MASTER SERVICES AGREEMENT
MSA-811370 (PHARMACY)

This master services agreement ("**Agreement**") between **AETNA LIFE INSURANCE COMPANY**, a Connecticut corporation located at 151 Farmington Avenue, Hartford, Connecticut ("**Aetna**"), and **POLK COUNTY,** a political subdivision of the State of Floridalocated at 330 West Church Street, Bartow, Florida("**Customer**") is effective as of January 1, 2024("**Effective Date**").

This Agreement replaces and supersedes Services Agreement number MSA-811370 (PHARMACY), which has an effective date of January 1, 2021.

The Customer has established one or more self-funded employee benefits plans (the "**Plan(s**)"), as described in the Customer's Request for Proposals 23-097, Integrated Medical and Pharmacy Benefits Administration (the "RFP"), a copy of which is attached hereto as Exhibit 1 and fully incorporated into this Agreement by reference, 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. Without in any manner limiting the foregoing, the Services shall also include all services set forth and described in the Scope and Objectives section of the RFP.

The parties therefore agree as follows:

1. TERM

The initial term of this Agreement will be three (3) years beginning on the Effective Date with two (2), one (1) year renewal periods. With regard to the two renewal periods, this Agreement will automatically renew annually unless otherwise terminated pursuant to section 17 (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

- Schedule A - General Administration Schedule,
- Schedule B - Prescription Drug Services Schedule, and
- Schedule C - Prescription Drug Service and Fee Schedule,

as attached hereto and incorporated herein by reference.

3. STANDARD OF CARE

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

4. SERVICE FEES

The Customer shall pay Aetna the fees according to the Prescription Drug Service and Fee Schedule ("**Service Fees**"). Aetna reserves the right to make appropriate changes to these fees, upon no less than 180 days' prior written notice to Customer, if any event materially impacts Aetna's net income derived under this Agreement, provided, however, that either party shall have the right to terminate this Agreement in accordance with the terms of section 17, Termination prior to the date on which such Service Fee changes take effect without penalty. However, if Customer's termination under this section 4 is determined to be without cause (i.e., bad faith), Customer will be subject to the Early Termination Fee described in the Prescription Drug Service and Fee Schedule. Such events shall be limited to those expressly described in the Prescription Drug Service and Fee Schedule. Changes will take effect on the anniversary of the Effective Date unless otherwise indicated in either the Prescription Drug Services Schedule or the Prescription Drug Service and Fee Schedule.

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 following receipt of a valid invoice (the "**Payment Due Date**"). On each statement submitted, the Aetna Billing and Premium Consultant shall, by affidavit, attest to the correctness and accuracy of all Service and Fee Schedules for which Aetna seeks payment.

The Customer shall provide with their payment either a copy of the Aetna invoice, modified to reflect current eligibility, or a copy of a pre-approved invoice which meets Aetna's billing requirements. The Customer shall also reimburse Aetna for certain additional expenses, as stated in this MSA and the General Administration Schedule sections 3(D), 3(F)(3), 3(G)(2), 3(H), 3(I,) and 4(F).

All overdue amounts are subject to the late charges outlined in the Prescription Drug Service and Fee Schedule, subject to the Florida Local Government Prompt Payment Act (Sections 218.70-80, *et. seq*., Florida Statutes).

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

The Customer's review, approval, acceptance, or payment for any of Aetna's Services shall not be construed to: (i) operate as a waiver of any rights the Customer possesses under this Service Agreement; or (ii) waive or release any claim or cause of action arising out of Aetna's performance or nonperformance of this Service Agreement. Aetna shall be liable to the Customer in accordance with applicable law and sections 3, Standard of Care, and 11, Indemnification.

5. BENEFIT FUNDING

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

Since funding is provided on a checks cleared basis, Aetna is not required to act on outstanding benefit checks (checks which have not been presented for payment) unless directed to do so by the Customer. The Customer may elect full escheat or stop pay services under a separate contract, to which additional fees may apply. In the

absence of an escheat or stop pay contract, checks will be voided when they age five years, which does not eliminate the Customer's potential escheat liability.

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

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

(ii) Aetna has exercised its right to suspend claim payments or terminate this Agreement as stated in section 17(B) (Termination).

At the end of any run off service period, the Customer may also request Aetna to perform escheat services on outstanding benefit checks for an additional charge.

6. FIDUCIARY DUTY

It is understood and agreed that the Customer, as plan administrator, retains complete authority and responsibility for the Plan, its operation, and the benefits provided 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.

Claim fiduciary responsibility is identified in the applicable Schedule.

7. CUSTOMER'S RESPONSIBILITIES

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

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

(C) Notice of Plan or Benefit Change – The Customer shall notify Aetna in writing of any changes in Plan documents or Plan benefits (including changes in eligibility requirements) at least 30 days prior to the effective date of such changes. Aetna will have 30 days following receipt of such notice to inform the Customer whether Aetna will agree to administer the proposed changes. If the proposed changes increase

Aetna's costs, alter Aetna's ability to meet any performance standards or otherwise impose substantial operational challenges, Aetna may require an adjustment to the Service Fees or other financial terms.

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

(E) 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. The Customer shall be liable for all Plan benefit payments made by Aetna, including those payments made following the termination date or which are outstanding on the termination date.

8. RECORDS

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

9. CONFIDENTIALITY

(A) Business Confidential Information – Subject to the provisions of Chapter 119, Florida Statutes, or other applicable law, neither party may use "Business Confidential Information" (as defined below) of the other party for its own purpose, nor disclose any Business Confidential Information to any third party. However, a party may disclose Business Confidential Information to that party's representatives who have a need to know such information in relation to the administration of the Plan, but only if such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them. The Customer shall not disclose Aetna's provider discount or payment information to any third party, including the Customer's representatives, without Aetna's prior written consent and until each recipient has executed a confidentiality agreement reasonably satisfactory to Aetna.

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

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

(B) Plan Participant Information - Each party will maintain the confidentiality of Plan Participant-identifiable information, in accordance with applicable law and, as appropriate, the terms of the HIPAA business

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

(C) Upon Termination - Upon termination of the Agreement, each party, upon the request of the other, will return or destroy all copies of all of the other's Business Confidential Information in its possession or control except to the extent such Business Confidential Information must be retained pursuant to applicable law including without limitation Chapter 119, Florida Statutes, or cannot be disaggregated from Aetna's databases. Either party may retain copies of any such Business Confidential Information it deems necessary for the defense of litigation concerning the Services provided under this Agreement, or for use in the processing of runoff claims for Plan benefits, or 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 shall not be responsible for any of Aetna's costs related to or arising out of the audit process set forth and described herein.

