MASTER SERVICES AGREEMENT
MSA-811370 (MEDICAL)

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 Florida, located 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 ASA-811370A, which has an effective date of January 1, 2018.

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 - Medical Service and Fee Schedule,
- Schedule C – Medical Services Schedule;
- Schedule D – Reimbursement Services Service and Fee Schedule Flexible Spending Account (FSA);
- Schedule E – Reimbursement Services Schedule;
- Schedule F – COBRA Services Service and Fee Schedule, and
- Schedule G – COBRA Services 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 Medical 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 caveat or assumption described in the Underwriting Caveats and Assumptions of the Service and Fee Schedule changes or occurs resulting in a material impact to 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. Changes will take effect on the anniversary of the Effective Date unless otherwise indicated in either the General Administration Schedule or the Medical 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 Sections 3(D), 3(F)(3), 3(G)(2), 3(H), 3(I), and 4(F) of the General Administration Schedule and the Medical Service and Fee Schedule.

All overdue amounts are subject to the late charges outlined in the Medical 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 check 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 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 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 runoff 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) Third Party Consents – The Customer shall obtain any consents, authorizations or other permissions from Employees or relevant third parties, which may be required under law or otherwise necessary in order for Aetna to access, use or disclose information and data for the purposes of providing Services under this Agreement.

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

8. RECORDS

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

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. Aetna may retain copies of any such Business Confidential Information it deems necessary for the defense of litigation concerning the Services it provided under this Agreement, for use in the processing of runoff claims for Plan benefits, and for regulatory purposes.

10. AUDIT RIGHTS

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

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

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

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

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

11. RECOVERY OF OVERPAYMENTS

Aetna shall reprocess any identified errors in Plan benefit payments (other than *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 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. REMEDIES

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

15. 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 (5) 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 Service and Fee Schedule(s). Runoff claims will be processed and paid in accordance with the terms of this Agreement. New requests for benefit payments received after the 12 month runoff period will be returned to the Customer or to a successor administrator at the Customer's expense. Claims which were pended or disputed prior to the start of the runoff period will be handled to their conclusion by Aetna, as well as provider performance or incentive payments paid for prior period performance pay outs, and Customer agrees to fund such claims or payments when requested by Aetna.

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

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

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. Customer agrees not to modify, create derivative product from, copy, duplicate, decompile, disassemble, reverse engineer or otherwise attempt to perceive the source code from which any software component of the Aetna IP is compiled or interpreted. Nothing in this Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent or otherwise transfer or convey, the Aetna IP to the Customer.

(C) Communications - Aetna and the Customer may rely upon any communication 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
4630 Woodland Corporate Blvd.
Mail Code F398
Tampa, FL 33614

If to the Customer:
Mark Thomas
Polk County BOCC
P.O. Box 9005, Drawer AS06
Bartow, FL 33831

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

(6) 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.

(7) 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.

21. 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 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 the Customer.

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 compliant 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

By: _____
Deputy Clerk

Date Signed By County _____

Reviewed as to form and legal sufficiency:

_____
County Attorney's Office

POLK COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF FLORIDA

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

ATTEST:

By: _____

Name: Karen Fuller

Title: Executive Assistant

AETNA LIFE INSURANCE COMPANY:

By: _____

Name: Cathy Aguirre

Title: Executive Director PLSS, SE Region

Date: 10/18/2023

SCHEDULE A
GENERAL ADMINISTRATION SCHEDULE
MASTER SERVICES AGREEMENT MSA- 811370 (MEDICAL)
EFFECTIVE January 1, 2024 ("Schedule Effective Date")

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

1. CLAIM SERVICES:

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

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

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

(D) If the Customer wishes to participate in Aetna's enhanced customer servicing framework, the program will be indicated as included in the Service and Fee Schedule. This initiative empowers Aetna's customer service representatives to resolve complex Plan Participant inquiries in a limited number of instances, in accordance with documented guidelines that fall within the context of Aetna's standard claims administration payment and audit procedures. The program allows an authorization of a one-time payment of a previously processed claim. The limits and requirements associated with the program are available to the Customer upon request.

2. MEMBER SERVICES:

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

3. PLAN SPONSOR SERVICES:

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

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

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

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

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

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

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

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

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

(c) a monthly listing of paid benefits;

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

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

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

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

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

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

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

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

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

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

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

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

4. NETWORK ACCESS SERVICES

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

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

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

(D) Aetna may contract with vendors who in turn are responsible for contracting with the providers who perform the health care services, and potentially for certain other services related to those providers such as claims processing, credentialing, and utilization management. Under some of these arrangements, the

vendor bills Aetna directly for those services by its network of providers at the vendor's contracted rate with Aetna, and Aetna pays the vendor for those services. In certain cases, the amount billed by the vendor to Aetna, paid pursuant to the plan, includes an administrative fee for delegated services by the vendor. As a result, the amount the vendor pays to the health care provider through the vendor's contract with the provider may be different than the amount paid pursuant to the Plan because the allowed amount under the Plan will be Aetna's contracted rate with the vendor, and not the contracted amount between the vendor and the health care provider.

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

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

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

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

5. NON-DIRECT NETWORKS

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

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

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

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

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

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

SCHEDULE B
MEDICAL SERVICE AND FEE SCHEDULE
MSA – 811370 (MEDICAL)

The Service Fees and Services effective for the period beginning January 1, 2024 and ending December 31, 2028 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement. For purposes of this document, Aetna may be referred to using 'we', 'our' or 'us' and Customer may be referred to using 'you' or 'your'. This Exhibit outlines the fees for the Medical Benefit Plan Administration Services contract between Polk County and Aetna Life Insurance Company (hereinafter "Aetna"). The fees are for services performed by Aetna under the Master Services Agreement (hereinafter "Agreement") for the Fee Cap Year period January 1, 2024, through December 31, 2028

Administrative Service Fees

If actual lines of business awarded differs from our current / proposed package of benefits, we reserve the right to revise our quoted fees.

