer shall pay Aetna fees according to the applicable Service and Fee Schedule(s) ("**Service Fees**"). Aetna may change the Services and the Service Fees annually by giving the Customer 90 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 31 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.

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 issued basis, Customer and Aetna agree that outstanding payments to providers (e.g., uncashed checks or checks not presented for payment) will be handled in the manner indicated and memorialized by the Parties in a separate form letter. The terms and conditions of this Agreement shall apply to that letter.

In the event that Aetna has exercised its right to suspend claim payments or terminate this Agreement as stated in section 16(B) (Termination), Aetna may place a stop payment order on all of the Customer's outstanding benefit checks.

## 6. FIDUCIARY DUTY

Except as provided with respect to claims fiduciary responsibilities in an applicable Schedule, 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 thereunder, 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.

Aetna's responsibility for acting as claims fiduciary with respect to medical, dental, and prescription drug claims, if any, is set forth 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, if any, 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, as applicable, and issuing any summaries deemed necessary by the Customer 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) **Miscellaneous** – The Customer shall promptly provide Aetna with such information regarding administration of the Plan as Aetna may reasonably request from time to time. 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, but will direct a requesting Plan Participant to contact the Customer with such requests or notify the Customer of any such requests in a timely manner. The Customer shall be liable for all Plan benefit payments made by Aetna, including those payments made following the last day this Agreement is in effect (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, to the extent permitted by applicable law and the terms of the HIPAA business associate agreement associated with this Agreement (the "**HIPAA BAA**"). 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.

## 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 applicable terms of the HIPAA BAA. 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 of particular services provided for under this Agreement are included in the applicable schedules.

## 11. RECOVERY OF OVERPAYMENTS

Aetna shall reprocess any identified errors in Plan benefit payments (other than errors that Aetna and the Customer reasonably determine to be *de minimis*) and seek to recover any resulting overpayment by attempting to contact the party receiving the overpayment twice by letter or email. Aetna will notify the Customer, in writing, of any such errors in a timely manner upon discovery. 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 reasonable fees charged by Aetna or those entities. Aetna will advise the Customer of any such fees that will be charged against any potential recovery**

**in advance of incurring such fees. The Customer will not be responsible for paying the costs of recovering overpayments resulting from Aetna's negligence, willful misconduct, bad faith, or failure to comply with the terms of this Agreement.**

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.

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)** If Customer seeks indemnification under this Agreement, Customer must notify Aetna in writing of any actual or threatened action, to which it claims such indemnification applies.

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.

**(C)** 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.

**(D)** These indemnification obligations above shall not apply to any claims caused by (i) an act, or failure to act, made in good faith 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. Aetna will cooperate with the Customer in good faith to provide information regarding such litigation in a timely manner.

**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 90 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 on or before 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 reasonable costs associated with the release of such data shall be paid by the Customer.

**18. 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. Nothing in this Agreement shall be deemed to grant any additional ownership rights in 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:
9606 North Mopac Expy
Ste. 600, F775
Austin, TX 78759

If to the Customer:
Webb County
1000 Houston St., 2nd Floor
Laredo, TX 78040

**(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 Texas 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 BAA, 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. In the event of a conflict

between the terms of this Agreement and a schedule or other attachment, the terms of the schedule or other attachment will control.

**(K) Amendment** – 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 16(D) shall survive termination of the Agreement.

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

**Webb County**

By: _____

Name: Rene E. Tijerina

Title: Webb County Judge

**AETNA LIFE INSURANCE COMPANY:**

By: _____

Name : Mark T. Bertolini

Title: Chairman, Chief Executive Officer and President

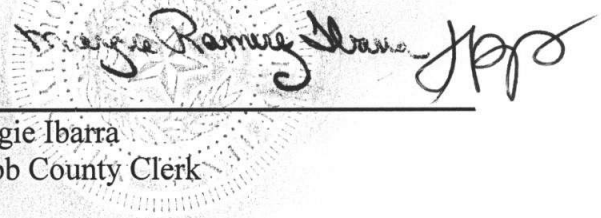
Financial Verification

By: _____

Name: Brian Donohue

Title: Director, Medical Underwriting

ATTESTED TO:



Margie Ibarra
Webb County Clerk

**GENERAL ADMINISTRATION SCHEDULE**
**MASTER SERVICES AGREEMENT MSA- 285620**
**EFFECTIVE January 1, 2017**

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 reasonable 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. Aetna will inform the Customer of any changes in the Account Management Team in a timely manner.

**(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, Department of Labor, or a state regulatory agency, as applicable.

**(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)** Contracted rates with Network Providers may be based on fee-for-service rates, case rates, per diems and in some circumstances, include 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. Such payments may be more specifically described in an addendum to the Agreement. The details of such payment arrangements are available upon request. 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.

(C) 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.

(D) 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.

(E) 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.

(F) 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.

(G) Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that might otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter's services on an in-network basis. Sutter also requires that the Customer agree to be bound by the terms of Aetna's contract with Sutter, including, but not limited to, the dispute resolution and binding arbitration provisions. The Customer agrees to be bound by the terms of the Sutter contract, including future amendments. The Customer may request a copy of the Sutter contract for its own use, upon completion of a confidentiality agreement. If a copy is furnished to the Customer, the Customer will hold the terms of the Sutter agreement in strict confidence in accordance with its confidentiality provisions.

**MEDICAL**
**SERVICE AND FEE SCHEDULE**
**MSA – 285620**

The Service Fees and Services effective for the period beginning January 1, 2017 and ending December 31, 2019 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.

## Self-Funded Medical Fee Exhibit - SOLD

January 1, 2017 through December 31, 2019

| ***Administrative Fees Per Employee Per Month*** | **Choice POS II** |
|---|---|
| | |
| Assumed Enrollment | 1,476 |
| | |
| **Medical Per Employee Per Month Fee (January 1, 2017 - December 31, 2017)** | **$41.76** |
| **Medical Per Employee Per Month Fee (January 1, 2018 - December 31, 2018)** | **$41.76** |
| **Medical Per Employee Per Month Fee (January 1, 2019 - December 31, 2019)** | **$41.76** |

**The fees above include expenses associated with processing runoff claims for one year following cancellation.**

**Please note that we have extended Webb County a $300,000 fee holiday for the Medical fees at the start of the contract period. This is contingent upon Aetna being the Total Replacement medical carrier for Webb County.**

**Our fees are based on the total number of employees enrolled in Aetna medical products and are contingent upon Aetna Pharmacy being included.**

**Please refer to the Financial Assumptions for a detailed description of the services, terms, and conditions associated with our self-funded proposal.**

| **Included Services / Programs in Above Administrative Fees** | **Choice POS II** |
|---|---|
| ***Implementation & Communications*** | |
| $300,000 Fee Holiday (To be used in 2017) | Included |
| $30,000 Enrollment Support Allowance (To be used in 2016) | Included |
| $2,000 Wellness Allowance (Years 1 - 3) | Included |
| Designated Implementation Manager | Included |
| Open Enrollment Marketing Material (noncustomized) | Included |
| Onsite Open Enrollment Meeting Preparation | Included |
| Standard ID Cards | Included |
| ***General Administration*** | |
| Experienced Account Management Team | Included |
| Designated billing, eligibility, plan set up, underwriting and drafting services | Included |
| Review or draft plan documents | Included |
| Summary of Benefits and Coverage (SBCs) | Included |

| | |
|---|---|
| Aetna Claim Fiduciary - Option 1 | Included |
| Aetna provides External Review | Included |
| ***Member and Claim Services*** | |
| Claim Administration | Included |
| Member Services | Included |
| Aetna Voice Advantage | Included |
| Designated toll-free number | Included |
| Designated Service Center | Included |
| Plan Sponsor Liaison | Included |
| Special Investigations / Zero Tolerance Fraud Unit | Included |
| ***Network*** | |
| Network Access / Full National Reciprocity | Included |
| Institutes of Excellence™ (Transplants) | Included |

| | |
|---|---|
| ***Care Management*** | |
| Utilization Management Inpatient Precertification | Included |
| Utilization Management Outpatient Precertification | Included |
| Utilization Management Concurrent Review | Included |
| Utilization Management Discharge Planning | Included |
| Utilization Management Retrospective Review | Included |
| Case Management | Included |
| Aetna Compassionate Care℠ Program (ACCP) | Included |
| Infertility Case Management | Included |
| National Medical Excellence® | Included |
| Institutes of Quality Program (IOQ) (same benefits) | Included |
| Informed Health® Line - 24-hour Nurseline 1-800 # | Included |
| Simple Steps To A Healthier Life ®- Health Assessment | Included |
| ***Behavioral Health*** | |
| Managed Behavioral Health | Included |
| Aetna Behavioral Health Basic Conditions Management Program | Included |
| AbilTo | Included |
| ***Web Tools*** | |
| DocFind® (online provider directory) | Included |
| Aetna Navigator® - Member Self Service Web | Included |
| Web-Chat Technology - Virtual Assistant Ann | Included |
| Online Programs | Included |
| Health Decision Support – Basic | Included |
| ***Reporting*** | |
| 5 Hours of Ad Hoc Reports, Annual Restoration | Included |
| Aetna Health Information Advantage™ | Included |
| e.Plan Sponsor Monitor™ - Level B Reporting (Standard Quarterly Utilization Reports) | Included |
| Monthly Financial Claim Detail Reports | Included |
| Monthly Banking Reports | Included |
| ***Aetna Discount Program*** | |
| at home products, books, fitness, hearing, national products and services, oral health care, vision and weight management | Included |

| *Claim Wire Billing - Charged through the claim wire. Not included in the PEPM fees above.* | |
|---|---|
| Subrogation | 30% of recovered amount will be retained |
| Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, Workers Compensation, DRG and Implant Audits | 30% of recovered amount will be retained |
| National Advantage™ Program | 35% of savings will be retained |
| Facility Charge Review Modified Balance Bill | 35% of savings will be retained |
| Itemized Bill Review | 35% of savings will be retained |
| Aetna Oncology Solutions℠ | $125 per month of active treatment |
| Teladoc Administrative Fee[6] | $0.20 per member per month |
| Teladoc Consultation Fee[6] | $3.00 for each Teladoc consultation |
| Teladoc Claim Charge[6] | $40 per Teladoc consultation |

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

We have made every effort to respond to Webb County's request in a manner that reflects our existing and expected business practices for the period of January 1, 2017 continuing through December 31, 2019. If you decide to establish a business relationship with us, we'll send you a Letter of Understanding confirming agreed upon benefits, services and fees. Then you will need to enter into an administrative services agreement (the "Agreement") with us.