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

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

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

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

11. RECOVERY OF OVERPAYMENTS

Aetna shall reprocess any identified errors in Plan benefit payments (other than *de minimis errors, defined as* fifteen dollars ($15.00) for both members and providers) and seek to recover any resulting overpayment by attempting to contact the party receiving the overpayment twice by letter, phone, or email. The Customer may direct Aetna not to seek recovery of overpayments from Plan Participants, in which event Aetna will have no further responsibility with respect to those overpayments. The Customer shall reasonably cooperate with Aetna in recovering all overpayments of Plan benefits.

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

Any requested payment from Aetna relating to an overpayment must be based upon documented findings or direct proof of specific claims, agreed to by both parties, and must be due to Aetna's actions or inactions. Indirect or inferential methods of proof – such as statistical sampling, extrapolation of error rate to the population, etc. – may not be used to determine overpayments. In addition, use of software or other review processes that analyze a claim in a manner different from the claim determination and payment procedures and standards used by Aetna shall not be used to determine overpayments.

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

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

12. INDEMNIFICATION

(A) Aetna shall indemnify the Customer, its affiliates and their respective directors, officers, and employees (only as employees, not as Plan Participants) for that portion of any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees) ("**Losses**") which arise out of (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) By its entering into this Services Agreement the Customer does not intend and in no way waives any sovereign immunity rights that it possesses. Therefore, the Customer will only to the extent allowable under Section 768.28, Florida Statutes, and without in any manner increasing the limits of liability thereunder, indemnify Aetna and hold Aetna, its directors, officers, employees and agents harmless against any and all losses, liabilities, penalties, fines, costs, damages, and expenses, Aetna incurs, including reasonable attorneys' fees, which arise out of the gross negligence or willful misconduct of the Customer's employees acting within the scope of the employees' office or employment when in the performance of the Customer's obligations under this Agreement, except where there has been a finding of gross negligence or willful misconduct in the performance of Aetna's obligations under this Agreement or where there has been material breach of this Agreement by Aetna, as determined by a court or other tribunal having jurisdiction of the matter. Nothing stated in this Section 12 or stated in any other provision of this Agreement shall be interpreted or construed as (i) a waiver of the Customer's sovereign immunity rights, (ii) an extension of the limited waiver of the Customer's sovereign immunity as stated in Section 768.28, Florida Statutes; (iii) a waiver of any requirement or condition stated in Section 768.28, Florida Statutes; or (iv) the Customer's consent to be sued. Any claims asserted against the Customer must comply with the procedures stated in Section 768.28, Florida Statutes.

(C) The party seeking indemnification under this Agreement must notify the indemnifying party within thirty (30) days in writing of any actual or threatened action, to which it claims such indemnification applies. Failure to so notify the indemnifying party will not be deemed a waiver of the right to seek indemnification, unless the actions of the indemnifying party have been prejudiced by the failure of the other party to provide notice as indicated above.

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

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

(E) These indemnification obligations above shall not apply to any claims caused by (i) an act, or failure to act, by one party at the direction of the other, or (ii) with respect to intellectual property infringement, the Customer's modification or use of the Services or materials that are not contemplated by this Agreement, unless directed by Aetna, including the combination of such Services or materials with services, materials or

processes not provided by Aetna where the combination is the basis for the claim of infringement. For purposes of the exclusions in this paragraph, the term "Customer" includes any person or entity acting on the Customer's behalf or at the Customer's direction. For purposes of (A) and (B) above, the standard of care to be applied in determining whether either party is "negligent" in performing any duties or obligations under this Agreement shall be the standard of care set forth in section 3.

13. DEFENSE OF CLAIM LITIGATION

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

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

14. LIMITATION OF LIABILITY

IN NO EVENT SHALL EITHER PARTY BE LIABLE TO THE OTHER FOR INDIRECT, INCIDENTAL, CONSEQUENTIAL, SPECIAL, EXEMPLARY, OR PUNITIVE DAMAGES OF ANY KIND OR NATURE, INCLUDING LOSS OF PROFIT, WHETHER FORESEEABLE OR NOT, ARISING OUT OF OR RESULTING FROM THE NONPERFORMANCE OR BREACH OF THIS AGREEMENT WHETHER BASED IN CONTRACT, COMMON LAW, WARRANTY, TORT, STRICT LIABILITY, CONTRIBUTION, INDEMNITY OR OTHERWISE.

15. MEDIATION OF CERTAIN DISPUTES

In the event that any dispute, claim, controversy of any kind or nature relating to this Agreement arises between the parties, the parties agree to meet and make a good faith effort to resolve the dispute. If the dispute is not resolved within thirty (30) days after the parties first met to discuss it, and either party wishes to pursue the dispute further, the party shall refer the dispute to non-binding mediation under the Commercial Mediation Rules of the American Arbitration Association ("AAA"). In no event may the mediation be initiated more than ninety (90) days after the date one party first gave written notice of the dispute to the other party. A single mediator engaged in the practice of law, who is knowledgeable about employee benefit plan administration, shall conduct the mediation under the current rules of the AAA. The mediation shall be held in Polk County, Florida, or another mutually agreeable site. Notwithstanding the forgoing, either party may reject the recommendation of the non-binding mediator within sixty (60) days of such recommendation, and avail itself to the state courts located in Polk County, Florida or in the appropriate federal court located in the State of Florida, as applicable. Each party shall be responsible for its own attorney's fees and costs incurred as a result of any action or proceeding under this Agreement.

16. 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**").

17. 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 ninety (90) 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 six (6) months' 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 which Aetna reasonably interprets an existing law to prohibit the continuance of the Agreement or some portion thereof, the Agreement or that portion shall terminate automatically as to such jurisdiction on the effective date of such law or interpretation; provided, however, if only a portion of the Agreement is impacted, the Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

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

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

Upon termination of the Agreement and provided all Service Fees have been paid, Aetna will release to the Customer, or its successor administrator, all claim data in Aetna's standard format, within a reasonable time period following the termination date. All costs associated with the release of such data shall be paid by the Customer. The fee schedule for all file transfer fees shall be as follows:

- $5,200 for all open home delivery and specialty pharmacy refill files;
- $1,500 for specialty user report (SUR) – specialty pharmacy file;
- $3,500 for precertification histories;
- $1,000 for accumulator files; and
- $1,000 for historical claims data

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 reasonably 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:
Scott Weber
Aetna
4639 Woodland Corporate Blvd
FL 33831

If to the Customer:
Mark Thomas
Polk County BoCC
P. O. Box 9005, Drawer AS06Tampa, FL 33614 Bartow,

(D) Force Majeure – With the exception of the Customer's obligation to fund benefit payments and Service Fees, either party may be temporarily excused from 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 (an "Event of Force Majeure"). 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. Neither party shall be excused from performance if non-performance is due to forces which are reasonably preventable, removable, or remediable and which the non-performing

party could have, with the exercise of reasonable diligence, prevented, removed, or remedied prior to, during, or immediately after their occurrence. Within five (5) days after the occurrence of an Event of Force Majeure, the non-performing party shall deliver written notice to the other party describing the event in reasonably sufficient detail, along with proof of how the event has precluded the non-performing party from performing its obligations hereunder, and a good faith estimate as to the anticipated duration of the delay and the means and methods for correcting the delay. The non-performing party's obligations, so far as those obligations are affected by the Event of Force Majeure, shall be temporarily suspended during, but no longer than, the continuance of the Event of Force Majeure and for a reasonable time thereafter as may be required for the non-performing party to return to normal business operations. If excused from performing any obligations under this Agreement due to the occurrence of an Event of Force Majeure, the non-performing party shall promptly, diligently, and in good faith take all reasonable action required for it to be able to commence or resume performance of its obligations under this Agreement. During any such time period, the non-performing party shall keep the other party duly notified of all such actions required for it to be able to commence or resume performance of its obligations under this Agreement.