		Year 1	Year 2	Year 3
Guarantee Period Effective Date		January 01, 2024	January 01, 2025	January 01, 2026
Fee Basis		Mature	Mature	Mature
Medical Fees as Billed (PEPM)	**Estimated Enrollment**	**Year 1**	**Year 2**	**Year 3**
Open Access Aetna Select	3,181	[redacted]	[redacted]	[redacted]
AHF HRA CPII	969	[redacted]	[redacted]	[redacted]
MDC Direct Indemnity	3	[redacted]	[redacted]	[redacted]
Illustrative Composite Service Fees (PEPM)	**4,153**	[redacted]	[redacted]	[redacted]
Plan Year Service Fees	**4,153**	[redacted]	[redacted]	[redacted]
Service Fee Summary (Plan Year)		**Year 1**	**Year 2**	**Year 3**
Administrative Service Fees		[redacted]	[redacted]	[redacted]
Service Fee Guarantee % Change†			**0.0%**	**0.0%**
Fee Credit††		[redacted]	[redacted]	[redacted]
Total Fees (incl Discounts, Credits, Broker Comp, Other Chrgs)		[redacted]	[redacted]	[redacted]

Additional Service Fee Guarantee† (Excluding Other Charges)	**Composite Fee**	**% Change**
Year 4 of 5 (January 01, 2027) Mature	[redacted]	[redacted]
Year 5 of 5 (January 01, 2028) Mature		

Clarifications

- PEPM is defined as Per Employee Per Month
- Please see Programs & Services for additional information. Some services may come at additional cost to the fees shown above.
- Broker Compensation is not applicable and would be subject to customer approval.

†Service Fee Guarantee

Our offer includes a service fee guarantee for the guarantee period January 01, 2024, to December 31, 2028 The guaranteed service fees excluding broker compensation are listed above. The service fee guarantee is subject to the terms and conditions as stated in the caveats and is contingent upon the customer maintaining all lines of business with Aetna.

†† Fee Credit

We have included an administrative service fee credit. Refer to the fee credit letter for specific details. Should you decide to terminate your medical plan(s) you have with us prior to the end of the guarantee period, December

31, 2026, you agree to pay us a transition fee. In addition, we are applying a fee credit of [redacted] for calendar year 2023 which is not illustrated in the fee exhibits above that pertain to the new contract period.

Administrative Fee Credit **Effective Date: January 01, 2024**

We are offering you an administrative fee credit for the following years:

Calendar Year 2023 [redacted]
Calendar Year 2024
Calendar Year 2025
Calendar Year 2026

The administrative fee credit will apply to the mutually agreed upon month(s) in the January 01, 2023 to December 31, 2026, Guarantee Period and will be included as part of the final Agreement. You will save approximately [redacted] in total to your overall Aetna medical plan costs if you stay with us for the full Guarantee Period.

The fee credit will be subject to the following provisions:

a. Our Self-Funded medical Agreement will remain in effect for the duration of the Guarantee Period.
b. You are required to make the medical fee payments in accordance with your Agreement.
c. Standard termination provisions apply.
d. All of the plan caveats as stated on the Caveats page in the final proposal are met.
e. Any producer compensations will be excluded from the medical fee credit.
f. Future renewals will be calculated based on the annualized medical fees before giving any effect to the medical fee credit.
g. Contingent upon Aetna being the Total Replacement medical carrier.

In the event that any of these provisions are not met or you terminate the Agreement prior to the end of the Guarantee Period listed above, you will be required to pay us the total amount of the fee credit within 31 days of notice of non-compliance.

The fees shown on the accompanying Fee Schedule will be billed every month of the Guarantee Period. The fee credit will be shown as a separate line item. When you accept our quote, the Fee Schedule will become part of your Agreement with us.

You may wish to consult with your legal advisors about any changes that you may need to make in the administration of your plan as a result of this credit consistent with your fiduciary obligations such as making adjustments to participant contributions.

Programs & Services Included in the Service Fee

Mature Base Service Fee	Included	Included	Included
Implementation, Account Management & Plan Administration			
Designated Account Management Team	Included	Included	Included
Designated Implementation Manager	Included	Included	Included
Onsite Open Enrollment Meeting Preparation	Included	Included	Included
Open Enrollment Marketing Material (Standard) Onsite Meeting Preparation	Included	Included	Included
ID Cards	Included	Included	Included
Summary of Benefits and Coverage (SBC)	Included	Included	Included
Claim Fiduciary Option 1	Included	Included	Included
External Review	Included	Included	Included
Non-ERISA	Included	Included	Included
Network Services			
Institutes of Excellence™	Included	Included	Included
Institutes of Quality® (IOQ) Benefit Differential	Included	Included	Excluded
National Medical Excellence Program® - Transplant Coordination	Included	Included	Included
Network access	Included	Included	Excluded
Teladoc Health (Standard) General Medical ‡, ‡‡	Included	Included	Included
Care Management			
Aetna Compassionate Care Program	Included	Included	Included
Aetna Enhanced Maternity Program	Included	Included	Excluded
Aetna Advice	Included	Included	Excluded
MedQuery®	Included	Included	Excluded
Personal Health Record	Included	Included	Excluded
Utilization Management	Included	Included	Included
Member Resources			
Aetna Concierge (includes First Impression Treatment)	Included	Included	Included

Integrated Service Model	Included	Included	Included
Member Website and Mobile Experience	Included	Included	Included
MindCheck℠	Included	Included	Included
Wellness			
24-Hour Nurse Line: 1-800# Only	Included	Included	Included
Aetna Healthy Actions℠	Included	Included	Included
Aetna Healthy Commitments℠ - Core	Included	Included	Included
Personal Health Record	Included	Included	Included
Simple Steps to Healthier Life® Health Assessment	Included	Included	Included
Allowances			
Pre-Implementation Audit Allowance - $40,000 (one-time only)	Included	Included	Included
Claims Audit - $75,000 (one-time only)	Included	Included	Included
Clinical Audit Allowance - $50,000 (one-time only)	Included	Included	Included
Wellness / Communication Allowance - $40,000 (Annual)	Included	Included	Included
Reporting and Integration			
Analytic Consultation from Plan Sponsor Insights	150 Hours	150 Hours	150 Hours
Clinical Consultation from Plan Sponsor Insights	150 Hours	150 Hours	150 Hours
Monthly Universal File Feeds to Third Party Vendors	Included	Included	Included
Behavioral Health			
Managed Behavioral Health	Included	Included	Included
Behavioral Health Condition Management Program - Standard	Included	Included	Included
Applied Behavior Analysis (ABA)	Included	Included	Included
AbleTo Network - subject to member cost share	Included	Included	Included
Onsite Dedicated Resource			
Health Coach	Included	Included	Included
Total Fees	[redacted]	[redacted]	[redacted]

‡ There is a per consultation charge which will be shared by the member and plan sponsor based on type of service provided and member's benefit plan. Specific charges are available from your Account Manager.

‡‡ With standard Teladoc setup, standard welcome letters, marketing materials, and structure setup are required. If your plan deviates from the standard, Teladoc custom pricing rates will apply. See Programs and Services for included Teladoc programs.