**Fee Guarantee Period**

We have provided a fee guarantee for each of the first three contract periods from January 1, 2017 through December 31, 2019 for the self-funded coverages included in this proposal (each, a "Guarantee Period"). The mature fees are guaranteed according to the per-employee, per-month fees as illustrated on the financial exhibits. Performance Guarantees are included. Aetna is including specific performance guarantees that in combination shall be an amount not to exceed three hundred and fifty thousand dollars ($350,000) at risk for performance.

Aetna guarantees that Webb County's incurred and paid health claims, which includes all medical, dental and pharmaceutical claims, for the first calendar year that this Agreement is in effect, January 1, 2017 to December 31, 2017, shall not exceed $13,500,000 (thirteen million, five hundred thousand Dollars and zero cents). The term incurred claims shall refer to those claims incurred during the 2017 calendar year (January 1, 2017 to December 31, 2017), to the extent that such claims are paid on or before the end of a 12 month run out period immediately following such calendar year (the "run out period"). If the claims incurred during the calendar period January 1, 2017 to December 31, 2017 and paid by the end of the run out period exceed the amount of $13,500,000 (thirteen million, five hundred thousand dollars and zero cents), Aetna shall pay to Webb County an amount of $350,000 (three hundred, fifty thousand dollars and zero cents). Webb County and Aetna shall negotiate in good faith possible future guarantees, taking into account relevant factors such as discussions of the parties at the time that this Agreement was entered into, underwriting formulas and commercial reasonableness.

**Fee Holiday** - We have provided you a $300,000 fee holiday for the Medical products at the start of the guarantee period. This is subject to Aetna being the sole medical carrier for Webb County.

**Underwriting Caveats**

Your pricing takes into account all of the multiple products, programs and services included in this proposal. We also assume the quoted products, programs and services will be in effect for the full 12 months of the plan year.

If any of the changes outlined below occur, we reserve the right to recalculate your guaranteed fees, using the Guarantee Period formulas. If this happens, you will be required to pay any difference between the fees collected and the new fees calculated back to the start of the Guarantee Period. During the Guarantee Period we may recalculate:

1. If, for any product:

    a. There is a 15 percent decrease in the number of enrolled employees in aggregate from our enrollment assumptions or from any subsequently reset enrollment assumptions.

    b. The member-to-employee ratio increases by more than 15 percent. We have assumed a member-to-employee ratio of:

    – 2.05 for Choice POS II

2. Maximum account structure exceeds 80 units per product. Account structure determines the reporting format. During the installation process, we will work with you to finalize the account structure and determine which report formats will be most meaningful. Maximum total account structure includes Experience Rating Groups (ERGs), controls, suffixes, billing and claim accounts.

3. A material change in the plan of benefits is initiated by Webb County or by legislative or regulatory action.

4. A material change in the claim payment requirements or procedures, claim fiduciary option, account structure or any other change materially affecting the manner or cost of paying benefits initiated by Webb County or by legislative or regulatory action.

5. The National Advantage™ Program (NAP), Facility Charge Review (FCR) or Itemized Bill Review (IBR) programs are changed or terminated by Webb County.

6. There are any changes to the Aetna programs and services offered to Webb County.

7. Webb County terminates any of our other products not addressed within this financial package including, but not limited to, Dental products and/or Pharmacy products.

8. Webb County places the products and services included in this multi-year fee guarantee out to bid, this guarantee is nullified for the remaining duration of the Agreement.

9. **Legislation, regulation or requests of government authorities result in material changes to plan benefits, we reserve the right to collect any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.**

    If one or more of the circumstances identified above occurs, then the additional financial guarantees between us including, but not limited to, discount guarantees, rebate guarantees and claim-based

performance guarantees may also be modified or terminated in accordance with the financial conditions contained in those documents.

We are relying on information from you and your representatives in establishing the fees and terms of this proposal. If any of this information is inaccurate and has an impact on the cost of the programs, we reserve the right to adjust our fees and terms upon the receipt of corrected information.

**Allowance**

- **Wellness Allowance** – We are including a wellness allowance of up to $2,000 that may be used towards reasonable wellness services procured by you from third party vendors to pay for wellness-related expense(s) incurred during the January 1, 2017 through December 31, 2017 plan year such as wellness fairs, biometric screenings, onsite flu vaccinations, etc. These funds will be available as of the effective date of the period. Our preferred method of payment of wellness-related expenses is directly to the vendor. Payments will be made once the expenses are incurred and invoice(s) are provided. As an exception, in the event that you require reimbursement directly we will require detailed paid receipts prior to payment of the wellness allowance. Invoices must be submitted within 60 days following the close of the plan year, otherwise you forfeit the funds. Expenses must be for wellness-related programs or activities that are designed to promote the health and wellbeing of plan participants, or to educate participants about healthy lifestyles and choices. Acceptable documentation includes, but is not limited to:

  - Vendor invoice(s) summarizing level of work completed, hourly rate and hours spent; and
  - Invoices or other documentation summarizing any other miscellaneous expenses incurred (such as travel and other business expenses related to service rendered)

  A wellness allowance of up to $2,000 is available in both the second and third Guarantee periods. Please note, the allowance of up to $2,000 is available for each year and is forfeited at the end of each year if not fully utilized (it does not get rolled over for a cumulative amount).

  Any expenses beyond the wellness allowance are the responsibility of the customer. Any amounts ("Wellness allowance") paid by Aetna to a plan sponsor to offset or reimburse such plan sponsor for any expense or cost incurred as a result of contracting with Aetna for benefits plan administration services, shall be paid in accordance with applicable law. You are advised to determine appropriate accounting for these payments with your own counsel or accountant. Any plan sponsor receiving a wellness allowance or other payments from us that offset or reimburse expenses that would otherwise be paid from plan assets, should consult with their own counsel to determine if such allowance must be credited to plan assets, and for additional counsel regarding the accounting for reporting of such payments. We assume the funding of any wellness allowance is either at the request of your plan administrator acting in their fiduciary capacity to your plan or for the exclusive benefit of your plan.

**Late Payment**

If you do not provide funds on a timely basis to cover benefit payments as provided in the Agreement, and/or fail to pay fees on a timely basis as provided in such Agreement, we will assess a late payment charge-pursuant to Texas Government Code, section 2251.025(b), which shall not exceed 1% plus the prime rate described in such section.

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 claim wire.

We will notify you of any change to 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.

## DENTAL
## SERVICE AND FEE SCHEDULE

The Service Fees and Services effective for the period beginning January 1, 2017 and ending December 31, 2019 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.

**ADMINISTRATIVE SERVICES AGREEMENT FEES:**

We have agreed upon the following:

| Benefit | Projected Enrollment | Year 1 Fee | Year 2 Fee | Year 3 Fee |
|---|---|---|---|---|
| DPPO | 1,476 | $3.27 | $3.27 | $3.27 |

**Self-Funded Fee Guarantee** - The first-year fees for the self-funded coverages included in this proposal for the period January 1, 2017 through December 31, 2019 are guaranteed according to the per employee, per month fees as illustrated above. Performance Guarantees are included.

Fees include:

Implementation & Communications

- Designated Implementation Manager
- Open Enrollment Marketing Material (non-customized)

Claim & Member Services

- Claims and Member Services
- Full claim fiduciary
- Designated Service Center
- Toll-free member services number with access to a multi-lingual language line
- Integrated Voice Response
- Plan Sponsor Liaison
- Claim Processing and Adjudication
- Special Investigations / Zero Tolerance Fraud Unit

Total Health Management

- Dental/Medical Integration Program Plan Sponsor Services
- Experienced Account Manager
- Designated Billing, Eligibility and Plan Set Up
- SPD Review and/or Drafting

Network

- Network Access / Full National Reciprocity
- Online Directories (DocFind®)

Web Tools

- Aetna Navigator® - Member Self Service Web Portal
- Web-Chat Technology - Virtual Assistant Ann
- Aetna Mobile App

Reporting

- Five ad-hoc reporting hour
- Quarterly Utilization Reports - Aetna Informatics Level A
- Monthly Financial Claim Detail Reports
- Monthly Banking Reports

Other

- Vision discounts
- Fitness discounts
- Natural Products and Services discounts
- Hearing discounts
- Weight Management discounts
- At Home Product discounts
- Book discounts
- iTriage

**Assumptions and Caveats -**
**The following is a list of additional factors that may impact our administrative services fees for the dental benefit plan. We reserve the right to change our fees, at any time during the policy year effective on the date the change occurred, in the following circumstances:**

| We assumed the following for purposes of our proposal: | We reserve the right to change our rates if: |
|---|---|
| Enrollment by line of coverage would be as follows:<br>**DPPO-1,476 employee lives** | The actual enrollment in any line of coverage changes from the assumed enrollment by 10%. |
| The enrolled member to employee ratio by line of coverage would be no greater than:<br>**DPPO- 1.99** | The actual member to employee ratio for case size less than 1,000 employees exceeds the assumed ratio by 10.0% or more. |
| Your plan design remains unchanged. | The plan design changes from the proposed benefits. Please note any changes must be approved. |

- If Webb County places the products and services included in this multi-year fee guarantee out to bid, then this guarantee will be nullified for the duration of the Agreement.

- If legislation, regulation or requests of government authorities result in material changes to plan benefits, we also reserves the right to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

**Dental Network Access Charge –**

**Aetna Dental® PPO II** – Dental PPO II is a vendor based program that offers access to contracted rates for dental claims that may otherwise be paid at billed charges under the out-of-network portion of the Dental PPO plan. The third party vendors participating in the Dental PPO II Program network are considered participating providers and services rendered by such providers will be reimbursed in accordance with the

terms of the Customer's plan as in-network service. With the addition of PPO II, In-Network utilization is expected to increase by approximately 4 percentage points, but actual results will vary by plan design and the geographic distribution of membership.

There is no impact to your self-funded per-employee-per-month (PEPM) administrative fee for adding this program. We retain 40% of the negotiated PPO II savings as a network access charge for this subset of the network.

**Dental Out-of-Network Savings Program** – The Dental Out-of-Network Savings program is available for Indemnity and PPO dental plans that determine the Recognized Charge for out-of-network services based on FAIR Health data; it is not, however, available for dental benefits that are integrated with a medical plan. Aetna contracts with third-party network vendors that, in turn, have contracted with dentists who have agreed to charge discounted rates. Those dentists are still considered out-of-network providers, and the services they provide will be covered in accordance with your plan's benefits for out-of-network services.