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

(F) Financial Sanctions – If Plan benefits or reimbursements provided under this Agreement violate or will violate any economic or trade sanctions, such Plan benefits or reimbursements are immediately considered invalid. Aetna cannot make payments for claims or Services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written office of Foreign Assets Control (OFAC) license.

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

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

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

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

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

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

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

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

(O) Subcontractors -The work to be performed by Aetna under the Agreement may, at its discretion, be performed directly by it or wholly or in any part through a subsidiary, an affiliate, or under a contract with an organization of its choosing. Aetna will remain liable for Services under the Agreement. Upon request, Aetna shall provide a written list of Tier 1 subcontractors to the Customer. Tier 1 subcontractors are defined as a subset of Aetna suppliers for whom a portion of the Services provided may include direct Plan Participant contact or significant access to Plan Participant-identifiable data. Not all Aetna suppliers on the list provided are utilized in providing services to all customers or plan participants. Aetna shall make an updated Tier 1 subcontractor list available to the Customer for informational purposes, as requested by the Customer, but no more frequently than once annually, during the term of the Agreement. For the avoidance of doubt, neither Aetna's obligation to provide, nor the Customer's right to receive a Tier 1 subcontractor list under this paragraph, shall constitute a right of the Customer to pre-approve any Aetna subcontractor or a right to require Aetna to terminate any agreements (or services under any agreements) with any Aetna supplier. Without limiting the generality of the foregoing, and notwithstanding anything to the contrary contained in this Master Services Agreement, including, without limitation, any Schedule hereto, Aetna acknowledges and agrees that Aetna is, and at all times shall remain, liable for the performance and the non-performance of Services performed by CVS Caremark on behalf of Aetna under this Agreement.

Aetna or its subcontractors will access the Customer or Plan Participant data from locations outside of the jurisdiction of the United States; provided that such access (i) is limited to screen viewing of the data, which shall, at all times, remain physically stored in the United States, and (ii) is subject to security controls, including limiting such access to devices with no download, print or storage capability.

(P) Public Records- Section 119.0701, Florida Statutes, requires that Aetna comply with Florida's public records law with respect to services performed on behalf of Customer. Specifically, Aetna shall:

(1) Keep and maintain public records required by Customer to perform the service.
(2) Upon request from Customer's custodian of public records, provide Customer with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119 of the Florida Statutes or as otherwise provided by law.
(3) Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the term of this Agreement and following completion of the Agreement if Aetna does not transfer the records to Customer.
(4) Upon completion of the Agreement, transfer, at no cost, to Customer all public records in the possession of Aetna or keep and maintain public records required by Customer to perform the service. If Aetna

transfers all public records to the Customer upon completion of the Agreement, Aetna shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If Aetna keeps and maintains public records upon completion of the contract, Aetna shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the public agency, upon request from the public agency's custodian of public records, in a format that is compatible with the information technology systems of the public agency.

(5) A request to inspect or copy public records relating to this Agreement must be made directly to Customer. If Customer does not possess the requested records, the public agency shall immediately notify Aetna of the request and Aetna must provide the records to Customer or allow the records to be inspected or copied within a reasonable time.

(5) The failure of Aetna to comply with these provisions, if applicable, shall constitute a default and material breach of this agreement, which may result in immediate termination, with no penalty to customer and may also result in penalties under Section 119.10, Florida Statutes.

(6) IF AETNA HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES TO AETNA'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT:

RECORDS MANAGEMENT LIAISON OFFICER
POLK COUNTY
330 WEST CHURST ST.
BARTOW, FL 33830
TELEPHONE: (863) 534-7527
EMAIL: RMLO@POLK-COUNTY.NET

19. Scrutinized Companies and Business Operations Certification; Termination.

A. Certification(s) -

(i) By its execution of this Agreement, Aetna hereby certifies to the Customer that Aetna is not on the Scrutinized Companies that Boycott Israel List, created pursuant to Section 215.4725, Florida Statutes, nor is Aetna engaged in a boycott of Israel, nor was Aetna on such List or engaged in such a boycott at the time it submitted its bid, proposal, quote, or other form of offer, as applicable, to the Customer with respect to this Agreement.

(ii) Additionally, if the value of the goods or services acquired under this Agreement are greater than or equal to One Million Dollars ($1,000,000), then Aetna further certifies to the Customer as follows:

(a) Aetna is not on the Scrutinized Companies with Activities in Sudan List, created pursuant to Section 215.473, Florida Statutes; and

(b) Aetna is not on the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, Florida Statutes; and

(c) Aetna is not engaged in business operations (as that term is defined in Florida Statutes, Section 287.135) in Cuba or Syria; and

(d) Aetna was not on any of the Lists referenced in this subsection A(ii), nor engaged in business operations in Cuba or Syria when it submitted its proposal to the Customer concerning the subject of this Agreement.

(iii) Aetna hereby acknowledges that it is fully aware of the penalties that may be imposed upon Aetna for submitting a false certification to the Customer regarding the foregoing matters.

B. Termination - In addition to any other termination rights stated herein, the Customer may immediately terminate this Agreement upon the occurrence of any of the following events:

(i) Aetna is found to have submitted a false certification to the Customer with respect to any of the matters set forth in subsection A(i) above, or Aetna is found to have been placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel.
(ii) Aetna is found to have submitted a false certification to the Customer with respect to any of the matters set forth in subsection A(ii) above, or Aetna is found to have been placed on the Scrutinized Companies with Activities in Sudan List, or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or has been engaged in business operations in Cuba or Syria, and the value of the goods or services acquired under this Agreement are greater than or equal to One Million Dollars ($1,000,000).

20. Employment Eligibility Verification (E-Verify)

A. Unless otherwise defined herein, terms used in this Section which are defined in Section 448.095, Florida Statutes, as may be amended from time to time, shall have the meaning ascribed in said statute.

B. Pursuant to Section 448.095(5), Florida Statutes, the contractor hereto, and any subcontractor thereof, must register with and use the E-Verify system to verify the work authorization status of all new employees of the contractor or subcontractor. The contractor acknowledges and agrees that (i) the County and the contractor may not enter into this Agreement, and the contractor may not enter into any subcontracts hereunder, unless each party to this Agreement, and each party to any subcontracts hereunder, registers with and uses the E-Verify system; and (ii) use of the U.S. Department of Homeland Security's E-Verify System and compliance with all other terms of this Certification and Section 448.095, Fla. Stat., is an express condition of this Agreement, and the County may treat a failure to comply as a material breach of this Agreement.