Programs & Services Included in the Claim Wire§§ (Charged through the claim wire. Not included in Above Administrative Fees)

No Surprises Act - Fees			
No Surprises Act (NSA) claim administration fee (per NSA eligible claim)*	$50	$50	$50
No Surprises Act (NSA) Independent Dispute Resolution (IDR) initial fee** (per arbitration case)	$50	$50	$50
No Surprises Act (NSA) Independent Dispute Resolution (IDR) arbitration expenses** (per	~ $200 to $700	~ $200 to $700	~ $200 to $700
Network Services			
Subrogation‡	37.5% of savings	37.5% of savings	37.5% of savings
Contracted Services‡	37.5% of savings	37.5% of savings	37.5% of savings
Claim and Code Review Program‡, ‡‡	30% of savings	30% of savings	30% of savings
National Advantage™ Program with Facility Charge Review, Itemized Bill Review, and Data iSightTM	We will retain 50% of savings, PEPM maximum of $9.98 PEPM, cap of $100,000 per individual claim		
Facility Charge Review (FCR) –	Included	Included	Included
Itemized Bill Review	Included	Included	Included
Data iSight™	Included	Included	Included
Care Management			
Aetna One® Flex (per engaged member, per month)◊	$735	$735	N/A

§§ Claim wire billing fees refers to the portion of the total administrative expenses that are charged through the claim wire as the services are rendered, and are subject to any future fee increases. Expenses that are charged through the claim wire include those described on the Fee Schedule as well as those fees that the parties may subsequently agree to add to the claim wire from time to time. Programs/services that are charged through the claim wire are excluded from the monthly PEPM Administrative Fees as illustrated above and will not appear on the monthly billing statement for PEPM Administrative Fees, but will appear in other monthly reports provided to the customer.

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

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

‡ Specific details on these programs and the associated fees can be found in the Self-Funded Underwriting Disclosure document, which is incorporated by reference into this package and considered part of your Agreement. The UW Disclosure is located at the following URL: https://www.aetna.com/document-library/large-group-public-labor-self-funded-medical-underwriting-disclosures-5-15-2022.pdf

‡‡ Certain editing capabilities were previously provided by Aetna as a service that was included as part of your base administrative fee. The Claim and Code Review Program has been

enhanced to include expanded capabilities at the fee set forth above.

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

Plan Administration
Mature Base Service Fees
Your administrative service fees are mature. The expenses associated with processing runoff claims following termination are covered for one year.
Non-ERISA
For a Non-ERISA plan, the risks and responsibilities are different from those under ERISA plans, since the ERISA preemption and ERISA standard of performance do not apply. Our charge for Non-ERISA plans must take into account the additional liability risk as compared to known risks under an ERISA plan.
Claim Fiduciary Option 1
We will be the claim fiduciary for medical coverage. As claim fiduciary, Aetna will be responsible for the final claims determination and the legal defense of disputed benefits payments for medical and dental.
National Advantage℠ Program
Details can be found in our UW Disclosure document located at the following URL: https://www.aetna.com/document-library/large-group-public-labor-self-funded-medical-underwriting-disclosures-5-15-2022.pdf

Allowances - Self-Funded — Effective Date: January 01, 2024

We are including allowance(s) for your Aetna plans applicable to each year of the Guarantee Period as outlined in the chart below.

Annual Allowance Type	Year 1	Year 2	Year 3	Year 4	Year5
Plan Year Effective Date	01/01/2024	01/01/2025	01/01/2026	01/01/2027	01/01/2028
Pre-Implementation Audit	$40,000	N/A	N/A	N/A	N/A
Claims Audit	$75,000	N/A	N/A	N/A	N/A
Clinical Audit	$50,000	N/A	N/A	N/A	N/A
Wellness or Communication	$40,000	$40,000	$40,000	$40,000	$40,000
Total	**$205,000**	**$40,000**	**$40,000**	**$40,000**	**$40,000**

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

Allowance

- Can be used for reasonable expenses applicable to the plan year for which they are offered.
- You can use the allowance(s) to offset expenses you incur as a result of promoting products, programs or services communicating with our members, and our system front-end charges.
- Should you terminate your contract with us, the allowance(s) cannot be used to fund implementation/communication expenses related to the new carrier's contract.

Wellness Allowance

- Can be used to pay for reasonable wellness-related programs or activities incurred during the Guarantee Period year for which the allowance was applicable.
- Wellness allowance expenses must be for wellness-related programs or activities that are designed to promote the health and well-being of members, or to educate participants about healthy lifestyles and choices. Any wellness-related allowance amounts we pay you directly to offset or reimburse you for any expense or costs you reimbursed a vendor for directly, must comply with these conditions. Examples of reimbursable wellness related activities include programs or activities such as wellness fairs and biometric screenings.

The above referenced fund(s) will be available after your first administrative fee payment for the applicable plan year has been recorded or after the effective date of each plan year, whichever is later. Only those expenses performed and billed by a third party are payable; reimbursement for time and materials incurred directly by the plan sponsor (e.g. hours worked by the plan sponsor's own employees) are not eligible. Our preferred method of payment is directly to the vendor. We will pay allowance related expenses directly to the vendor only after you send us proper documentation outlining the expenses you have incurred. On an exception basis, we can reimburse you directly. In the event the exception is granted, we'll require you to submit detailed paid receipts from the vendor.
To facilitate allowance processing, documentation should be submitted within 60 days of the invoice date, whenever possible.

All documentation must be submitted no later than 60 days following the end of the plan year for which expenses were incurred. Acceptable documentation includes, but is not limited to:

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

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

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

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

For the purposes of this document, Aetna may be referred to using "we", "our" or "us "and Polk County, A Political Subdivision of The State of Florida may be referred to using "you" or "your".

Underwriting Caveats

Your pricing considers all the products, programs and services you have with us and will be in effect for the full 12 months of the plan year. Pricing for some programs and services are amortized over a 12-month period. Therefore, fees will not be reduced if termination occurs prior to the end of the plan year. We also assume the renewal assumptions below remain consistent throughout the plan year. We require notice to properly terminate before the plan year ends in accordance with section 17, the Termination provision, in your Agreement. Otherwise, you may be charged for the cost until that notice is met.

If any of the changes outlined below occur, we may adjust your Guaranteed Fees. If this happens, you'll have to pay any difference between the fees collected and the new fees calculated back to the start of the Guarantee Period. If you are not notified of the change in advance, such difference will be reconciled in the annual accounting for the Guarantee Period. If fees are adjusted, the caveats below will be based on the new assumptions.

During the Guarantee Period we may adjust your Guaranteed Fees if:

Enrollment

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

Member-to-Employee Ratio

The member-to-employee ratio changes by more than 15 percent from the 1.9 ratio assumed in this quote.