There is no additional charge to your per-employee-per-month (PEPM) administrative services fee for adding this program. We will retain 40% of the savings as a network access and servicing charge. Savings are calculated as the difference between your plan's Recognized Charge and the vendor's negotiated rates with providers participating in the Dental Out-of-Network Savings Program.

**Late Payment** - If Webb County fails to provide funds on a timely basis to cover benefit payments as provided in the Agreement, and/or fails to pay service fees on a timely basis as provided in such Agreement, we will assess a late payment charge pursuant to Texas Government Code, section 2251.025(b), which shall not exceed 1% plus the prime rate described in such section.

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 claim wire.

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.

**PRESCRIPTION DRUG**
**SERVICE AND FEE SCHEDULE**
**MSA – 285620**

The Service Fees and Services effective for the period beginning January 1, 2017 and ending December 31, 2019 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.

# Table of Contents

## Benefit Plan

| Effective Date 01/01/2017<br>Benefit Plan<br>Incented [1] | | | |
|---|---|---|---|
| Price Points | | Participating Retail Pharmacy Network | Aetna Rx Home Delivery |
| Brand Drugs | Guaranteed AWP Discount | Year 1: AWP – 17.50% | Year 1: AWP – 24.00% |
| | | Year 2: AWP – 17.60% | Year 2: AWP – 24.10% |
| | | Year 3: AWP – 17.70% | Year 3: AWP – 24.20% |
| | Guaranteed Dispensing Fee / Rx | Year 1: $1.00 | Year 1: $0.00 |
| | | Year 2: $1.00 | Year 2: $0.00 |
| | | Year 3: $1.00 | Year 3: $0.00 |
| Generic Drugs | Guaranteed AWP Discount | Year 1: AWP – 78.75% (overall, includes MAC and non-MAC) | Year 1: AWP – 80.50% (overall, includes MAC and non-MAC) |
| | | Year 2: AWP – 78.95% (overall, includes MAC and non-MAC) | Year 2: AWP – 80.70% (overall, includes MAC and non-MAC) |
| | | Year 3: AWP – 79.15% (overall, includes MAC and non-MAC) | Year 3: AWP – 80.90% (overall, includes MAC and non-MAC) |
| | Guaranteed Dispensing Fee / Rx | Year 1: $1.00 | Year 1: $0.00 |
| | | Year 2: $1.00 | Year 2: $0.00 |
| | | Year 3: $1.00 | Year 3: $0.00 |
| Administrative Fee | The following administrative fee will apply: | Year 1: $1.00 ( PEPM ) Agent servicing fees | |
| | | Year 2: $1.00 ( PEPM ) Agent Servicing Fees | |
| | | Year 3: $1.00 ( PEPM ) Agent Servicing Fees | |
| Rebates | Plan sponsor will receive the following minimum rebate guarantees: | Year 1: Greater of 100.00% or $70.50 Per Brand Script | Year 1: Greater of 100.00% or $189.00 Per Brand Script |
| | | Year 2: Greater of 100.00% or $76.50 Per Brand Script | Year 2: Greater of 100.00% or $204.75 Per Brand Script |
| | | Year 3: Greater of 100.00% or $84.00 Per Brand Script | Year 3: Greater of 100.00% or $224.75 Per Brand Script |

[1]To qualify for 3-tier rebates, the members in this plan must be covered by a plan design which contains at least three tiers, where the first tier consists of generic drugs, the second tier consists of preferred brand drugs, and the third tier consists of non-preferred brand drugs, with a minimum $15.00 retail/$30.00 mail order copay differential between the second and third tier, or in the case of co-insurance plans a minimum 1.5 times difference in the co-insurance percentage between the second and third tier (for example, if the second tier co-insurance is 20%, the third tier co-insurance must be at least 30%); for plans that have co-insurance with minimums, there must be a minimum $15.00 retail/$30.00 mail order copay differential between the second and third tier regardless of the co-insurance percentage; if there are copay maximums, the minimum copay on the third tier must be greater than the maximum copay on the second tier. Plan designs that do not conform to the above will be considered Non-Incented.

Aetna will adjudicate Claims through our retail pharmacy network at the lowest of U&C, MAC, or discounted AWP. Words beginning with capital letters shall have the meaning set forth in Section II of the Statement of Available Services. Any reference to "Member" shall mean a Plan Participant as defined in the Statement of Available Services.

## General Allowance

Allowance will be available as of the Effective Date of the pharmacy services 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 the Plan year otherwise the Customer forfeits the funds. Any unused allowance monies at the end of the Plan year will be forfeited. Aetna is including a general first year allowance of $10,000. The Customer can use this allowance to pay for implementation, audit or communication related expenses along with external data files or feeds.

## Pricing Updates & New To Market Products

When new Specialty Products gain FDA approval, Aetna Pharmacy Management notifies Customer on a monthly basis of the availability and projected pricing of these Specialty Products. However, whether such Specialty Products will be included as Covered Services will depend on the Customer's Plan design. Aetna Pharmacy Management also notifies Customer on a monthly basis of limited distribution Specialty Products newly available through Aetna Specialty Pharmacy.

Aetna Specialty Pharmacy determines the pricing for new to market Specialty Products by considering various factors, such as acquisition cost, expected dosages, package sizes and utilization. In any case, such Specialty Products will have a minimum market introduction guarantee of AWP less 10%.

## Producer Compensation

Aetna shall not pay producer compensation to Customer's benefit consultant Roger Garza, Valley Risk Consulting, or any employee of Valley Risk Consulting or any Valley Risk Consulting employee's relative for services provided to Aetna or Customer. Customer does not consent to Aetna paying such producer compensation to Customer's benefit consultant.

## Assumptions

The Service Fees and Services set forth herein are based on, among other things, the assumption that a total of 1,476 of Customer's employees will be receiving Covered Services through Aetna. If there is a change of greater than 15% of this enrollment or in the geographic, demographic or eligible mix of the population, Aetna reserves the right to revisit the structure and/or conditions of this Service and Fee Schedule.

For the purposes of Discounts, the savings percentage will be calculated by dividing the AWP less the ingredient cost for the drugs dispensed by the AWP for such drugs. For each eligible prescription-drug claim, Calculated Ingredient Cost will be calculated at the lesser of the applicable MAC, or AWP Discount price in determining the Discount achieved for purposes of calculating Discounts, including 100% Plan Participant Cost Share Claims at the applicable calculated Discount prior to the application of the Plan Participant Cost Share. Cost Share will be calculated on the basis of the rates charged to Customer by Aetna for Covered Services except as required by law to be otherwise.

Discount and Dispensing Fee guarantees shall not apply to Compound drug claims, claims that process at U&C, direct member reimbursement (DMR) claims, and claims for products dispensed by Aetna Specialty Pharmacy. Aetna reserves the right to exclude claims for over-the-counter products, supplies, vaccines, workers compensation claims, and in-house pharmacy or 340b claims from the discount and dispensing fee guarantees. Single Source Generics are excluded from the Retail and Mail Order Generic Discount Guarantees and included in the Retail and Mail Order Brand Discount Guarantees.

Specialty drugs dispensed at a retail pharmacy are included in the retail brand discount guarantee.

Rebates will be distributed on a quarterly basis. Rebate allocations will be made within 180 days from the end of such allocation period according to the following schedule:

Rebate calculations related to the first quarter will be paid in September of the same year
Rebate calculations related to the second quarter will be paid in December of the same year
Rebate calculations related to the third quarter will be paid in March of the following year
Rebate calculations related to the fourth quarter will be paid in June of the following year

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. Customer shall adopt the Aetna Formulary in order to be eligible to receive Rebates as provided in the Service and Fee Schedule as set forth herein unless otherwise agree upon by Customer and Aetna. Rebates are paid on Specialty Products dispensed through Participating Pharmacies and covered under the Plan.

Rebate, Discount and Dispensing Fee Guarantees are based on the Plan in effect and as disclosed to Aetna during any Agreement Period. Accordingly, if Customer fails to disclose to Aetna that it employs, or intends to employ, a consumer driven health plan, major cost sharing changes, any utilization management program promoting Generic or OTC Drugs over Brand Drugs during any Agreement Period, Aetna reserves the right to adjust Guarantees.

Retail and Mail Order rebate guarantee components are measured individually and reconciled in aggregate on an annual basis.

Retail brand, retail generic, mail order brand and mail order generic discount and dispensing fee guarantee components are measured individually and reconciled in aggregate on an annual basis.

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 plan sponsor. The pharmacy pricing that Aetna is presenting does not include any such plan sponsor liability.

Aetna reserves the right to make appropriate changes to these guarantees if (a) there are any significant changes in the composition of Aetna's pharmacy network or in Aetna's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with Aetna, including but not limited to disruption in the retail pharmacy delivery model, and bankruptcy of a chain pharmacy, or (b) there is a change in government laws or regulations which have a significant impact on pharmacy claim costs, or (c) any material manufacturer rebate contracts with Aetna are terminated or modified in whole or in part, or (d) there is any legal action or Law that materially affects or could materially affect the manner in which Aetna administers the rebate program, or if an existing Law is interpreted so as to materially affect or potentially have a material affect on Aetna's administration of the program, or (e) there is a material change in the Plan that is initiated by the Customer which impacts Aetna's costs, or (f) there is a material change in the assumption used to develop the financial offer, including but not limited to customer's expected drug utilization, plan design, average days' supply by distribution channel, alignment with proposed formulary(ies) and associated formulary management programs (where applicable), and utilization of Hepatitis C or other specialty drug products.

Customer and Aetna agree that AWP, the underlying financial basis of the Statement of Available Services and this Service and Fee Schedule, may become modified or discontinued by means outside of the control of Customer and Aetna, thereby impairing the financial intent of the parties hereunder. In the event of such modification or discontinuance, the parties agree that Aetna, in order to preserve such financial intent, may opt to (i) change the AWP source from MediSpan to another AWP source, (ii) maintain the AWP as modified but make appropriate adjustments with Customer and/or Participating Pharmacies, or (iii) change the pricing index from AWP to another industry standard index, such as Wholesale Acquisition Cost. Aetna shall provide Customer with at least ninety (90) days written notice of the option taken by Aetna together with a sufficiently detailed explanation demonstrating how such option has preserved the parties' financial intent. If ninety (90) days notice is not practicable under the circumstances, Aetna shall provide notice as soon as practicable. If Customer disputes this explanation, the parties agree to cooperate in good faith to resolve such dispute.