C. By entering into this Agreement, the contractor becomes obligated to comply with the provisions of Section 448.095, Fla. Stat., "Employment Eligibility," as amended from time to time. This includes but is not limited to utilization of the E-Verify System to verify the work authorization status of all newly hired employees, and requiring all subcontractors to provide an affidavit attesting that the subcontractor does not employ, contract with, or subcontract with, an unauthorized alien. The contractor shall maintain a copy of such affidavit for the duration of this Agreement. Failure to comply will lead to termination of this Agreement, or if a subcontractor knowingly violates the statute or Section 448.09(1), Fla. Stat., the subcontract must be terminated immediately. If this Agreement is terminated pursuant to Section 448.095, Fla. Stat., such termination is not a breach of contract and may not be considered as such. Any challenge to termination under this provision must be filed in the Tenth Judicial Circuit Court of Florida no later than 20 calendar days after the date of termination. If this Agreement is terminated for a violation of Section 448.095, Fla. Stat., by the contractor, the contractor may not be awarded a public contract for a period of 1 year after the date of termination. The contractor shall be liable for any additional costs incurred by the County as a result of the termination of this Agreement. Nothing in this Section shall be construed to allow intentional discrimination of any class protected by law.

INSURANCE REQUIREMENTS

Aetna shall maintain at all times the following minimum levels of insurance and shall, without in any way altering its liability, obtain, pay for and maintain insurance for the coverage and amounts of coverage not less than those set forth below. All insurance shall be written with an insurer licensed to do business in the State of Florida; rated "A VIII" or better by A.M. Best Rating Company for Class VIII financial size category.

Commercial General Liability Insurance: $5,000,000 each occurrence limit of liability for bodily injury, death, property damage, and personal injury resulting from any one occurrence. Policy shall include coverage for all contractual liability that Vendor has agreed to herein. Policy shall include the following sublimits:

Products Completed Operations: $1,000,000
Personal and Advertising Injury: $1,000,000

Comprehensive Automobile Liability Insurance: $1,000,000 combined single limit of liability for bodily injury, death and property damage resulting from any one occurrence, including all owned, hired and non-owned vehicles and shall be primary to any other insurance available to Polk County.

Workers' Compensation Insurance: Aetna shall maintain Workers' Compensation coverage for all employees, agents, volunteers and subcontractors as required under Florida Statutes. In the event that Aetna, at any location associated with the County, has employees, agents, volunteers or subcontractors with a permanent home address or principal place of business outside of Florida, Vendor shall also obtain and maintain Workers' Compensation insurance complaint with the laws, statutes and/or regulations of the state where such permanent home address or principal place of business exists.

Employers Liability Insurance: Vendor shall maintain the following limits:

Each Accident	$1,000,000
Disease – Each Employee	$1,000,000
Disease – Policy Limit	$1,000,000

Professional Services Errors and Omissions Liability Insurance: $20,000,000 combined single limit of liability, to include, but not limited to, Medical Malpractice insurance as applicable.

Crime: Vendor shall maintain 3rd party liability coverage to cover employee dishonesty, theft, robbery, forgery, extortion and other similar criminal acts, of at least $5,000,000. Polk County, a political subdivision of the State of Florida shall be included as a joint loss payee.

Cyber Liability: $20,000,000 combined single limit of liability. Policy shall include, but not limited to, coverage for computer or network systems attacks, denial or loss of service, introduction, implantation or spread of malicious software code, unauthorized access and use of computer systems. Policy shall also include coverage for collection, theft, loss or disclosure of confidential information and data, to include patient personal and medical data.

Limits of liability may be obtained using any combination of primary and excess policies, with all excess policies following form of the underlying primary policy.

The County shall be listed as an additional insured on the General Liability, Automobile Liability, policies. The General Liability, Automobile Liability, and Workers' Compensation policies shall contain a waiver of subrogation in favor of the County.

The certificate holder must be Polk County, a political subdivision of the State of Florida, 330 W Church St, Rm 150, Bartow, Florida 33830. An original certificate of insurance must be on file in the Procurement Division before a purchase order will be issued. All policies required under this Agreement shall provide for 30 days' advance notice of non-renewal, cancellation or a reduction in coverage.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Effective Date.

ATTEST:

STACY M. BUTTERFIELD
CLERK OF THE BOARD

Polk County, a political subdivision
of the State of Florida

By: _____
Deputy Clerk

By: _____
George Lindsey, III, Chairman
Board of County Commissioners

Date Signed By County _____

Reviewed as to form and legal sufficiency:

_____
County Attorney's Office Date

ATTEST:

AETNA LIFE INSURANCE COMPANY,
a Connecticut corporation

By: _____

_____
PRINT NAME

_____
TITLE

By: _____

_____
PRINT NAME

_____
TITLE

Date: _____

SEAL

SCHEDULE A
GENERAL ADMINISTRATION SCHEDULE
MASTER SERVICES AGREEMENT MSA- 811370 (PHARMACY)
EFFECTIVE January 1, 2024

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 pharmacy 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 antiduplication 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 Prescription Drug Service and Fee Schedule.

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

2. MEMBER SERVICES:

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

3. PLAN SPONSOR SERVICES:

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

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

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

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

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

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

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

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

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

(c) a monthly listing of paid benefits;

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

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

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

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

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

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

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

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

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

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

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

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

4. NETWORK ACCESS SERVICES

(A) Aetna shall provide Plan Participants with access to Aetna's network 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) 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.

(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.

5. NON-DIRECT NETWORKS

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

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

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

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

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

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

SCHEDULE B
PRESCRIPTION DRUG SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA- 811370 (PHARMACY)
EFFECTIVE January 1, 2024 ("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 Pharmacy 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. SCHEDULE TERM

The initial term of this Schedule shall be 36 months beginning on the Schedule Effective Date (referred to as an "Agreement Period"). This Schedule will automatically renew for additional Agreement Periods (successive one-year terms) unless otherwise terminated pursuant to the Agreement.

II. CLAIM FIDUCIARY

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

III. EXTERNAL REVIEW

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

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

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

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

The external review process will be conducted by an independent clinical reviewer with appropriate expertise in the area in question. External Review shall be available for certain "Adverse Benefit Determinations" as defined in 29 CFR 2560.503-1 as amended by 26 CFR 54.9815-2719. It shall also be available for eligible "Final Internal Adverse Benefit Determinations", which is an eligible Adverse Determination that has been upheld by the appropriate named fiduciary at the completion of the internal review process or an Adverse Benefit Determination for which the appeal process has been exhausted. If the Customer has issued a final denial of an appeal and the Plan Participant is eligible for External Review, the Customer will: (i) notify the Plan Participant in writing of their right to External Review, (ii) enclose the appropriate Aetna External Review form (standard or expedited), and (iii) inform the Plan Participant in writing of the steps necessary to seek external review. Aetna's 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 fee for an external review shall be paid by the appropriate named fiduciary (Customer).