Age 65 and Over Enrollment

The number of enrolled employees age 65 and over (excluding those enrolled on Medicare Direct plans) exceeds 3 percent of the total enrolled group or changes by more than 15 percent from the 131 enrollees assumed in this quote. Patient Management programs are excluded for Medicare primary members.

Quoted Benefits and Administration

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

National Advantage™ Program

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

Bundle up Discount

If existing products terminate during the multi-year Guarantee Period, any applicable Bundle up Discounts as outlined in your fee exhibit will be removed.

Multi-Year Provision

You place the products, programs and services included in this multi-year fee guarantee out to bid with an effective date prior to December 31, 2028, then this guarantee is no longer valid.

Total Replacement

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

Performance Guarantees

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

Proposal Acceptance

Our proposal is valid until the earliest of days from the date this quote is released or 30 days prior to the effective date. We reserve the right to update this quote if not accepted within this timeframe.

Non-Compliance Notice

In the event that any of these provisions are not met or you terminate the contract prior to the end of the Guarantee Period, you'll be required to remit the total amount of any prior reduction in fees and/or charges, except where prohibited [as allowed by legislative or regulatory actions]. Such amount shall be remitted to us within 30 days of our notice regarding your non-compliance or termination, as applicable.

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

Assumptions

Underwriting

Agreement Provisions

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

Plan Design

This proposal is based on the current benefit plan designs.

Claim Fiduciary

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

External Review

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

Member Communications

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

Third-Party Audits

We don't typically charge to recoup internal costs associated with a third-party audit. We reserve the right to recover these expenses if significant time and materials are required.

Mental Health/Substance Abuse Benefits

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

Prescription Drug Benefits

Our quotation assumes that prescription drug benefits are included and will be provided through Aetna Integrated Pharmacy Solutions. If you terminate your Aetna prescription drug benefits, we will increase your Guaranteed Fees and medical trend assumption used for any applicable claim projections or claim target guarantee, and you may also be subject to additional charges to integrate data with external Pharmacy vendors.

Aetna Specialty Pharmacy℠ Program

The Aetna Specialty Pharmacy℠ program covers specialty prescription drugs when filled through a network retail or specialty pharmacy, including CVS Specialty© Pharmacy. CVS Specialty is an ideal specialty pharmacy for members needing injectables and specialty medications. Members receive the full support of CVS Specialty's clinical staff, including pharmacists, registered nurses, certified pharmacy technicians and regional clinical liaisons. In addition to providing convenient access to specialty medications, CVS Specialty provides educational support to help members, their family members and caregivers manage self-injectable medications. CVS Specialty also offers enhanced care coordination and access to health care providers, so care delivery is streamlined and effective.

Each prescription is limited to a maximum supply. Depending on plan design, members may be required to fill specialty drug prescriptions at a network specialty pharmacy, unless an emergency exists.

Stop Loss Reporting

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

Aetna HealthFund® (AHF)

Our quotation assumes that any Health Reimbursement Account (HRA) for our Aetna HealthFund® plan(s) is funded by you.

Additional Products, Programs and Services

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

Billing Information

Advanced Notification of Fee Change

We'll notify you of any off-anniversary fee change within 180 days of the fee change.

Late Payment

We'll assess a late payment charge in accordance with Section 218.74, Florida Statutes, Florida Local Government Prompt Payment Act if you fail to pay plan benefit payments or administrative service fees on a timely basis as outlined in the Agreement. The late payment charges described in this section are without limitation to any other rights or remedies available to us under the Agreement or at law or in equity for failure to pay.

Extended Grace Period

As we agreed, we'll accept payment of service fees within 45 days. If you fail to pay service fees within 45 days, we'll assess a late payment charge.

We reserve all rights to enforce Agreement remedies as to any Service Fees overdue.

Producer Compensation

The quoted fees don't include producer compensation.

Runoff Claims Processing

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

Medical Service Center

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

Coverage Determination

All plans administered by Aetna will make current information about our medical coverage policies available to the Fund and TPA on its behalf through online access to our Clinical Policy Bulletins (CPBs). The CPBs are used in conjunction with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for our members. The CPBs are to be used by the TPA administering the pan as a guide when making coverage determinations. A complete index of published CPBs can be found on our internet site at: www.aetna.com/cpb/cpb_menu.html

Reporting and Data Transfer

Aetna Intellectual Property

Under the Agreement, you may have access to certain of Aetna's Plan Sponsor reporting systems. Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under the Agreement ("Aetna IP"). Aetna will grant you, as the Plan Sponsor, a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in the Agreement. You agree not to modify, create derivative product from, copy, duplicate, decompile, dissemble, reverse engineer or otherwise attempt to perceive the source code from which any software component of the Aetna IP is compiled or interpreted. Nothing in the Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent, or otherwise transfer or convey, the Aetna IP to you.

Data Integration (Historical)

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

Data Integration (Ongoing)

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

Data Transfer at Termination

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

The fee schedule for all file transfer fees shall be as follows:

- $5,200 for claim files;
- $3,500 for precertification histories;
- $1,000 for accumulator files; and
- $1,000 for historical claims data.

Banking

We've assumed that you provide funds in which Polk County pushes ACH wire transfer for drafts clearing the bank under the self-funded arrangement assumed in this renewal.

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

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

Additional

Please review the additional important information found at the following URL. This information is incorporated by reference into this package and considered part of your Agreement. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriting Disclosure Document, the information in your package prevails.
https://www.aetna.com/document-library/large-group-public-labor-self-funded-medical-underwriting-disclosures-5-15-

Legislative and Regulatory Requirements

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

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

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

NSA Payment Practices

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

Recovery of Overpayments

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

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

APPENDIX I

Guarantees

All 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 service guarantees will be renewed for each calendar year of the Agreement unless modified through mutual written agreement of the parties.

The care management guarantee will be evaluated by Aetna on an annual basis and may be renewed for each calendar year of the Agreement, subject to modifications, upon mutual written agreement of the parties.

The net effective trend guarantee is only applicable for the first year of the policy period in which we guarantee trend for the 12-month guarantee period, January 1, 2024 through December 31, 2024 and processed through July 1, 2025.

Guarantee Summary **Effective Date: January 01, 2024**

Aetna Life Insurance Company, on behalf of itself and its affiliates (“Aetna”, “our” or “we”) provides health benefits administration and other services (set forth in this document) for the self-funded Aetna medical plans operated on behalf of Polk County, A Political Subdivision Of The State Of Florida (also "you" or "your").

These performance guarantees are considered an amendment to your existing services agreement. Continuance of your benefit plan and payment of fees constitutes an acceptance of these performance guarantees.