If (a) Webb County terminates the Agreement prior to the date the pharmacy rebate credit is issued, or (b) the Agreement is terminated by Aetna for Webb County's failure to meet its obligations to fund benefits or pay administrative fees (medical or pharmacy) under the Agreement, Aetna shall invoice for any outstanding

administrative fees and any claims incurred but unfunded by Webb County. Webb County may elect to have those fees and claims paid from any rebate credit due.

To the extent this Service and Fee Schedule is part of a proposal to Customer, the Service Fees and Services set forth herein are valid for 90 days from the date of such proposal. All guarantees and underlying conditions are subject and limited to Prescription Drugs dispensed by Participating Pharmacies.

Aetna's Premier Plus Formulary will be used.

## Programs & Services

Aetna offers a comprehensive suite of trend and integrated health management programs and services. Below is a list, by product, of those services and programs that are available to Webb County. This offering may change or be discontinued from time to time as we update our offering to meet the needs of the marketplace. Please note the following:

- Services and programs included in our quoted pricing are indicated as "Included"
- Services and programs that are optional are noted as "Optional - No additional cost". Additional fees are noted when applicable.

**Pharmacy Programs and Services**

| Categories | Included / Optional |
|---|---|
| **General Administration** | |
| Implementation Services | Included |
| Account Management | Included |
| Customer Team Services | Included |
| Banking | Included |
| Standard Communication Materials | Included |
| ID Cards | Included |
| Eligibility | Included |
| Standard Reporting | Included |
| **Network Administration** | |
| Pharmacy Network Management | Included |
| **Claim & Member Services** | |
| Claim Administration | Included |
| Member Services | Included |
| Aetna Rx Home Delivery | Included |
| **Patient Management** | |
| Formulary Management | Included |
| Custom Formulary Management - rebates are subject to change upon review | $1.00 PEPM if selected |
| Pre-Certification | Optional - No additional cost |
| Step Therapy | Optional - No additional cost |
| Quantity Limits | Optional - No additional cost |
| **Internet Services** | |
| Aetna Navigator | Included |
| Public Site | Included |
| Secure Site (log in) | Included |
| Price a Drug℠ | Included |
| Find-A-Pharmacy | Included |
| **Safety** | |
| Concurrent Drug Utilization Review (DUR) | Included |
| Point of Care Edits | Included |
| Safety Edits | Included |
| Expanded Age Edits | Optional - No additional cost |
| Expanded Gender Edits | Optional - No additional cost |
| Enhanced Safety Edits | Optional - No additional cost |
| **Member Education and Value** | |
| Controlled Substance Use Program | Included |
| Blood Glucose Monitor | Included |
| Prescription Savings Program | Included |
| ExtraCare® Health Card | Optional - No additional cost |
| Heart Care for Life | Optional - No additional cost |
| Migraine Management | Optional - No additional cost |
| **Generic Solutions** | |

| Categories | Included / Optional |
|---|---|
| Save-A-Copay | Optional - No additional cost |
| Generic Sampling | Included |
| Generic Launch letter program (targeted at members filling certain brands at Mail Order) | Included |
| Aetna Rx Step*<br>*Custom step therapy may not be used with standard step therapy program. | Optional - No additional cost |
| **Specialty Solutions** | |
| Specialty Utilization Management including National Precertification | Included |
| Aetna Specialty Health Care℠ Management | Included |
| Retail to Specialty Outreach | Included |
| Aetna Specialty Pharmacy® | Included |
| **Adherence** | |
| Aetna Rx Courtesy Start℠ | Included |
| Aetna Rx AutoFill | Included |
| Aetna Pharmacy Advisor* | Optional - No additional cost |
| Preventative and Chronic Drug List | Optional - No additional cost |
| *Requires Aetna Rx AutoFill and Adherence to Drug Therapy | |
| **Access Solutions** | |
| National Network | Included |
| Maintenance Choice® - Mandatory (Requires Mandatory Mail Order) | Optional - No additional cost |
| Maintenance Choice® - Incentivized (Requires Incentivized Mail Order) | Optional - No additional cost |
| Maintenance Choice® - Voluntary | Optional - No additional cost |
| Aetna Rx Value Network | Optional - No additional cost |
| Aetna Rx Preferred Network* | Optional - No additional cost |
| Aetna Rx Choice Network* (Includes National Network) | Optional - No additional cost |
| Extended Day Supply Network* (Includes National Network) | Optional - No additional cost |
| Retail to Mail Outreach | Optional - No additional cost |
| *These programs cannot be offered with Maintenance Choice or another retail network | |
| **Clinical Management** | |
| Smart Edit Technology Integrated Intelligence | Included |
| ePrior Authorization | Included |
| **Programs Available at an Additional Charge** | |
| Aetna Rx Check – Expanded Offering<br>(Includes: Acute Frequency, Brand-to-Generic, High Utilization, Therapeutic Duplication, Patient Safety, Streamlining Therapy, Therapeutic Optimization, Length of Therapy, Maximum Dose, Prescription Cascade and Drug Interactions) | $0.55 Per Employee Per Month |
| Aetna Healthy Actions – Rx Savings | |
| o Care Engine Powered Condition-Based | $0.25 Per Employee Per Month |
| o Care Engine Powered Drug-Based | $0.15 Per Employee Per Month |
| o Drug Class Driven (Rx Claims Logic Only) | $0.15 Per Employee Per Month |
| Aetna Rx Health Outcomes | $0.10 Per Employee Per Month or $300 Per Program Participant |

## Important Information About Aetna's Pharmacy Benefit Management Services

### Other Payments

Customer acknowledges that from time to time, Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary 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 Customers. 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 Prescription Drug Formulary Rebates as compensation for (i) bona fide services it performs, such as the analysis or provision of aggregated information regarding utilization of health care services and the administration of therapy or disease management programs and (ii) the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder.

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 Customer, if any.

Aetna's PBM subcontractor 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 the Agreement by either Aetna or Aetna's PBM subcontractor, and instead are received by Aetna or Aetna's PBM subcontractor in connection with network contracting, provider education and other activities Aetna conducts across its book of business. Customer further agrees that the amounts described above belong exclusively to Aetna or Aetna's PBM subcontractor, and Company has no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or Aetna's PBM subcontractor.

### Late Payment Charges

If Webb County fails to provide funds on a timely basis to cover benefit payments as provided in the Service and Fee Schedule, and/or fails to pay service fees on a timely basis provided in such Service and Fee Schedule, Aetna will assess a late payment charge pursuant to Texas Government Code, section 2251.025(b), which shall not exceed 1% plus the prime rate described in such section.

In addition, Aetna will make a charge to recover its costs of collection including reasonable attorney's fees.

We will notify Webb County 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 Service and Fee Schedule or at law or in equity for failure to pay.

### Participating Retail Pharmacy Network

Aetna contracts with Participating Retail Pharmacies directly or through a pharmacy benefit management ("PBM") subcontract to provide Customer and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna or PBM to Participating Retail Pharmacies vary among Participating Retail Pharmacies in Aetna's network, and can vary from one pharmacy product, plan or network to another.

Under the Statement of Available Service and Service and Fee Schedule, Customer and Aetna have negotiated and agreed upon a uniform or "lock-in" price to be paid by Customer for all Claims for Covered Services dispensed by Participating Retail Pharmacies. This uniform price may exceed or be less than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services. Where the uniform price exceeds the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, Aetna realizes a positive margin. In cases where the uniform price is lower than the actual price negotiated

and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, 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 Customer, as compensation for the pharmacy benefit management services Aetna provides to Customer. Also, when Aetna receives payment from Customer before payment to a Participating Pharmacy or PBM, Aetna retains the benefit of the use of the funds between these payments.

### Mail-Order and Specialty Covered Services

Covered Services may be provided by Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy. In such circumstances, Aetna Mail Order Pharmacy refers to Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, both of which are subsidiaries of Aetna that are licensed Participating Pharmacies. Aetna's negotiated reimbursement rates with Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy, which are the rates made available to Customer, generally are higher than the pharmacies' cost of fulfilling orders of Prescription Drugs and Specialty Products and providing Covered Services and therefore these pharmacies realize an overall positive margin for the Covered Services they provide. To the extent Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy purchase Prescription Drugs and Specialty Products for their own account, the cost therefor takes into account both up-front and retrospective purchase Discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors. Such purchase Discounts, credits and other amounts are negotiated by Aetna Mail Order Pharmacy, Aetna Specialty Pharmacy or their affiliates for their own account and are not considered Rebates paid to Aetna by manufacturers in connection with Aetna's Rebate program.

### Pharmacy Audit Rights and Limitations

Aetna will share Rebate information with a qualified auditor under a strict confidentiality agreement that prohibits disclosure of such information to any third party, including Customer, and will not use such information for any purposes other than the Rebate audit. Auditor will be provided with the relevant portions of the applicable Formulary Rebate contracts, including, but not limited to, the manufacturer names, Prescription Drug names, details of all monies as defined by the term Rebate, and Rebate amounts for the Prescription Drugs being audited. The parties will reasonably cooperate to select Prescription Drugs for each audit that: (i) represent the fewest unique manufacturer Rebate contracts required for audit so that the selected drugs represent up to a maximum of 15% of Customer's Rebates; and (ii) are subject to manufacturer Rebate agreements that do not contain restrictions prohibiting Aetna from disclosing to Customer portions of such contracts concerning the Rebates, payments or fees payable thereunder. For purposes of this Section, the term "Aetna" as defined in Section III of the Statement of Available Services shall not include subcontractor.

In addition to the above stated auditor qualification, auditor must also have no conflict of interest or past business or other relationship which would prevent the auditor from performing an independent audit to conclusion. A conflict of interest includes, but is not limited to, a situation in which the audit agent: (i) is employed by an entity, or any affiliate of such entity, which is a competitor to Aetna's benefits or Claims administration business or Aetna's mail order or specialty pharmacy businesses; (ii) is affiliated with a vendor subcontracted by Aetna to adjudicate Claims or provide services in connection with Aetna's administration of benefits or provision of mail order or specialty pharmacy services. Auditors shall enter into an appropriate confidentiality agreement with, and acceptable to, Aetna prior to conducting any audit.

Customer is entitled to only one annual Rebate audit.

Claim audits are subject to the above referenced audit standards for Rebates in the case of a physical, on-site, Claim-based audit. 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, Customer may elect to audit 100% of Claims. Customer is entitled to only one annual Claim audit.