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 are independent contractors and not agents of Aetna, and that Aetna is not responsible for the decision of the Independent Review Organization.

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

IV. DEFINITIONS

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

"Authorized Generic" means prescription drugs that are produced by brand companies and marketed as generics under private label.

"Average Wholesale Price" or **"AWP"** means the average wholesale price for the actual package size of the legend drug dispensed as set forth in the most current pricing list in Medispan's Prescription Pricing Guide (with supplements). Aetna will use a single nationally recognized reporting service of pharmaceutical prices and such source will be mutually agreed upon by Aetna and Customer. Aetna will use the manufacturer's full actual 11-digit NDC to determine AWP for the actual package size on the date the drug is dispensed through retail pharmacies, mail service pharmacies and specialty pharmacies. Repackaging which has the effect of inflating AWP is explicitly prohibited. "Price shopping", meaning the use of multiple AWP reporting services in order to select the most advantageous AWP price as a means to inflate discount calculations, is prohibited.

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

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

"Biosimilar Drug" means a drug that is approved by the Food and Drug Administration as a "biosimilar" product, as such term is defined at 42 U.S.C. §262(i)(2), pursuant to the provisions of 42 U.S.C. §262(k), or pursuant to any successor legislative provision relating to expedited approval of biological products which are highly similar to a reference biological product.

"Brand Drug" means a Multi-Source Brand Drug or a Single-Source Brand Drug and additionally not a House Generic (DAW 5 Claim):

i. "Multi-Source Brand Drug" means a Legend Drug, Product or OTC identified as "O" by Medi-Span Multi-Source Code indicator.
ii. "Single-Source Brand Drug" means a Legend Drug, Product or OTC identified as "M" or "N" by Medi-Span Multi-Source Code and additionally as "T" or "B" by Medi-Span Brand Name Code.

"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" means a prescription that meets the following criteria: two or more solid, semi-solid, or liquid ingredients, at least one of which is a covered drug that are weighed or measured then prepared according to the Prescriber's order and the pharmacist's art.

"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 Multi-Source Generic Drug or a Single-Source Generic Drug or a House Generic (DAW 5 Claim) with the exception of DAW 9 Claims which shall be classified as Brand Drug Claims:

i. "Single-Source Generic Drug" means a Legend Drug, Product or OTC identified as "M" or "N" by Medi-Span Multi-Source Code and additionally as "G" by Medi-Span Name Type Code.
ii. "Multi-Source Generic Drug" means a Legend Drug, Product or OTC identified as "Y" by Medi-Span Multi-Source Code indicator.

"House Generic" means those Brand Drugs submitted with DAW 5 code in place of their generic equivalent(s) and for which, therefore, pharmacies are reimbursed at Generic Drug rates, including MAC, as applicable, for these drugs (e.g., Amoxil v. amoxicillin).

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

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

"Maximum Allowable Cost" or **"MAC"** means the Maximum Allowable Cost for a drug. This will be the amount of the ingredient cost charged to the plan/member and also be the amount paid to the pharmacy (MAC spread is not allowed).

"MAC List(s)" means the list of drugs designated from lists established by Aetna for which reimbursement to a pharmacy shall be paid according to the MAC price established by Aetna for such list.

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

“**Manufacturer Administrative Fees”** means the administrative fees received by Aetna or its affiliate from pharmaceutical companies for administrative services rendered in its capacity as a group purchasing organization for the Plan in contracting for Rebates and administering Rebate contracts.

“Multi-Source” means a legend drug or OTC that is manufactured by more than one labeler.

“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 contracted retail, mail, or specialty network pharmacy (or Pharmacy Provider) which has agreed to provide pharmaceutical services to all Polk County members and to be reimbursed at an agreed upon rate by Aetna.

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

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

“Precertification” means a process under which certain drugs require 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 or product that, by law, cannot be sold without a written prescription from an authorized Prescriber. For purposes of this Schedule, insulin, certain supplies, and devices shall be considered a Prescription Drug.

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

“Rebates” means the formulary rebates, including base and market share rebates collected by Aetna, whether directly or indirectly, in our connection with CVS Caremark or other affiliates acting in the capacity as a group purchasing organization (GPO) on behalf of the Plan, that are attributable to the utilization of covered prescription drugs by members, including price/inflation protection received by Aetna.

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

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

"Single-Source" means a legend drug manufactured by one labeler.

"Single Source Generic Drug" means a new Generic Drug introduction manufactured by one labeler during the exclusivity period, not to exceed six (6) months. Additionally, Single Source Generics must have a Medi-Span code of "Y".

"Specialty Products" means those injectable and non-injectable Prescription Drugs, other medicines, agents, substances and other therapeutic products that are designated in the Pharmacy 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.

"340B Claim" means a Claim identified by the submission of "20" in any of the submission clarification code fields and/or a Claim submitted by a Participating Pharmacy owned by a covered entity, as defined in Section 340B(a)(4) of the Public Health Services Act, whose 340B status is coded as "38" or "39" in the NCPDP DataQ database. Claims administered from a CVS Health owned Retail, Mail or Specialty Pharmacy are not 340B claims.

V. ADMINISTRATIVE SERVICES

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

1. General Responsibilities and Obligations

a. Exclusivity

During the term of this Schedule, the Customer shall use Aetna as the exclusive provider of the Benefit Plan Design for Plan Participants covered thereby, including without limitation, for pharmacy claims processing, pharmacy network management, clinical programs, formulary management and rebate management. All terms under this Schedule and on the attached Pharmacy Fee Schedule are

conditioned on Aetna's status as the exclusive provider of the Benefit Plan Design. Any failure by the Customer to comply with this Section shall constitute a material breach of this Schedule and the Agreement. Without limiting Aetna's other rights or remedies, in the event the Customer fails to comply with this section, Aetna shall have the right to modify the terms and conditions of this Schedule, including without limitation, the financial terms set forth in the Pharmacy 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 Participating Retail Pharmacy. For the avoidance of doubt, the Benefit Cost paid by the Customer in connection with On-Line Claims for services rendered by the Participating Retail Pharmacy will be equal to the Discount and Dispensing Fees negotiated between Aetna and such pharmacy. This is considered "transparent" or "pass through" pricing.

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

(iii) Specialty Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Specialty Pharmacy on its internet website and via its member services call center. The Specialty Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Specialty Pharmacy generally will require that Specialty 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 Specialty Pharmacy obtains consent of the Prescriber, the Specialty Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. The Specialty Pharmacy shall make refill reminder services available to Plan Participants. Aetna and/or the Specialty Pharmacy may promote the use of the Specialty Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Specialty Pharmacy's cost, unless otherwise agreed upon by Aetna and the Customer. Further information regarding Specialty Product pricing and limitations is provided in the Prescription Drug Service and Fee Schedule.

c. Clinical Programs

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

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

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

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

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

(v) Drug Savings Review If purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule, Aetna shall administer the Drug Savings Review program. Drug Savings Review uses Retrospective DUR approach. Claims are systematically analyzed within 72 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.