The performance guarantees shown below will apply to the actual collected medical administrative service fees (through a "Services Agreement" or "Master Services Agreement", but each from this point on referred to as the “Agreement”). These guarantees do not apply to non-Aetna benefits or networks.

The performance guarantees described herein will not apply if the Agreement is terminated prior to the end of the Guarantee Period. In addition, all included performance guarantees are subject to enrollment requirements as outlined in the financial conditions of each included guarantee.

Service Performance Guarantee

We are committed to delivering high quality service as we administer your healthcare benefits. We demonstrate our commitment to quality performance with the Performance Guarantee outlined below:

Performance Category	Minimum Standard	Maximum Fees at Risk
Implementation		
Implementation	Average evaluation score of 3.0 of higher	1.0%
Account Management		
Overall Account Management	Average evaluation score of 3.0 of higher	1.0%
Management Reports	Processed claim information within 45 days; Incurred claim information within 90 days	0.5%
Monthly Reports	Available within 10 business days following the month's end	0.5%
File Delivery (Data Files)	Delivered by 20th of the month after the end of the quarter	1.0%
Claim Administration		
Turnaround Time (TAT)	10 business days (or 12 calendar days) for 94.0% of processed claims	2.0%
Turnaround Time (TAT Tier-2)	30 calendar days for 98.0% of processed claims	2.0%
Financial Accuracy	99.2%	2.0%
Payment Incidence Accuracy	97%	2.0%
Total Claim Accuracy	95%	2.0%
Overpayment Recovery Rate	85%	2.0%
Member Services		
Average Speed of Answer (ASA)	30 seconds	2.0%
Abandonment Rate	2.0%	2.0%
First Call Resolution (FCR)	90%	1.0%
Open Inquiries Resolution (Tier 1)	85% within 10 calendar days	1.0%
Open Inquiries Resolution (Tier 2)	90% within 28 calendar days	1.0%
Network Management		
Voluntary Physician Turnover Rate	5%	1.0%
In Network Utilization Admissions	98%	1.0%
Total		**25.0%**

Care Management ROI Guarantee

Aetna is willing to place up to 100% of the Program Guarantee Period administrative service fees at risk.

Care Management Program ROI	1.5:1

Claim Target Guarantee

We are offering a claim target guarantee in order to demonstrate our confidence in our claim projection. This guarantee is illustrated below:

Net Effective Trend	[redacted]
Risk Free Corridor	0.0%
Payout Slope	2 to 1
Percent of Fees at Risk	25.0%

Aggregate Maximum
In no event will the total collected medical administrative service fees be adjusted by more than 50 percent due to the result of all guarantees combined.

"Collected Fees" means those fees collected for the Guarantee Period as of the time of the final reconciliation of the guarantee.

Termination Provisions
Termination of the guarantee obligations shall become effective upon written notice by us in the event of one of the following occurrences:

(i) A material change in the plan initiated by you or by legislative action that impacts the claims adjudication process, member services functions, medical management or network management
(ii) Failure to meet your obligations to pay administrative services fees or fund claim payment wires under the Agreement

(iii) Failure to meet your administrative responsibilities (for example, a submission of incorrect or incomplete eligibility information)

These guarantees will not apply if you terminate your Aetna medical or pharmacy plan in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal), prior to the end of the multi-year Guarantee Period (December 31, 2028).

Refund Process
We will provide you with final results for the guarantees when reporting is available after the end of the respective Guarantee Period.

Penalty and Measurement Criteria:
Via timely responses to the online survey, you agree to make us aware of possible sources of dissatisfaction throughout the implementation period. Each question will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. We will tally the results from the online survey when received. Your responses to the survey are used to facilitate a discussion between you, your Implementation Manager and Account Executive regarding the results achieved. If the online survey is not completed and returned within 30 days of receipt, it is assumed that the service provided to you is satisfactory and the guarantee is deemed met. If, at the end of the implementation process, the score of the final evaluation falls below a 3.0 (meaning that service levels have not improved), we will make a mutually agreed upon reduction in compensation. The maximum reduction will be **1.0 percent** of the Guarantee Period administrative service fees.

Account Management

Overall Account Management Guarantee

Guarantee:
We guarantee that the services we provide you (i.e., on-going account management, financial, eligibility, drafting and benefit administration) during the Guarantee Period will be satisfactory to you.

https://aetna.co1.qualtrics.com/jfe/form/SV_6DPuqukxjAwTFtP

Penalty and Measurement Criteria:
Via semi-annual responses to the Account Management Evaluation Tool at the link above, you agree to make us aware of possible sources of dissatisfaction throughout the Guarantee Period. Your responses will evaluate account management services in the following categories:

- technical knowledge
- professionalism
- proactive management
- accessibility
- responsiveness of personnel

Each category will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. We will tally the results from the report card(s) when received. The results of the survey(s) are used to facilitate a discussion between you and your Account Team regarding the results achieved and opportunities for improvement.

If all report cards based on the frequency of the guarantee are not completed and returned within 15 days after the end of the quarter, it is assumed that the service provided to you is satisfactory and the guarantee is deemed met. If the score on the first report card and the report card(s) for the subsequent survey(s) average a 3.0 or higher, no credit is due. Satisfactory service would equal a score of 3.0 and would be based on the total average of 24 questions with a rating scale of 1 to 5. Should the score from the first report card and the average of the remaining report card(s) fall below a 3.0 (meaning that service levels have not improved), we will make a mutually agreed upon reduction in compensation. The maximum reduction will be **1.0 percent** of the Guarantee Period administrative service fees.

Management Reports

Guarantee:
We guarantee that the processed claim information will be available on our utilization/financial reporting platform within 45 days after the end of the reporting period. Note that incurred claims may not be complete until 90 days after the end of the reporting period.

Penalty and Measurement Criteria:
We will reduce our compensation by an amount equal to 0.2 percent of the Guarantee Period administrative service fee each quarter the reports were not available within the guaranteed time frame. The maximum reduction will be **0.5 percent** the Guarantee Period administrative service fees. Our records are used to determine if the terms of this guarantee have met.

Monthly Reports Guarantee:
We guarantee the monthly reports of lag, combined large claimant, and claims summary data will be available within 10 business days following the month's end.

Penalty and Measurement Criteria:
If monthly reports are not delivered within 10 business days following the month's end we will apply a maximum reduction of **0.5 percent** of the Guarantee Period administrative service fees. Our records are used to determine if the terms of the guarantee have been met.

File Delivery (Data Files) Guarantee:
We guarantee delivery of either monthly or quarterly data files to a specified vendor no later than the 20th of the month and/or at the end of the month or quarter requested. If the 20th falls on a weekend, the delivery would be no later than end of the following Monday.