## Maximum Allowable Cost ("MAC")

As part of the administration of Covered Services, Aetna maintains MAC Lists of Prescription Drug products identified as requiring pricing management due to the number of manufacturers, utilization and/or pricing volatility. Criteria for inclusion on a MAC List include whether the Prescription Drug has readily available Generic Drug equivalents and a cost basis that will allow for pricing below Brand Drug rates. Aetna maintains correlative MAC Lists based on current price references provided by drug data compendia, market pricing, availability information from Generic Drug manufacturers and other sources which are subject to change.

**Aetna Specialty Pharmacy**

**Discounts and Dispensing Fees for Specialty Products that are covered under the pharmacy plan and dispensed to Plan Participants through Aetna Specialty Pharmacy (ASRx) are indicated on the ASRx fee schedule. A copy of the Customer's ASRx fee schedule will be provided at renewal and upon request and may be modified by Aetna from time to time.**

**Limited Distribution Specialty Products**

**Certain Specialty Products may not be available at Aetna Specialty Pharmacy (ASRx) due to restricted or limited distribution requirements. These Specialty Products are referred to as Limited Distribution Specialty Products. Aetna has contracted with other network pharmacies to dispense Limited Distribution Specialty Products which are excluded from the pricing and terms contained in this Agreement. A copy of the current list of Limited Distribution Specialty Products may be obtained from Aetna upon request.**

**MEDICAL SERVICES SCHEDULE**
**MASTER SERVICES AGREEMENT MSA- 285620**
**EFFECTIVE January 1, 2017**

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 Aetna will be the "claims fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of claims fiduciary duties 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. If a claim is denied and the denial is upheld through the final level of appeal, Aetna will determine if the appeal is eligible for external review (**"ERO"**). If the appeal is eligible for ERO, then Aetna will inform the Plan Participant of his right to appeal through the ERO process. If the appeal is upheld, Aetna will inform the Plan Participant of the reasons for the denial. If the appeal is not eligible for ERO, then Aetna will inform the Plan Participant of the reasons for the ineligibility. 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 and 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 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.

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℠** - 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.

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

3. **Aetna In Touch Care℠ Programs:**
Aetna In Touch Care Program 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 In Touch Care 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 In Touch Care 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 In Touch Care℠ Solutions and Aetna In Touch Care℠ Premier offerings.

4. **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.

- **Infertility Case Management:** - Aetna operates two types of infertility programs:
  - Basic Infertility Program coordinates covered diagnostic services and treatment of the underlying medical causes of infertility, helps Plan Participants understand complex infertility treatments and helps control treatment costs through care coordination and patient education.
  - Infertility Case Management Program provides education and information resources for Plan Participants who are experiencing infertility. Depending on the plan selected, the program may guide eligible Plan Participants to a select network of infertility providers for covered or non-covered services. If the services are covered, Aetna's Infertility Case Management Unit issues any appropriate authorizations required under the Plan.

5. **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.

6. **Aetna Health Connections℠ Disease Management:**
Aetna Health Connections Disease Management is an enhancement to Aetna's medical/disease management spectrum, designed to engage the Plan Participant at the appropriate level of care, and assist the Plan Participant to close gaps in care in order to avoid complications, improve clinical outcomes and demonstrate medical cost savings.

   While traditional disease management is focused on delivering education to Plan Participants about a specific chronic condition, Aetna Health Connections focuses on the entire person with specific interventions driven by the CareEngine® System, a patented, analytical technology platform that continuously compares individual patient information against widely accepted evidence-based best medical practices in order to identify gaps in care, medical errors and quality issues.

7. **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.

8. **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.

**Member Health Engagement Plan ("MHEP")** offering aims to help Plan Participants better identify health opportunities and take action to improve their health and wellness. MHEP features include an enhanced Plan Participant specific "to-do" list, which includes personalized tasks unique to each Plan Participant's health status and needs, and a progress bar added to the "My Health Activities" page, which visually shows the percentage of completed "to-do" list tasks. The progress bar is updated when evidence of action is collected from lab data, pharmacy claim data, medical claims data, or self-reported data.

9. **Beginning Right® Maternity Program:**
Through an intensive focus on prevention, early treatment and education, the Beginning Right Maternity Program provides women with the tools to help improve pregnancy outcomes and control maternity-care costs through a variety of services including: risk identification, care coordination by obstetrical nurses and board certified OB/GYNs, and Plan Participant support.

10. **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.

11. **Healthy Lifestyle Coaching:**
    - **Healthy Lifestyle Coaching –** This program provides online educational materials, web-based tools and telephonic coaching interventions with a primary health coach. The program is designed to help Employees quit smoking, manage their weight, deal more effectively with stress and learn about proper nutrition and physical fitness. Support is provided through One-on-one telephonic coaching and group coaching. Additionally, Plan Participants or Employees can receive peer-to-peer support through clinically moderated online communities.
    - **Healthy Lifestyle Coaching Lite –** This program provides online educational materials, web-based tools and group coaching interventions designed to help Employees quit smoking, manage their weight, deal more effectively with stress and learn about proper nutrition and physical fitness. Support is provided through group coaching. Additionally, Employees can receive peer-to-peer support through clinically moderated online communities
    - **Healthy Lifestyle Coaching Tobacco Free -** This program provides support to Employees and dependents (18 and older) who want to stop using Tobacco. Employees work with a tobacco cessation specialist to examine the pros and cons of kicking the habit, set a quit date, understand the mental, physical and social aspects of using tobacco, develop strategies to overcome their urges and create a plan for staying tobacco free.
    - **Healthy Weight** – This program drives employee engagement, encourages healthier lifestyle choices and helps create lasting behavioral changes. The program targets the risk factors associated with being overweight so Employees and their families can change before disease develops or complications arise.

12. **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™.

13. **Aetna Healthy Actions℠:**
    Aetna Healthy Actions provides participation tracking for many of Aetna's wellness and care management programs. The participation reports generated may be used for incentive administration. Customers can use the reports to provide their own incentives, which may be HSA deposits, payroll credits, premium reductions/credits, raffles, etc. Additionally, Aetna can provide incentive administration through gift cards and credits to Employee's Health Reimbursement Arrangements (HRAs) and Health Incentive Credit (HIC) accounts.

14. **Get Active℠ Program:**
    Get Active is an evidence-based Employee health and wellness program that focuses on bringing employees together on teams to pursue healthy lifestyles. The program takes the form of a company-wide, multi-week exercise, walking, and weight loss competition that promotes friendly competition, group support, and camaraderie in the workplace. The site also allows for the ability to create personal challenges (exercise, sports, nutrition, smoking cessation, relaxation, etc.), find activity partners, form health-related interest groups (e.g. healthy cooking club, lunch-time walking group), and share fitness plans with colleagues.

15. **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 Catheterization, 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.

16. **Newtopia**
    Aetna has partnered with Newtopia, to provide a high-touch, personalized health program to Employees and eligible dependents, which is focused on obesity and reducing an individual's metabolic syndrome risk factors. The program includes a genetic saliva testing for 3 genes (unless prohibited by state law) related to obesity, appetite and eating behavior. The program is tailored to the individual's genetic profile and health assessment, and is paired with live coaching (either online or via phone) to motivate and engage the individual.

## 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. **AbilTo**
   AbilTo 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. AbilTo provides condition-specific, structured, fixed duration support. AbilTo 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. **DocFind®**
   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. **Aetna Navigator®**
   Aetna Navigator is a secure Employee website that can be used as an online resource for personalized health and financial information.

3. **Web-Chat Technology – Virtual Assistant Ann**
   Aetna's virtual assistant, nicknamed Ann, assists Plan Participants with the Aetna Navigator registration process, log in questions, or assists those who have forgotten their user name or password.

4. **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 Aetna Navigator® 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.

5. **Metabolic Health in Small Bytes:**
   Metabolic Health in Small Bytes is a program promoting metabolic syndrome risk reduction and reversal. This program targets the root cause of obesity by using a holistic approach (mental, emotional, and physiological) to help Employees identify underlying reasons for their weight and what barriers may exist which impede weight loss. This program was created through a collaborative effort with Aetna, Duke Diet and Fitness, Duke Integrative Medicine and eMindful.

6. **iTriage®**
   iTriage is a mobile decision support tool that is designed to increase in-network usage by Plan Participants and assist employers in managing health care costs, while providing employees with a range of appropriate treatment options. It is designed to assist Plan Participants answer the three most common medical questions: *What could be wrong?; Where can I go for treatment?; Where can I go according to my plan?* It is a unique symptom-to-provider pathway that helps Plan Participants search symptoms, conditions, and treatment options and helps them determine the most appropriate level of care in or out of their Aetna provider network.

   Customer Requirements:
   - Customer will be responsible for coordinating the marketing of the iTriage application to their employees for adoptions, including communicating iTriage marketing materials to employees.
   - If Customer Co-Branding is included, Customer shall provide Aetna with two forms of their logo (one for use with a dark background, and another for use with a light background) in vector format no later than 30 days prior to the iTriage launch date, or as mutually agreed by the Parties. Failure to do so may result in delay in implementation.
   - Customer must provide all input and materials reasonably necessary for implementation of any customizations, if applicable, no later than 30 days prior to the iTriage launch date, or as mutually agreed by the Parties. Failure to do so may result in delay in implementation.

7. **NeoCare Solutions℠**
   Aetna, through its subsidiary Healthagen, LLC, ("**Healthagen**") will provide a consumer application, NeoCare Solutions (the "**Application**") to Employees whose infants have been admitted to a Neonatal Intensive Care Unit ("**NICU**"). The Application will include tools, content, and access to a Nurse Coach via phone or tablet device, to better engage Employee parents of NICU children and enable them to be more involved in the infant's care. A "Nurse Coach" is a Healthagen-employed, Aetna-employed, or independently contracted resource made available to Employees through the Application via chat and telephone, to provide support, answer questions, and select and send educational content that is relevant to an infant's care. A Nurse Coach is not a provider of health care services. The Application will be made available to Employees for up to the first year of their infant's life.

8. **Wellmatch®**
   WellMatch is a web-based tool that allows Employees to shop for health care services by comparing aspects of price, quality, and convenience. WellMatch users can search for nearby in-network providers to see what their out-of-pocket cost will be, as well as applicable quality designations and patient reviews.

## 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 Teledoc program are independent contractors and are neither employees nor agents of Teladoc or Aetna.