Drug Savings Review will analyze Claims on a daily basis, identify potential opportunities for quality and cost improvements, and will notify physicians of those opportunities. The physician-based programs will identify:

- Certain medications that may duplicate each other's effect;
- Certain drug to drug interactions; and
- Prescriptions for a multiple daily dose when symptoms might be controlled with a once-daily dosing.

(vi) Pharmacy Advisor Program. Aetna shall implement and administer as specified in the description of Plan benefits the Pharmacy Advisor Program which focuses on improving adherence, reducing costs and closing gaps in care in targeted conditions where adherence is critical, such as diabetes, asthma and heart failure. Identifying members with such targeted conditions will enable the Pharmacy Advisor Program to alert and provide pharmacists at local Participating Retail Pharmacies with information that will be helpful in their treatment. Effective January 1, 2021, the Pharmacy Advisor Program will be available only if purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule.

(vii) Aetna Healthy Actions^{SM} Rx Savings. If purchased by the Customer as indicated on the Pharmacy 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.

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

If no generic equivalent medication or corresponding MAC amount is available or the prescriber has written "dispense as written" on the prescription order, the cost differential described above is not applied to the higher cost. In some instances, a Brand Drub is not eligible for a corresponding MAC amount due to Formulary and/or Rebate contract requirements that prohibit application of "member pay

the difference" logic or mandate minimum copay steerage levels. In other instances, a Brand Drug may not be eligible for a corresponding MAC amount due to supply and/or pricing considerations.

(ix) 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 the Secure Member Portal, Plan Participants have access to the Aetna website and Aetna Health mobile app. Plan Participants have access to the following:

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

e. Rebate Administration

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

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

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

- Election of, and compliance with, Aetna's Formulary;

- Adoption of and conformance to certain benefit plan design requirements related to the Formulary as described in Pharmacy Fee Schedule; and

- Compliance with other generally applicable requirements for participation in Aetna's rebate program, as communicated by Aetna to the Customer from time to time.

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

VI. IMPORTANT INFORMATION ABOUT THE PHARMACY BENEFIT MANAGEMENT SERVICES

1. Rebate amounts vary based on several factors, including the volume of utilization, benefit plan design, and Formulary or preferred coverage terms. These Rebates are earned when members use drugs listed on Aetna's Formulary and preferred Specialty Products. Aetna determines each customer's Rebates based on actual Plan Participant utilization of those Formulary and preferred Specialty Products for which Aetna receives Rebates from CVS Caremark. The amount of Rebates will be determined in accordance with the terms set forth in the Customer's Prescription Drug 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 Prescription Drug Service and Fee Schedule. Interest (if any) received by Aetna prior to allocation to eligible self-funded customers is retained by Aetna.

2. The Customer acknowledges that from time to time, Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Rebates and which are paid separately to Aetna or designated third parties (e.g., mailing vendors, printers). These payments are to reimburse Aetna for the cost of various educational programs. These programs are designed to reinforce Aetna's goals of maintaining access to quality, affordable health care for Plan Participants and the Customer. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Rebates. These payments are generally for one of three purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data, (ii) to reimburse Aetna for the cost of various educational and other related programs, such as

programs to educate physicians and Plan Participants about clinical guidelines, disease management and other effective therapies, or (iii) to compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder. These payments are not considered as Rebates and are not included in rebate sharing arrangements with plan sponsors, including without limitation, Customer.

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

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

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

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

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

4. The Customer acknowledges that Aetna contracts with Participating Pharmacies through CVS Caremark to provide the Customer and Plan Participants with access to Covered Services. The prices negotiated

and paid by Aetna to CVS Caremark for Covered Services dispensed by Participating Pharmacies can vary from one pharmacy product, plan or network to another.

Customer pays the actual prices paid by Aetna to CVS Caremark. When Aetna receives payment from the Customer before payment to CVS Caremark, Aetna retains the benefit of the use of the funds between these payments.

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

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

VII. 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 Prescription Drug 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 CVS Caremark for Covered Services dispensed by Participating Pharmacies, (b) paid Rebates in accordance with this Schedule and the Prescription Drug 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 Prescription Drug Service and Fee Schedule. In addition to such qualification requirements, 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) one of the major public accounting firms (currently the "Big 4") approved by Aetna whose audit department is a separate stand alone function of its business, (b) a national CPA firm approved by Aetna whose audit department is a separate stand alone function of its business, or (c) a mutually agreeable independent third party retained by the Customer and which agrees to the terms of Aetna's Non-Disclosure Agreement.

(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 Pharmacy 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 Pharmacy 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 minimum of 15% of the Customer's Rebates; which are attributable to the drugs most highly utilized by Plan Participants (b) shall be limited to (four) 4 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 per contract year. Prior to the commencement of such audit, the Customer and auditor shall enter into a rebate audit confidentiality agreement mutually acceptable to Aetna and the Customer.

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. Aetna will review and respond to an industry standard sample size from the auditor's fall out within 30 business days. The Customer is entitled to only one annual Claim audit per contract year.

SCHEDULE C
PRESCRIPTION DRUG SERVICE AND FEE SCHEDULE
MASTER SERVICES AGREEMENT – MSA-811370 (PHARMACY)

The Service Fees and Services effective for the period beginning January 1, 2024 and ending December 31, 2026 are specified below. They shall be amended for future periods, in accordance with section 1 of the Master Services Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

Pharmacy Discounts & Fees

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

Pricing Arrangement	Pass Through at Retail
Network	Aetna National with Extended Day Supply (Retail 90) Network
Employees	4,142

RETAIL 30			
	01/01/2024	**01/01/2025**	**01/01/2026**
Brand Discount	AWP - [redacted]%	AWP - [redacted]%	AWP - [redacted]%
Generic Discount	AWP - [redacted]%	AWP - [redacted]%	AWP - [redacted]%
Dispensing Fee	$[redacted] per script	$[redacted] per script	$[redacted] per script

RETAIL 90			
	01/01/2024	**01/01/2025**	**01/01/2026**
Brand Discount	AWP - [redacted]%	AWP - [redacted]%	AWP - [redacted]%
Generic Discount	Included in Retail 30 pricing above		
Dispensing Fee	$[redacted] per script	$[redacted] per script	$[redacted] per script

MAIL ORDER PHARMACY			
Mail Benefit Type	Mail Order Pharmacy		
	01/01/2024	**01/01/2025**	**01/01/2026**
Brand Discount	AWP - [redacted]%	AWP - [redacted]%	AWP - [redacted]%
Generic Discount	AWP - [redacted]%	AWP - [redacted]%	AWP - [redacted]%
Dispensing Fee	$[redacted] per script	$[redacted] per script	$[redacted] per script