Definition:
We can send either monthly or quarterly medical files to a specified vendor based upon a pre-determined cycle. If the specified vendor cannot process our data files, and the files are deemed accurate and not corrupted, the specified vendor be responsible for the re-creation of the data files, and we will not be penalized for a later delivery.

Penalty and Measurement Criteria:
There will be a total maximum annual reduction of **1.0 percent** of the Guarantee Period administrative service fees if we do not meet the turnaround time above.

Claim Administration

Turnaround Time (TAT)

Guarantee:
We guarantee that the claim TAT during the Guarantee Period will not exceed 10 business days (or 12 calendar days) for 94 percent of the processed claims on a cumulative basis each year.

Definition:
We measure TAT from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied or pended). TAT excludes those claims identified as rework. **Weekends and holidays are included in turnaround time.** This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the Guarantee Period.

Penalty and Measurement Criteria:
If the cumulative year TAT exceeds the day guarantee as stated above, we will reduce our compensation by an amount equal to 0.40 percent of the Guarantee Period administrative service fees for each full day that TAT exceeds 10 business days (12 calendar days) for 94 percent. The maximum reduction will be **2.0 percent** of the Guarantee Period administrative service fees.

If you have more than 3,000 enrolled members, a computer generated TAT report for your specific claims will be provided on a quarterly basis. If you have less than 3,000 enrolled members, results will be reported at the site level.

Turnaround Time (TAT) (Tier-2)

Guarantee:
We guarantee that the claim TAT during the Guarantee Period will not exceed 30 calendar days for 98 percent of the processed claims on a cumulative basis each year.

Definition:
We measure TAT from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied or pended). TAT excludes those claims identified as rework. **Weekends and holidays are included in turnaround time.** This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the Guarantee Period.

Penalty and Measurement Criteria:
If the cumulative year TAT exceeds the day guarantee as stated above, we will reduce our compensation by an amount equal to 0.40 percent of the Guarantee Period administrative service fees for each full day that TAT exceeds 30 calendar days for 98 percent. The maximum reduction will be **2.0 percent** of the Guarantee Period administrative service fees.

If you have more than 3,000 enrolled members, a computer generated TAT report your specific claims will be provided on a quarterly basis. If you have less than 3,000 enrolled members, results will be reported at the site level.

Financial Accuracy

Guarantee:
We guarantee that the financial accuracy will be 99.2 percent or higher.

Definition:
Financial accuracy is measured using industry accepted stratified audit methodology. Each overpayment and underpayment is considered an error; they do not offset each other. Financial accuracy includes both manual and auto adjudicated claims. Accuracy in each stratum (a subset of the claim population) is calculated by:

$$\frac{\text{Dollars Paid Correctly}}{\text{Total Dollars Paid}}$$

We then extrapolate the results based on the size of the population and combine them with the extrapolated results of the other strata.

Penalty and Measurement Criteria:
We will reduce our compensation by an amount equal to 0.40 percent of the Guarantee Period administrative service fees for each full 1.0 percent that financial accuracy drops below 99.2 percent. The maximum reduction will be **2.0 percent** of the Guarantee Period administrative service fees.

Our audit results for the unit(s) processing your claims are used. Those results include our performance in processing ALL customers' claims handled by the unit(s) in question during the Guarantee Period, not just your plan's claims.

Payment Incidence Accuracy

Guarantee:
We guarantee that the payment incidence accuracy will be 97 percent or higher.

Definition:
Payment incidence accuracy is measured by industry accepted stratified audit methodology. Accuracy in each stratum (a subset of the claim population) is calculated by:

$$\frac{\text{Number of claims paid correctly}}{\text{Total number of claims audited}}$$

We then extrapolate the results based on the size of the population and combine them with the extrapolated results of the other strata.

Penalty and Measurement Criteria:
We will reduce our compensation by 0.40 percent of the Guarantee Period administrative service fees for each full 1.0 percent that payment incidence accuracy drops below 97 percent. The maximum reduction will be **2.0 percent** of the Guarantee Period administrative service fees.

Our audit results for the unit(s) processing your claims are used. Those results include our performance in processing ALL customers' claims handled by the unit(s) in question during the Guarantee Period, not just your plan's claims.

Total (Overall) Claim Accuracy

Guarantee:
We guarantee that the total (overall) claim accuracy will be 95 percent or higher.

Definition:
Overall accuracy is measured using industry accepted stratified audit methodology. Accuracy in each stratum (a subset of the claim population) is calculated by:

$$\frac{\text{Number of claims processed correctly}}{\text{Total number of claims audited}}$$

We then extrapolate the results based on the size of the population and combine them with the extrapolated results of the other strata.

Penalty and Measurement Criteria:
We will reduce our compensation by 0.4% percent of the Guarantee Period administrative service fees for each full 1.0 percent that total claim accuracy drops below 95 percent. The maximum reduction will be **2.0 percent** of the Guarantee Period administrative service fees.

Our audit results for the unit(s) processing your claims are used. Those results include our performance in processing ALL customers' claims handled by the unit(s) in question during the Guarantee Period, not just your plan's claims.

Overpayment Recovery Rate:

Guarantee:
We will guarantee that the annual claim overpayment recovery rate during the guarantee period will be 85 percent or higher. The overpayment recovery rate will be defined as the refund dollars applied during the guarantee period plus 180 days, divided by the related net overpaid dollars to provider or members as validated in the Overpayment Tracking OPT system during the guarantee period. Net overpaid dollars are defined as validated overpayments less adjustments (overpayments logged in error or reclassified as non-overpayments). The guarantee is for overpayments handled by Shared Services only, includes unsolicited refunds by providers and members and assumes our standard overpayment recovery process.

Penalty and Measurement Criteria:
If the annual overpayment recovery rate is over 85 percent or better there will be no payout. If the overpayment recovery rate is below 85 percent, we will reduce our compensation by an amount equal to 0.1 percent of the Guarantee Period administrative service fees for each 0.5 percent that the overpayment recovery rate is below 85 percent. There will be a maximum reduction to the Guarantee Period administrative service fees of **2 percent.**

Member Services

Average Speed of Answer (ASA)

Guarantee:
We guarantee that the ASA for the phone skill(s) providing your customer service will not exceed 30 seconds.

Definition:
ASA is defined as the amount of time that elapses between the time a call is received into the telephone system and the time a Customer Service Professional (CSP) responds to the call. The result is calculated as follows:

$$\frac{\text{Sum of all waiting times for all calls answered by the queue}}{\text{Number of incoming calls answered}}$$

ASA measures the average speed of answer for all calls answered. Interactive Voice Response (IVR) system calls are not included in the measurement of ASA. In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the Guarantee Period.