2. **ALEX® Benefits Advisor**
   ALEX Benefits Advisor ("**ABA**") is an interactive, online decision support tool designed to assist employees in making their benefits elections during open enrollment. A virtual host ("**ALEX**") asks employees questions relevant to the type of coverage the employee may wish to buy (regarding health care needs, lifestyle, financial status, etc.) and makes plan recommendations based on those responses and Customer's benefit options. There are also several modules available for the Customer for an additional charge: Dental, Life (includes Basic/Supplemental/AD&D/Spouse/Child), Disability (includes STD/LTD), Vision (when integrated with medical coverage) and Aetna Pharmacy Savings. The Customer will have use of ABA throughout Customer's open enrollment period, and during the plan year as well for new hires or others eligible to make benefit changes during the year. Customization options are also available for purchase.

3. **Aetna Concierge:**
   Aetna Concierge is a level of customer service that provides a dedicated team of Aetna employees to support the delivery of high-touch, tailored service for Customers. The dedicated Aetna Concierges obtain Customer-specific training in order to serve as a single point of contact across the full-spectrum of plan and benefit offerings available to Plan Participants, even if such offerings are external to Aetna. The dedicated team is staffed with more customer service representatives than Aetna's traditional Customer Service Model, without call handle time guidelines, thereby allowing for longer, more relevant Plan Participant interactions. Aetna Concierges use their skills and training to listen for opportunities to educate and empower Plan Participants by sharing insights, providing useful information, and offering guidance through the use of Aetna tools and resources so that Plan Participants become more informed health care consumers. Aetna Concierge include a dedicated team, individual Aetna Concierges can serve as an extension of the Customer benefits team, and as an available single point of contact for Plan Participants via a dedicated, toll-free 800-number, as well as via live web chat through Aetna Navigator®.

4. **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.

5. **Mind-Body Stress Reduction Programs:**
Aetna's Mind-Body Stress Reduction programs are evidence-based mind-body solutions that target Employees with stress.

- Mindfulness at Work (in coordination with eMindful Inc.) - Teaches evidence-based stress management skills, including mindfulness awareness, breathing techniques and emotions management. Employee participants are required to have online access to participate. Customer can choose from a 12-week class; a monthly class; or combined weekly and monthly classes. All three options can be offered in a single Customer dedicated or public class setting.
- Viniyoga Stress Reduction (in coordination with American Viniyoga Institute) - Teaches tools for managing stress through Viniyoga postures (breath combined with movement), breathing techniques, guided relaxation and mental techniques. Helps reduce stress, relieve muscle tension and headaches, improves sleep and more. Program features includes 12-week onsite class for one-hour per week.

6. **Aetna Fitness Reimbursement Program:**
The Aetna Fitness Reimbursement Program (the "**Program**"), powered by GlobalFit®, is available to Employees. The Program provides reporting and reimbursement for fitness expenses, including fitness club/gym dues, group exercise class fees for classes led by certified instructor; fitness equipment purchases; personal training; and weight management and nutrition counseling sessions.

7. **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.

8. **Subrogation Services:**
Aetna will provide subrogation/reimbursement services in accordance with the applicable terms of the Plan(s).

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 termination date of the Agreement.

## 9. NATIONAL ADVANTAGE PROGRAM (NAP)

The National Advantage Program includes three components, Contracted Rates, 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. In order to elect the Facility Charge Review or Itemized Bill Review components, the Contracted Rates component must be selected.

### A. Contracted Rates Component

Through the Contracted Rates component of NAP, Aetna either contracts with third-party vendors to access their contracted rates with providers, or directly contracts with providers (collectively **"NAP Providers"**) 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"**).

When Aetna accesses rates through direct contracts or third-party vendors, the Provider is contractually bound not to balance bill Plan Participants. To limit balance billing for Plan Participants, contracted rates will apply even if the contracted 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")**.

For Voluntary Out-of-Network Claims, allowed amounts will be based upon the Contracted Rates component, as available, or a percentage of Medicare rates. If a Medicare or analogous rate is not available, the claim will be referred for an Ad Hoc Rate or Facility Charge Review (as described below), as applicable. For Involuntary Out-of-Network Claims, all aspects of the Contracted Rates component will apply.

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

FCR applies to inpatient and outpatient facility claims for which a 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 reasonable charge for a Plan benefit in the geographic area where such benefit was provided to the Plan Participant (**"Reasonable Charge Amount"**). The Reasonable Charge Amount is based on the Provider's estimated cost, including an anticipated profit margin. The claim will be paid based on the Reasonable Charge Amount.

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) Access Fees

As compensation for the services provided by Aetna under NAP, the Customer shall pay ~~a~~ thirty-five percent (35%) of the amount of Savings for a claim paid under NAP (**"Access Fee"**) to Aetna as described in the Service and Fee Schedule.

(a). The Customer shall not owe any Access Fees with respect to any portion of a claim that is the financial responsibility of Aetna, such as when Aetna writes stop loss insurance and the claim exceeds the stop loss individual or aggregate attachment point.

(b). The Customer shall not be responsible for Access Fees owed where Aetna refers a plan participant to an out of network provider. In those instances both the Customer and Plan Participant shall be billed as if services are provided by an in network provider and Aetna shall bear the difference in cost.

(c). Aetna shall provide a quarterly report of Savings and Access Fees. Access Fees may be included with claims in other reports.

(ii) Plan Participant Information Regarding National Advantage Program

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) Definitions applicable to the National Advantage Program:

**"Ad Hoc Rate"** means the rate defined in subsection A above.

**"Involuntary Out-of Network Claims"** means the claims defined in subsection A above.

**"Reasonable Charge Amount"** means the amount defined in subsection B above.

**"Reference Price"** means (i) for Involuntary Out-of Network Claims, the amount billed by the Provider for the Covered Service; (ii) for 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.

**"Savings"** means the difference between (i) the Reference Price, and (ii) the amount Aetna allows the provider under NAP, for services or benefits covered under the Plan affected by NAP. If Aetna pays more than the Reference Price, the Savings will be defined as zero.

**"Voluntary Out-of Network Claim"** means the claims defined in subsection A above.

(iv) Customer Acknowledgements

Customer acknowledges that:

(a). Aetna does not credential, monitor or oversee those providers who participate through third party contracts. Providers listed as participating in NAP through 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.

(v) 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 Access Fees actually paid to Aetna by the Customer for services rendered; provided, however, this limitation will not apply to or affect any performance standards set forth in the Agreement.

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

**DENTAL SERVICES SCHEDULE**
**MASTER SERVICES AGREEMENT MSA- 285620**
**EFFECTIVE January 1, 2017**

Subject to the terms and conditions of the Agreement, the 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 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 documents describing the Services.

## I. CLAIM FIDUCIARY

The Customer and Aetna agree that Aetna will be the "claims fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of claims fiduciary duties 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. ADDITIONAL AUDIT GUIDELINES

Aetna is not responsible for paying the 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.

## III. DENTAL MANAGEMENT SERVICES:

### 1. Dental Utilization Management:

The Dental utilization management program provides for appropriate review, by licensed dentists and other dental professionals, of certain dental claims, as well as of voluntary predeterminations, in order to assist in making coverage determinations based on the necessity and appropriateness of services rendered to treat Plan Participants' dental conditions.

### 2. Dental/Medical Integration (DMI) Program:

The DMI program is designed to educate Plan Participants on the impact of good oral health care on the management of certain diseases and conditions. Plan Participants identified with diabetes, coronary artery disease/cerebrovascular disease or who are pregnant, are sent educational materials explaining the correlation between their disease or condition and periodontal disease. The following programs are included:

- Enhanced Benefit Program for Pregnant Women (offers additional benefits, i.e., an additional cleaning).

- Enhanced Benefit Program for Diabetes and Coronary Artery Disease (offers additional benefits, i.e., an additional cleaning).
- Member Outreach Program (educational materials sent to Plan Participants or outreach phone calls made to Plan Participants encouraging the importance of oral care).

## IV. TECHNOLOGY/WEB TOOLS

### 1. DocFind®

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. Aetna Navigator®

Aetna Navigator is a secure Employee website that can be used as an online resource for personalized health and financial information.

### 3. iTriage®

iTriage contains comprehensive dental health information in collaboration with The Columbia University College of Dental Medicine. The site includes detailed information on conditions and procedures, and information on the effects that medical conditions such as diabetes and heart disease can have on oral health. The site also features resources for children to learn about dental terms and the importance of taking care of their teeth at an early age; and provides important information to parents about children's dental health, from a baby's first dental visit to the teen years.

## V. ID CARDS

Dental ID cards are not required to obtain dental services; therefore Aetna does not mail ID cards to Plan Participants. However, Plan Participants can print their card by going to their secure website at www.aetna.com.

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.

## VI. DENTAL SAVINGS PROGRAMS

### 1. Available Programs

A. **DENTAL PPO II NETWORK PROGRAM (PPO II).**
PPO II dental Providers are considered participating providers in the Customer's Plan, and Covered Services rendered by such Providers will be paid as in-network services in accordance with the terms of the Customer's Plan. When available, the Contracted Rates with PPO II Providers may result in savings for the Customer and Plan Participants. Aetna contracts with one or more third-party network vendors to access their Contracted Rates with Providers. The Providers have agreed to accept the Contracted Rate and not to balance bill Plan Participants.

B. **DENTAL OUT OF NETWORK SAVINGS PROGRAM.**
The Dental Out of Network Savings Program provides access to reduced rates for many dental claims paid under non-network standalone dental Indemnity plans and the out-of-network portion of standalone dental PPO plans. Aetna contracts with one or more third-party network vendors to access their Contracted Rates with Providers. The Providers have agreed to accept the Contracted Rate and not to balance bill Plan Participants. Dental Out of Network Savings Program dental Providers are *not* considered participating provider's in the Customer's Plan.

**2. Terms and Conditions Applicable to Both Programs**

A. Customer Charges For Provider Payments
For Plan benefits rendered by a Provider for which Aetna has accessed a Contracted Rate, the Customer shall be charged the amount paid to the Provider, less any applicable coinsurance and/or deductible owed by the Plan Participant under the Plan.

B. Access Fees
(i) As compensation for the services provided by Aetna under either program for Savings achieved, the Customer shall pay an Access Fee to Aetna as described in the Service and Fee Schedule (excluding Savings with respect to claims for which Aetna is liable for funding, e.g., claims in excess of an individual or aggregate stop loss point).

(ii) Aetna shall provide a quarterly report of Savings and Access Fees. Access Fees may be included with claims in other reports.

C. Plan Participant Information Regarding the Programs
The Customer is responsible for informing Plan Participants of the availability of the programs. For the Dental Out of Network Savings Program, a Customer's summary plan description must define Recognized Charge in a way that conforms to Aetna's requirements and must clearly indicate that Plan benefits under the program are covered at the benefit level for out-of-network (non-preferred) providers.