SPECIALTY PHARMACY			
Network	Specialty Performance Network		
Product List	Aetna Specialty Product List		
	01/01/2024	**01/01/2025**	**01/01/2026**
Discount	AWP - [redacted]%	AWP - [redacted]%	AWP - [redacted]%

ADMINISTRATIVE FEES			
	01/01/2024	01/01/2025	01/01/2026
Admin Fee	$ Per Script	$ Per Script	$ Per Script

ALLOWANCES			
	01/01/2024	01/01/2025	01/01/2026
Total Allowances	$	$	$

Rebates

REBATES			
Formulary	Aetna Standard Formulary		
Plan Design	3 Tier Qualifying		
Rebate Terms	Customer will receive the following minimum rebate guarantees:		
	01/01/2024	01/01/2025	01/01/2026
Retail	Greater of Per Brand Script	Greater of Per Brand Script	Greater of Per Brand Script
Retail 90	Greater of Per Brand Script	Greater of Per Brand Script	Greater of Per Brand Script
Mail Order	Greater of Per Brand Script	Greater of Per Brand Script	Greater of Per Brand Script
Specialty	Greater of Per Brand Script	Greater of Per Brand Script	Greater of Per Brand Script

REBATES			
Formulary	Aetna Standard Formulary		
Plan Design	2 Tier		
Rebate Terms	Customer will receive the following minimum rebate guarantees:		
	01/01/2024	**01/01/2025**	**01/01/2026**
Retail	Greater of [redacted] Per Brand Script	Greater of [redacted] Per Brand Script	Greater of [redacted] Per Brand Script
Retail 90	Greater of [redacted] Per Brand Script	Greater of [redacted] Per Brand Script	Greater of [redacted] Per Brand Script
Mail Order	Greater of [redacted] Per Brand Script	Greater of [redacted] Per Brand Script	Greater of [redacted] Per Brand Script
Specialty	Greater of [redacted] Per Brand Script	Greater of [redacted] Per Brand Script	Greater of [redacted] Per Brand Script

Capitalized terms in the pricing charts above are not intended to reflect defined terms except where specifically noted in the Prescription Drug Services Schedule and/or this Prescription Drug Service and Fee Schedule. In the event a term defined in this Prescription Drug Service and Fee Schedule conflicts with a term defined in the Prescription Drug Services Schedule, the term defined in this Prescription Drug Service and Fee Schedule shall prevail.

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

Terms & Conditions

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

- This pricing has an effective date of January 1, 2024. In order for Aetna to implement the pricing as set forth above by the effective date, a notification of award must be given 90 days prior to effective date.
- Our renewal assumes that Aetna administers both the medical and pharmacy benefits for Customer on an integrated basis. If Customer elects to use a different vendor to provide medical benefits, then Aetna reserves the right to adjust the pricing contained in this proposal.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.

[redacted]

- [redacted].
- [redacted]

[redacted].

- Discounts and Dispensing Fees contained in this Prescription Drug Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
  - [redacted].
- Pricing and terms in this proposal assume the Customer has elected the Aetna Standard formulary and the Choose Generics program.

[redacted]

[redacted]

- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein.
- Rebate guarantees may be subject to:
  - [redacted]
- The above rebate guarantees exclude:
  [redacted]
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Rebate guarantee assumes Performance Generic Step Therapy.
- Specialty rebate guarantees apply to Specialty Product claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:
  [redacted]

- [redacted]).
- [redacted].

Allowances

Allowances which are based on the information available to Aetna during this process will be available as of the Effective Date of the pharmacy services schedule. Aetna will pay related expenses directly to a third-party vendor once the Customer sends the invoice(s) outlining the expenses incurred to Aetna.

Invoices must be submitted before the end of each Plan year otherwise the Customer forfeits the funds. Any unused allowance monies at the end of each Plan year will be forfeited. It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, this credit shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. §1320a-7b(b)(3)(A). The parties acknowledge and agree that the allowances provided by Aetna are commercially reasonable and necessary services related to this Agreement, including without limitation, implementation, audit, communication and/or external data file/feeds, and represent fair market value for the services provided.

General Allowance

Aetna is including a general allowance up to [redacted] annually. The Customer can use this allowance to pay for implementation, audit or communication related expenses along with external data files or feeds.

Market Check

Once during the second quarter of the second contract year, and at Customer's reasonable request, Aetna and Customer or a mutually agreed upon third party with a signed non-disclosure agreement may review the financial terms of Customer compared to financial offering presented to similar employers in the marketplace as deemed appropriate. [redacted]. If Customer and Aetna agree to any revisions to the financial terms as a result of this review

(i) the agreement shall be amended and (ii) shall be effective January 1 of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the contract year as to which the revisions are to apply.

[redacted]

Additional Disclosures

The Customer acknowledges that the Discounts and Dispensing Fees contained in this agreement reflect a Transparent or Pass Through pricing arrangement at Retail. [redacted]

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

[redacted]

If one or more of such triggering events occurs, Aetna may initiate a review to determine if an Equitable Adjustment to any of the financial provisions is warranted as a direct result of the triggering event(s).

Aetna will conduct an analysis based upon Customer-specific Claims, utilization, and membership data demonstrating how the triggering event(s) result in the proposed Equitable Adjustment. [redacted]

[redacted]. Aetna will disclose necessary facts and data to an independent auditor for validation.

Any material plan changes impacting administration, utilization or demographics may impact Rebate projections and actual Rebates received. [redacted].

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

Rebate Payment Terms

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

[redacted]

Formulary Management

Aetna offers several versions of formulary options ("Formulary") for Customer to consider and adopt as Customer's Formulary. The formulary options made available to Customer will be determined and communicated by Aetna prior to the implementation date. Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted Customer the right to use one of our Formulary options during the term of the Agreement solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. As such, Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the Plan.

[redacted]

[redacted]. Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

Other Payments

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Early Termination

[redacted]

Late Payment Charges

If the Customer fails to provide funds on a timely basis to cover benefit payments and/or fails to pay service fees on a timely basis as required in the Agreement, Aetna will assess a late payment charge in an amount not to exceed that prescribed by Section 218.74(4), Florida Statutes.

In addition, Aetna will make a charge to recover our costs of collection including reasonable attorney's fees. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Prescription Drug Service and Fee Schedule or at law or in equity for failure to pay.

Pharmacy Audit Rights and Limitations

[redacted]

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

SCHEDULE C - APPENDIX I

PHARMACY PERFORMANCE GUARANTEES

The Pharmacy Performance Guarantees described within this Appendix I will be effective for a period of twelve (12) months and will run from January 1, 2024 through December 31, 2024 (hereinafter "guarantee period"). The guarantees will be evaluated by Aetna on an annual basis and are renewable for each calendar year of the Agreement upon good faith negotiations and mutual agreement of the parties.