Penalty and Measurement Criteria:
We will reduce our compensation by 0.20 percent of the Guarantee Period administrative service fees for each full second that the ASA exceeds 30 seconds. The maximum reduction will be **2.0 percent** of the Guarantee Period administrative service fees. The phone skill(s) providing your customer service is used.

Abandonment Rate

Guarantee:
We guarantee that the average rate of telephone abandonment for the phone skill(s) providing your customer services will not exceed 2.0 percent.

Definition:
The result is calculated as follows:

$$\frac{\text{Total number of calls abandoned}}{\text{Number of calls accepted into the skill}}$$

In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the Guarantee Period.

Penalty and Measurement Criteria:
We will reduce our compensation by 0.20 percent of the Guarantee Period administrative service fees for each full 1.0 percent that the average abandonment rate exceeds 2.0 percent. The maximum reduction will be **2.0 percent** of the Guarantee Period administrative service fees. The phone skill(s) providing your customer service are used.

First Call Resolution Rate (FCR)

Guarantee:
We guarantee that the first call resolution rate will be 90 percent or higher.

Definition:
We will share with you the first call resolution results with you annually from the accountable unit or business segment level that services you. We define the first call resolution rate as the percentage of member calls resolved on the first call as reported by the member utilizing the Aetna member survey process in effect at the time of the member's call.

Penalty and Measurement Criteria:
We will reduce our compensation by 0.40 percent of the Guarantee Period administrative service fees for each full 1.0 percent that the first call resolution rate falls below 90 percent. The maximum reduction will be **1.0 percent** of the Guarantee Period administrative service fees. Results will be based on the Aetna member survey process that is in effect at the time of the member's call.

Open Inquiries Resolution (Tier 1)

Guarantee:
We guarantee to resolve 85 percent of member services unresolved calls (open inquiries) within 10 calendar days.

Definition:
On an annual basis, we will share with your Aetna strategic desktop report results. In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply, and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the Guarantee Period.

Penalty and Measurement Criteria:
We will reduce our compensation by 0.40 percent for each full 1.0 percent that the member services open inquiries call resolution rate falls below 85 percent completed within 10 calendar days. The maximum reduction will be **1.0 percen**t of the Guarantee Period administrative service fees. Aetna's strategic desktop report results for you will be used.

Open Inquiries Resolution (Tier 2)

Guarantee:
We guarantee to resolve 90 percent of member services unresolved calls (open inquiries) within 28 calendar days.

Definition:
On an annual basis, we will share with your Aetna strategic desktop report results. In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply, and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the Guarantee Period.

Penalty and Measurement Criteria:
We will reduce our compensation by 0.4 percent for each full 1.0 percent that the member services open inquiries call resolution rate falls below 90 percent within 28 calendar days. The maximum reduction will be **1 percent** of the Guarantee Period administrative service fees. Aetna's strategic desktop report results for you will be used.

Network Management

Voluntary Physician Turnover Rate

Guarantee:
We guarantee that the average voluntary physician turnover rate shall not exceed 5 percent annually.

Definition:

$$\frac{\text{Number of provider terminations year-to-date}}{\text{Total provider base as of the end of the prior year}} \times 100$$

We use the HEDIS industry standard definition of voluntary turnover that measures the percent of network PCPs and specialists who voluntarily leave the network during the reporting period. The voluntary turnover rate is calculated as follows:

Termination of the provider turnover guarantee is effective upon written notice by us in the event of an acquisition and/or any other material change in the plan that impacts network management.

Penalty and Measurement Criteria:
We will reduce our service fee by 0.4 percent for each full 1.0 percent that turnover exceeds 5 percent on an annual basis. The maximum reduction will be **1 percent** of the Guarantee Period administrative service fees. The results from a system-generated report will be used to determine whether the terms of the guarantee have been met.

In Network Admissions Percentage Guarantee:

Guarantee:
We guarantee that the calendar year 2024 in network admission utilization will be 98%.

Definition:
This measurement will be reporting using data from Aetna's Informatics data warehouse. Specifically, the Provider Network Experience report within the standard medical utilization report package will be utilized. The guarantee will be reconciled using Percent Admissions In Network. This report will be generated on a calendar year basis.

Penalty and Measurement Criteria:
We will reduce our service fee by 0.4 percent for each full 1.0 percent that admissions percentage is below 98 percent on an annual basis. The maximum reduction will be **1 percent** of the Guarantee Period administrative service fees. The results from a system-generated report will be used to determine whether the terms of the guarantee have been met.

$$\frac{\text{Number of par admissions}}{\text{Number of admissions}}$$

Care Management Guarantee Summary		Effective Date: January 1, 2024
Guaranteed Metric	**Minimum Standard**	**PEPM at Risk**
Financial Performance		
- Care Management ROI	1.5:1	[redacted]
Operational Performance		
- Engaged of Reach Rate	70%	[redacted]
- Inpatient Admission Outreach	95%	[redacted]
- High Cost Claimant Screening	95%	[redacted]
- Utilization Management (UM) Touch Rate	90%	[redacted]
- Depression Screening	90%	[redacted]
Member Satisfaction Survey		
- Care Management, Nurse Line, Maternity Program	90%	[redacted]
Aetna Enhanced Maternity Program		
- Participation Rate	90%	[redacted]
- Engagement Rate	85%	[redacted]
- Post-Partum Depression Screening	88%	[redacted]
Total PEPM at risk for Guarantee	[redacted]	
Total Estimated Employees	**4,194**	
Total Estimated Annual Amount at Risk	[redacted]	

In no event will the total collected administrative service fees be adjusted by more than 50 percent due to the result all guarantees combined. 'Collected Fees' means those fees collected for the Guarantee Period as of the time of the final reconciliation of the guarantee.

Guarantee Period

The Guarantee Period shall be represented as a one-year guarantee effective from January 1, 2024 through December 31, 2024 (hereinafter the "Guarantee Period"). The guarantee may be reviewed annually, and any changes will be subject to mutual agreement of the parties.

You may receive reporting throughout the year relative to utilization or operational data. The data contained in those reports may differ from the actual performance guarantee results due to the timing of the reports and/or auditing of performance guarantee results.

The performance guarantees shown below will apply to the incremental costs for each of the programs administered under the Administrative Services Only arrangement (through a 'Services Agreement' or Master Services Agreement', as the case may be, but each hereinafter referred to as the "Agreement"). The incremental costs for each of the programs are represented in the "amount at risk" column in the Guarantee Summary section. These guarantees do not apply to
non-Aetna benefits or networks.