D. Definitions
As used in this section VI:

**"Access Fee"** means the amount to be paid by the Customer to Aetna for access to the Savings provided under the program, as indicated in the Service and Fee Schedule.

**"Contracted Rate"** means the amount the Provider has agreed to accept as payment under the Provider's contract with a third party network vendor.

**"Provider"** means those dentists and other dental care providers who have agreed pursuant to a contract with a third-party network vendor to provide Plan benefits at a Contracted Rate under the program.

**"Recognized Charge"** is defined in the Customer's Plan. Where a similar term (such as "reasonable charge amount") is used in the Customer's Plan instead of "recognized charge", it will have the same meaning as Recognized Charge.

**"Savings"** means: (i) for the PPOII Program, the difference between the average charges for the area as identified in the FAIR Health claims database and the Contracted Rate; (ii) for the DONS Program, the difference between the Recognized Charge for each Plan benefit, and the Contracted Rate for the Plan benefit under the program. For any Plan benefit where the Recognized Charge is lower than the Contracted Rate, the Savings will be zero.

The Customer acknowledges that:

(i) Aetna does not credential, monitor or oversee those Providers who participate through third party contracts, or in the Dental Out of Network Savings Program. Providers in either program may not necessarily be available or convenient.

(ii) For the Dental PPO II Network Program, information about participating PPO II Providers can be found on DocFind®, Aetna's online provider listing, on our website at www.Aetna.com or by other comparable means. PPO II Providers listed on DocFind may not necessarily be available or convenient.

(iii) For the Dental Out of Network Savings Program, Aetna does not publish a directory of Providers that have agreed to provide Plan benefits at Contracted Rates under their contract with a third party network vendor.

(iv) The following claim situations may not be eligible for either program:

- Claims involving Medicare when Aetna is the secondary payer
- Claims involving coordination of benefits (COB) when Aetna is the secondary payer

E. General Provisions

(i) Aetna's only liability to the Customer for any loss of access to a discount arising under or related to either program, regardless of the form of action, shall be limited to the Access Fees actually paid to Aetna by the Customer for services rendered; provided, however, this limitation will not apply to or affect any performance standards set forth in the Agreement.

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

**PRESCRIPTION DRUG SERVICES SCHEDULE**
**MASTER SERVICES AGREEMENT MSA- 285620**
**EFFECTIVE January 1, 2017 ("Schedule Effective Date")**

Subject to the terms and conditions of the Agreement, the 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.

## I. CLAIM FIDUCIARY

The Customer and Aetna agree that Aetna will be the "claims fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of claims fiduciary duties 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. If a claim is denied and the denial is upheld through the final level of appeal, Aetna will determine if the appeal is eligible for external review (**"ERO"**). If the appeal is eligible for ERO, then Aetna will inform the Plan Participant of his right to appeal through the ERO process. If the appeal is upheld, Aetna will inform the Plan Participant of the reasons for the denial. If the appeal is not eligible for ERO, then Aetna will inform the Plan Participant of the reasons for the ineligibility. 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 and 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 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 the 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.

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. DEFINITIONS

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

**"Aetna Mail Order Pharmacy"** or **"Aetna Specialty Pharmacy"** means a licensed pharmacy designated by Aetna to provide or arrange for Covered Services to Plan Participants and shall include a subcontractor of its choosing for the purposes of services to be performed under this Schedule and/or the Service and Fee Schedule.

**"Average Wholesale Price"** or **"AWP"** means the average wholesale price of a Prescription Drug as identified by Medispan (or other drug pricing service determined by Aetna). The applicable AWP for Prescription Drugs filled in any Participating Pharmacy will be the AWP on the date the drug was dispensed for the 11-digit NDC for the package size from which the drug was actually dispensed as reported to Aetna by such Participating Pharmacy

**"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.

**"Brand Drug"** means a Prescription Drug with a proprietary name assigned to it by the manufacturer and distributor. Brand Drug does not include those drugs classified as a Generic Drug hereunder.

**"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 dilatants.

**"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.

**"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 Drug"** means a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that (a) is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient, or (b) is deemed by Aetna to be pharmaceutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

**"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 Service and Fee Schedule

**"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.

**"Mail Order Exception List"** means the list of Prescription Drugs established by Aetna that includes Brand Drugs adjudicating as Generic Drugs, trademark Generic Drugs, any Generic Drug that is manufactured by one (1) manufacturer (or multiple manufacturers, for example, in the case of "authorized" Generic Drugs), and any Generic Drug that has an AWP within twenty-five percent (25%) of the AWP of the equivalent Brand Drug. The Mail Order Exception List is subject to change.

**"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, Aetna Mail Order Pharmacy or Aetna 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.

**"Precertification"** means a process under which certain drugs require prior authorization (prior approval) before Plan Participants can obtain them as a covered benefit. The Aetna Pharmacy Management 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"** shall mean certain monetary distributions made to the Customer by Aetna under the pharmacy benefit and funded from retrospective amounts paid to Aetna (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (ii) in consideration for the inclusion of such manufacturer's drug(s) on Aetna's Formulary, and (iii) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain Prescription Drugs by Plan Participants.

**"Rebate Guarantee"** means the Rebate amount that Aetna guarantees the Customer will receive as set forth in the 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.

**"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.

**"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 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.

**"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.

## IV. 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 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 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 after the Effective Date, and submitted electronically to Aetna's on-line claims processing system. On-Line Claim 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 negotiated between Aetna and the Customer. For the avoidance of doubt, the Benefit Cost paid by the Customer in connection with On-Line Claims for services rendered by Participating Retail Pharmacies may or may not be equal to the Discount and Dispensing Fees negotiated between Aetna and such pharmacies. This is considered "traditional" or "lock in" pricing.

(ii) Aetna Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Aetna Mail Order Pharmacy on its internet website and via its member services call center. The Aetna 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 Aetna 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 Aetna Mail Order Pharmacy obtains consent of the Prescriber, the Aetna 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 Aetna Mail Order Pharmacy. The Aetna Mail Order Pharmacy shall make refill reminder and on-line ordering services available to Plan Participants. Aetna and/or the Aetna Mail Order Pharmacy may promote the use of the Aetna Mail Order Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Aetna Mail Order Pharmacy's cost, unless otherwise agreed upon by Aetna and the Customer.

(iii) Aetna Specialty Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Aetna Specialty Pharmacy on its internet website and via its member services call center. The Aetna 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 Aetna Specialty Pharmacy generally will require that Specialty Drug medications and supplies 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 Aetna Specialty Pharmacy obtains consent of the Prescriber, the Aetna Specialty Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. The Aetna Specialty Pharmacy shall make refill reminder services available to Plan Participants. Aetna and/or the Aetna Specialty Pharmacy may promote the use of the Aetna Specialty Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Aetna 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"). The formulary options implemented will be determined and communicated prior to the implementation date. Aetna grants the Customer the right to use the Formulary during the term of this Schedule solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. The Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary for the Plan. The Customer further acknowledges and agrees that the Formulary is subject to change at Aetna's sole discretion as a result of a variety of factors, including without limitation, market conditions, clinical information, cost, rebates and other factors. The Customer also acknowledges and agrees that the Formulary is the Business Confidential Information of Aetna and is subject to the requirements set forth in this Schedule and 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) Aetna Rx Check Program. If purchased by the Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Aetna Rx Check Program. Aetna Rx Check programs use a rapid Retrospective DUR approach. Claims are systematically analyzed, often within 24 hours of adjudication, for possible physician outreach based on program algorithms. The specific outreach programs are designed to promote quality, cost-effective care in accordance with accepted clinical guidelines through mailings or telephone calls to physicians and Plan Participants.

Aetna Rx Check will analyze Claims on a daily basis, identify potential opportunities for quality and cost improvements, and will notify physicians or Plan Participants of those opportunities. The physician-based Aetna Rx Check programs will identify:

- Certain medications that may duplicate each other's effect;
- Certain drug to drug interactions;

- Multiple prescriptions and/or Prescribers for certain medications with the potential for misuse;
- Prescriptions for a multiple daily dose of a targeted Prescription Drug when symptoms might be controlled with a once-daily dosing; and
- Plan Participants who have filled prescriptions for brand-new medications that have an A-rated generic equivalent available that could save Plan Participants money.

Another Aetna Rx Check program will notify Plan Participants in selected plans with mail-order drug benefits when they can save money by filling maintenance prescriptions at Aetna Rx Home Delivery versus filling prescriptions at a Participating Retail Pharmacy.

(vi) Save-A-Copay℠: If included as indicated on the Service and Fee Schedule, Aetna shall administer the Save-A-Copay program. Aetna's Save-A-Copay program is designed to encourage Plan Participants to use Generic Drugs, where appropriate and with the approval of their physician. If Plan Participants switch to a generic alternative from a brand-name product, the Plan Participant Cost Share is reduced for a three month period. In such circumstances, the Customer incurs an additional cost for such Claim equal to the amount the Cost Share is reduced.

(vii) Disease Management Educational Program. If purchased by the Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Disease Management Educational Program. The Disease Management Educational Program is available to customers who purchase Aetna managed prescription drug benefit management services, but not Aetna medical benefit plan services. The program consists of Plan Participant identification and outreach based on active Claims analysis for targeted risk conditions, such as asthma and diabetes. Upon identification, Plan Participants will receive a welcome kit introducing the program, complete with important information including educational materials and resources. The Customer may choose either the Asthma or Diabetes program or a combination of the two programs.

(viii) Aetna Rx Step®. If included as indicated on the Service and Fee Schedule, Aetna Rx Step steers Plan Participants to preferred products within 13 key drug classes that have significant savings opportunities. The Customer will have the option to select all of the 13 of these drug classes, or just choose which of the 13 they want. The goal is to help keep members safe and save money, when possible.

(ix) Aetna Rx Healthy Outcomes. If purchased by the Customer as indicated on the Service and Fee Schedule, Aetna Rx Healthy Outcomes is designed to promote drug adherence and sustained positive health outcomes for Plan Participants who survive an Acute Myocardial Infarction (heart attack), Coronary Artery Stent Placement or Acute coronary syndrome.

(x) Aetna Healthy Actions℠ Rx Savings. If purchased by the Customer as indicated on the Service and Fee Schedule, the Aetna Healthy Actions Rx Savings program helps to reduce a Plan Participant's cost share for certain prescription drugs and can include outreach to Plan Participants and prescribing doctor to help promote adherence. It targets drugs for which compliance has been found to be most critical to realize cost savings for Plan Participants and plan sponsors. The targeted drugs treat certain chronic conditions such as diabetes, hypertension, and asthma.