General Performance Guarantee Provisions

Aetna Life Insurance Company (ALIC) provides benefits administration and other services for the self-funded pharmacy plans. The services set forth in this document will be provided by ALIC (hereinafter "Aetna").

Performance Objectives

Aetna believes that measuring the activities described below are important indicators of how well we service Polk County, A Political Subdivision of the State of Florida. We are confident that pharmacy administration services provided to Polk County, A Political Subdivision of the State of Florida will meet their high standards of performance. To reinforce Polk County, A Political Subdivision of the State of Florida's confidence in Aetna's ability to administer their program, we are offering guarantees in the following areas:

Performance Guarantee Category	Minimum Standard	Proposed Penalty
Reporting		
• Quarterly Utilization Management Reporting	[redacted]	[redacted]
Claim Administration		
• Claim Processing Accuracy	[redacted] or greater	[redacted]
Retail Claim Administration		
• Pharmacy System Availability	[redacted] or greater	[redacted]
• Turnaround Time – Paper Claims	[redacted]	[redacted]
• On-Site Pharmacy Audits	[redacted] or greater	[redacted]
Mail Order Claim Administration		
• Turnaround Time – Clean Claims	[redacted]	[redacted]
• Turnaround Time – Claims Requiring Intervention	[redacted]	[redacted]
• Mail Order Dispensing Accuracy	[redacted]	[redacted]
Member Services		
• Average Speed of Answer	[redacted]	[redacted]
• Abandonment Rate	[redacted]	[redacted]
• Pharmacy First Call Resolution	[redacted]	[redacted]
• Member Satisfaction	[redacted]	[redacted]
Total		[redacted]

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **January 1, 2024 through December 31, 2024** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the self-funded Aetna Pharmacy Management plans administered under the Administrative Services Only Agreement ("Services Agreement"). These guarantees do not apply to non-Aetna benefits or networks.

For purposes of the performance standards herein, the term "Business Day" will mean Aetna's normal business hours on any day other than a Saturday or Sunday or a day on which Aetna is closed for general business purposes.

This offer does not contemplate significant changes in volume of claims and calls that may occur with novel conditions or circumstances affecting broad populations that place a significant strain on the health care system and/or your plan(s). [redacted] We reserve the right to adjust the terms and factors of this guarantee in response to these conditions and/or circumstances if necessary.

The proposed performance guarantees will be adjusted equitably by the parties to the extent that Aetna has suffered a force majeure event during the applicable measurement period.

Aetna will diligently attempt to maintain its performance at the levels represented herein, provided that failure to achieve or maintain those levels does not constitute a default for purposes of the termination provisions set forth in the Agreement.

Aetna will not be liable to Client for any failure to satisfy a performance guarantee during any time that no agreement existed between Aetna and Client, even if a subsequent written agreement between the parties provides that the effective date of the Agreement is prior to the time at which the written agreement actually was executed by the parties

[redacted]

If any period covered by the Agreement is less than the period covered by the proposed performance guarantee, and Aetna has not met such performance guarantee for such period, the amount at risk associated with such failure will be prorated to reflect the actual period during which the Agreement was in effect.

[redacted].

Aggregate Maximum

In total, Aetna agrees to place [redacted] at risk through the Performance Guarantees outlined in this document. Our offer assumes 4,142 employee lives. Aetna reserves the right to revisit the guarantees if there is a change in enrollment of more than [redacted]. Polk County, A Political Subdivision of the State of Florida can re-allocate up to [redacted] on any one guarantee ([redacted] Ongoing Maximum at Risk).

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

i. a material change in the plan initiated by Polk County, A Political Subdivision of the State of Florida or by legislative action that impacts the claim adjudication process, member service functions, pharmacy network management or rebates;
ii. failure of Polk County, A Political Subdivision of the State of Florida to meet its obligations to remit administrative service fees or fund the Polk County, A Political Subdivision of the State of Florida bank account as stipulated in the General Conditions Addendum of the Services Agreement;
iii. failure of Polk County, A Political Subdivision of the State of Florida to meet their administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by Polk County, A Political Subdivision of the State of Florida or by Aetna.

Penalty Reconciliation and Refund Process

At the end of each guarantee period, Aetna will compile the Performance Guarantees results. If necessary, Aetna will provide a refund to Polk County, A Political Subdivision of the State of Florida for any penalties incurred

Reporting

[redacted]

Guarantee: Aetna guarantees [redacted]

Definition: [redacted].

Penalty and Measurement Criteria: [redacted].

Claim Administration

[redacted]

Guarantee: [redacted].

Definition: [redacted].

Penalty and Measurement Criteria: [redacted].

Retail Claim Administration

[redacted]

Guarantee: Aetna guarantees that the [redacted].

Definition: [redacted].

Penalty and Measurement Criteria: A penalty of [redacted].

[redacted]

Guarantee: Aetna guarantees that the [redacted].

Definition: [redacted].

Penalty and Measurement Criteria: [redacted].

[redacted]

Guarantee: Aetna guarantees that [redacted].

Definition: [redacted].

Penalty and Measurement Criteria: A penalty of [redacted].

[redacted]

[redacted]

Guarantee: Aetna guarantees that [redacted].

Definition: For the respective guarantee period [redacted]

[redacted].

Penalty and Measurement Criteria: [redacted].

[redacted]

Guarantee: Aetna guarantees [redacted].

Definition: For the respective guarantee period, [redacted].

Penalty and Measurement Criteria: A penalty of [redacted].

[redacted]

- [redacted]
- [redacted]
- [redacted]

Guarantee: Aetna guarantees that [redacted].

Definition: For the respective guarantee period, [redacted].

Penalty and Measurement Criteria: A penalty of [redacted].

Member Services

[redacted]

Guarantee: Aetna guarantees that the [redacted].

Definition: [redacted].

Penalty and Measurement Criteria: A penalty of [redacted].

[redacted]

Guarantee: Aetna guarantees that the [redacted]

Definition: On an ongoing basis, Aetna [redacted].

Penalty and Measurement Criteria: A penalty of [redacted].

[redacted]

Guarantee: Aetna guarantees that [redacted].

Definition: [redacted].

Penalty and Measurement Criteria: A penalty of [redacted].

[redacted]

Definition: Aetna guarantees [redacted].

Penalty and Measurement Criteria: Aetna will [redacted]

SCHEDULE C - ADDENDUM
SPECIALTY PRODUCT PRICING

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount
[redacted]	[redacted]	[redacted]

Polk County, A Political Subdivision of the State of Florida		Exclusive
Drug Therapy	Drug Name	AWP Discount

NOTES:

-[redacted].

[redacted]).

PRODUCT SHORTAGE:

[redacted]

Note:

-This list will be updated from time to time and may include [redacted]

CONFIDENTIALITY:

-Customer acknowledges and agrees that the information included is confidential, proprietary and trade secret to Aetna and will agree to protect the information from disclosure.