(xi) 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 Aetna Navigator and Aetna Pharmacy Website.**

Through Aetna Navigator, Plan Participants have access to the following:

- Estimating the cost of Prescription Drugs (Price a Drug[SM]).
- Prescription Comparison Tool – Compares the estimated cost of filling prescriptions at a Participating Retail Pharmacy to Aetna's Rx Home Delivery mail-order prescription service.
- Preferred Drug List – 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.

Through the Aetna Pharmacy website, Plan Participants have access to the following:

- Find-A-Pharmacy – This service helps locate an Aetna participating chain or independent pharmacy on hundreds of medications and herbal remedies.
- Tips on drug safety and prevention of drug interactions.
- Answers to commonly asked questions about prescription drug benefits and access to educational videos.
- Preferred Drug List and Generic Substitution List.
- Step Therapy List.

**e. Rebate Administration**

(i) The Customer acknowledges that Aetna contracts for its own account with pharmaceutical manufacturers to obtain Rebates attributable to the utilization of certain prescription products by Plan Participants who receive benefits from customers for whom Aetna provides pharmacy benefit management services. Subject to the terms and conditions set forth in this Schedule, including without limitation, Aetna may pay to the Customer, Rebates based on the utilization by Plan Participants of rebateable Prescription Drugs administered and paid through the Plan Participant's pharmacy benefits.

(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 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.

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

1. The Customer acknowledges that Aetna contracts for its own account with pharmaceutical manufacturers to obtain Prescription Drug Formulary Rebates directly attributable to the utilization of certain Prescription Drugs by Plan Participants who receive Covered Services. The Rebate amounts negotiated by Aetna with pharmaceutical manufacturers 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 and paid 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 also has manufacturer Rebate contracts. 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.

Any material plan changes impacting administration, utilization or demographics may impact Rebate projections and actual Rebates received. Aetna reserves the right to terminate or change this program prior to the end of any Agreement Period for which it is offered if: (a) there is any legal, legislative or regulatory action that materially affects ~~or could~~ affect the manner in which Aetna conducts its Rebate program; (b) any material manufacturer Rebate contracts with Aetna are terminated or modified in whole or in part; or (c) the Rebates actually received under any material manufacturer Rebate contract are less than the level of Rebates assumed by Aetna for the applicable Agreement Period. If there is any legal action, law or regulation that prohibits, or could prohibit, the continuance of the Rebate program, or an existing law is interpreted to prohibit the program, the program shall terminate automatically as to the state or jurisdiction of such law or regulation on the effective date of such law, regulation or interpretation.

2. The Customer acknowledges that from time to time, Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary 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 Prescription Drug Formulary Rebates as compensation for (i) bona fide services it performs, such as the analysis or provision of aggregated information regarding utilization of health care services and the administration of therapy or disease management programs and (ii) drug therapies that underperform pursuant to value-based contracting arrangements.

   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 Aetna 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 a Prescription Drug manufacturer 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 Aetna'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 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 may be more than the negotiated Participating Pharmacy payment rate for the non-Formulary Prescription Drug; and (ii) Rebates received by Aetna from Prescription Drug manufacturers are not reflected in the cost of a Prescription Drug obtained by a Plan Participant.

4. The Customer acknowledges that Aetna contracts with Participating Retail Pharmacies directly or through a pharmacy benefit management ("**PBM**") subcontract to provide the Customer and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna or PBM to Participating Retail Pharmacies vary among Participating Retail Pharmacies in Aetna's network, and can vary from one pharmacy product, plan or network to another. Under this Schedule and 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 Retail Pharmacies. This uniform price may exceed or be less than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services. Where the uniform price exceeds the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, Aetna realizes a positive margin. In cases where the uniform price is lower than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, 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 a Participating Pharmacy or the PBM, Aetna retains the benefit of the use of the funds between these payments.

5. The Customer acknowledges that Covered Services under a Plan may be provided by Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy. In such circumstances, Aetna Mail Order Pharmacy refers to Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, both of which are subsidiaries of Aetna that are licensed Participating Pharmacies. Aetna's negotiated reimbursement rates with Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy, which are the rates made available to the Customer, generally are higher than the pharmacies' cost of fulfilling orders of Prescription Drugs and Specialty Products and providing Covered Services and therefore these pharmacies realize an overall positive margin for the Covered Services they provide. To the extent Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy purchase Prescription Drugs and Specialty Products for their own account, the cost therefor takes into account both up-front and retrospective purchase discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors. Such purchase discounts, credits and other amounts are negotiated by Aetna Mail Order Pharmacy, Aetna Specialty Pharmacy or their affiliates for their own account and are not considered Rebates paid to Aetna by manufacturers in connection with Aetna's Rebate program.

6. The Customer acknowledges that Aetna generally pays Participating Pharmacies (either directly or through PBM) for Brand Drugs 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 Participating Pharmacies (or PBM) based on MAC or continue to pay Participating Pharmacies (or PBM) 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 Prescription Drug manufacturers 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 Participating Pharmacies (or PBM) 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 Aetna Mail Order Pharmacy than if such Generic Drug were dispensed by a Participating Retail Pharmacy. These situations may result from: (i) the terms of Aetna's arrangements with Participating Pharmacies (or PBM); (ii) the amount of the Cost Share; (iii) reduced retail prices and/or discounts offered by Participating Pharmacies to patients; and (iv) the amount, if any, of Rebates to which the Customer is entitled under the Schedule and the Service and Fee Schedule.

Prescription Drugs falling within the definition of the Mail Order Exceptions List may be excluded from the reconciliation of its standard pharmacy Discount and Dispensing Fee financial guarantees.

## VI. AUDIT RIGHTS

### 1. General Pharmacy Audit Terms and Conditions

a. Subject to the terms and conditions set forth in the Agreement and disclosures made in the Service and Fee Schedule, the Customer shall be entitled to have audits performed on its behalf (hereinafter "**Pharmacy Audits**") to verify that Aetna has (a) processed Claims submitted by participating pharmacies or a pharmacy benefits manager under contract with Aetna, and (b) paid Rebates in accordance with this Schedule and the Service and Fee Schedule. Pharmacy Audits may be performed at Aetna's Minnetonka, MN or Hartford, CT location.

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 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) Auditor Qualifications and Requirements specific to Rebate Audits

Any audit of Aetna's agreements with pharmaceutical manufacturers will be conducted by a national CPA firm that is mutually agreeable to both the Customer and Aetna whose audit department is a separate stand alone function of its business.

(iii) 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 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 Claim and Rebate Audit Terms and Conditions**

a. Rebate Audits

Subject to the terms and limitations of this Schedule, the Agreement, and the Service and Fee Schedule including without limitation the general Pharmacy Audit terms and conditions set forth in this section VII, the Customer shall be entitled to audit Aetna's calculation of Rebates received by the Customer as set forth below. Aetna will share the relevant portions of the applicable formulary rebate contracts, including the manufacturer names, drug names and rebate percentages for the drugs being audited. The drugs to be audited will be selected by mutual agreement of the parties. The parties will reasonably cooperate to select drugs for each audit that (a) represent the fewest unique manufacturer rebate contracts required for audit so that the selected drugs represent a maximum of 15% of the Customer's Rebates; which are attributable to the drugs most highly utilized by Plan Participants (b) shall be limited to 2 (two) consecutive quarters and (c) are subject to manufacturer rebate agreements that do not contain restrictions prohibiting Aetna from disclosing to the Customer portions of such contracts concerning the rebates, payments or fees payable there under. Aetna will also provide access to all documents reasonably necessary to verify that Rebates have been invoiced, calculated, and paid by Aetna in accordance with this Schedule. The Customer is entitled to only one annual Rebate audit. Prior to the commencement of such audit, the Customer and auditor shall enter into a rebate audit confidentiality agreement acceptable to Aetna.

b. Pharmacy Claim Audits. Claim audits are subject to the above referenced audit standards for Rebates in the case of a physical, on-site, Claim-based audit. 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 claims. The Customer is entitled to only one annual Claim audit.

**TEMPORARY EXHIBIT 1 –HEALTH COVERAGE**
**PLAN OF BENEFITS**
**MASTER SERVICES AGREEMENT MSA - 285620**
**EFFECTIVE January 1, 2017**

The following Plan(s) is intended to be covered by this Agreement:

- Aetna Choice POSII

While certain details of the Plan(s) are being resolved:

the classes of employees eligible for coverage under the Plan(s) will be determined in accordance with the instructions furnished to Aetna by the Customer; and

the benefits applicable will be payable in accordance with the plan of benefits furnished to Aetna by the Customer, and in accordance with all standard Aetna claim practices.

The terms of this Temporary Exhibit control until superseded by a subsequent Plan document(s), for any specific benefits applicable to any class(es) of employees, as indicated therein.

No. 285620

# Amendment 1

Attached to and made a part of the Master Services Agreement MSA-285620.

An agreement between

**Aetna Life Insurance Company**
(hereinafter referred to as Aetna)

and the Customer

**Webb County**

It is understood and agreed that the Services Agreement is changed as follows:

The "Exhibit 1 – Health Coverage", attached to this rider is substituted for the Temporary Exhibit 1 – Health Coverage appearing in the Services Agreement.

Nothing contained in this amendment shall be held to alter or affect any of the terms of the Services Agreement other than as herein specifically stated.

**In Witness Whereof**, Aetna has signed this amendment at **Hartford, Connecticut**, to become effective January 1, 2017.

Signed by Aetna June 23, 2017.

By:
Mark T. Bertolini
Chairman, Chief Executive Officer and President

Signed by the ~~Customer~~ Webb County, Date: June 26, 2019

Signature

Webb County Judge
Official Title

**EXHIBIT 1 – HEALTH COVERAGE**
**PLAN OF BENEFITS**
**MASTER SERVICES AGREEMENT MSA-285620**
**EFFECTIVE January 1, 2017**

This Exhibit consists of the provisions found in the Plan document(s) listed below. Aetna shall administer the Plan(s) consistent with such provisions.

| Name of Document | Issue Date | Effective Date of Document | Eligible Group and/or Type of Coverage |
|---|---|---|---|
| Booklet: 1 | March 15, 2017 | January 1, 2017 | Aetna Choice POS II - HDHP |
| SOB: 1A | March 15, 2017 | January 1, 2017 | Aetna Choice POS II – Buy Up Plan |
| SOB: 1B | March 15, 2017 | January 1, 2017 | Aetna Choice POS II – Medical Plan |