Changes in Clinical Practice Guidelines

Medical knowledge is dynamic and as research progresses the recommendations for evidence-based clinical guidelines change. Such changes may involve:

- A test, service or medication is no longer recommended
- A change in the frequency or intensity of a test or service, or dosage of a medication
- A change in the clinical goal or target
- A change in the specifications for the denominator population

When a recognized national organization changes clinical practice guidelines that impact these performance guarantees, we reserve the right to amend or eliminate the performance guarantees. This is necessary because physicians will start to manage their patients in accordance with the revised guidelines. If a test, service or medication is no longer recommended, then the performance guarantee will be eliminated since we cannot recommend to physicians and patients to have a test done or a medication be taken. When the service continues to be recommended, but at a different frequency or with a new target, we will modify the associated metric accordingly.

We will notify you when such changes are being made. It may be necessary to recalculate performance for the baseline year to reflect changes in clinical target or specifications for denominator population. This is required to accurately calculate improvement from baseline.

Care Management Guarantee Maximum

We will place up to $7.43 per employee, per month (PEPM) at risk of the actual collected Care Management programs Guarantee Period administrative service fees. The Care Management Guarantee Period administrative service fees will be calculated at the end of the respective Guarantee Period and will be based on the total number of your
subscribers enrolled in the underlying medical plans that also offer the services of the programs for each Guarantee Period.

Aggregate Maximum

In no event will the total collected Medical administrative service fees be adjusted by more than 50 percent of actual collected fees due to the result of this guarantee and all other guarantees combined. "Collected Fees" means those fees collected for the Guarantee Period as of the time of the final reconciliation of the guarantee.

Refund Process

We will provide you with final results for the scorecard when reporting is available after the end of the respective Guarantee Period. Reporting that outlines associated savings for the contract period is estimated to be available at the end of the third quarter following the close of the respective Guarantee Period. If the guarantees have not been met, at your sole discretion, we shall (1) provide a cash payment to you for the amount due as a result of our non-compliance within thirty (30) days of your receipt of such results or (2) reduce future administrative fee payment(s) by the amount due to you. In the no event will more than 100 percent of the collected Care Management Program fees be refunded.

Financial Conditions

We reserve the right to revise or remove any or all of the performance guarantees described herein if any of the following conditions are not met:

- Actual Aetna medical enrollment stays within 10 percent of the enrollment assumed within this guarantee.
- This guarantee requires a minimum of 3,000 employee lives and less than 20 percent turnover.
- This offer does not contemplate the changes in costs, utilization, risk or any form or type of testing associated with novel conditions or circumstances affecting broad populations that place a significant strain on the health care system and/or your plan(s). These conditions include but are not limited to COVID-19. We reserve the right to adjust the terms and factors of this guarantee in response to these conditions and/or circumstances if necessary.
- The average member age of your enrolled Aetna medical plan participants is greater than 34.
- Your member to employee ratio is at least 1.9.
- We service both the medical and pharmacy products.
- If you utilize an external vendor for biometric screenings or other wellness programs, we require receipt of those external feeds.
- If you have a direct contract with Quest, you will need to notify Quest to provide us the lab data.
- Under age 65 retiree population is structured separately from the over age 65 Medicare prime population for accounting/reporting purposes with us. This guarantee excludes populations that are over age 65 with Medicare primary.
- Member eligibility (complete, accurate and viable enrollment data, including member phone numbers) is fully loaded in our eligibility system 35 days prior to the effective date.
- You agree to not prevent or otherwise restrict us from contacting your members for purposes of the Aetna Advice® program, except where required by law or regulation.
- You do not turn off any of the Aetna Advice® campaigns.
- If you terminate your Aetna medical plan within 180 days after the Guarantee Period or do not continue in a Care Management Program that includes MedQuery, we reserve the right to revert the Return on Investment (ROI) guarantee to book of business results rather than customer-specific results.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by us in the event of one or more of the following occur:

(1) A material change in the plan initiated by you or by legislative action that impacts the claims adjudication process, member services functions, medical management or network management.
(2) Failure to meet your obligations to pay administrative service fees or fund claim payment wires under the Agreement.
(3) Failure to meet your administrative responsibilities (for example, a submission of incorrect incomplete eligibility information).

These guarantees will not apply if you:

- Terminate Aetna One Flex prior to the end of the Guarantee Period.
- No guarantees will apply for a Guarantee Period during which the Agreement is terminated by either party prior to the end of such Guarantee Period.

Care Management ROI

Guarantee:
We will guarantee that the savings associated with the Care Management Program will be equal to one and a half times the Guarantee Period administrative service fee. The fee is estimated at $7.43 PEPM based on book of business engagement and member to employee ratio. We will reconcile to your actual PEPM, which we will calculate after the Aetna One Flex engagement and enrollment for the Guarantee Period is known.

The guaranteed fee includes program fees for the following:

- Concurrent Review
- Precertification
- Aetna One® Flex
- CareEngine®/MedQuery®
- Aetna Advice®

The guarantee will be reconciled annually using a MedQuery® CC and HEM Report, the Program Savings Report and an Aetna Advice Savings Report.

For customers with more than 3,000 subscribers lives, customer specific results will be used. For customers with less than 3,000 subscribers lives, book of business results will be used.

Penalty and Measurement Criteria:
We will place $5.58 PEPM of the Guarantee Period administrative service fees at risk for this metric. If the achieved Care Management ROI savings result in a savings ratio less than 1.5:1 we will reduce our compensation by the amount necessary to result in a savings of 1.5:1 Guarantee Target times the fees paid. The PEPM at risk will be adjusted based on your actual PEPM, which we will calculate after the Aetna One Flex engagement and enrollment for the Guarantee Period is known.

If the Guarantee Period administrative fees for the care management program are $150,000, and the care management program savings are $180,000, we will reduce the Guarantee Period administrative fees by $30,000. This $30,000 reduction would lower the administrative service fees paid to $120,000, resulting in a 1.5:1 ratio of program savings to program costs. The guarantee will be reconciled annually using a MedQuery® CC and HEM Report, the Program Savings Report and an Aetna Advice Savings Report.

Engaged of Reach Rate

Guarantee:

We will guarantee an engagement rate of 70 percent or better of those we are successful in reaching in our Aetna One® Flex Program. Engagement is defined as at least one call with a nurse where clinical information is exchanged.

The calculation is as follows:

$$\frac{\text{Cumulative nurse engaged year-to-date*}}{\text{All members with outreach minus the unable-to-reach**}}$$

* The numerator is calculated as nurse engaged (member or provider) participation level
** The denominator is calculated as all members targeted for nurse engagement and reached, excludes unable to reach Aetna

One® Flex book of business results will be used to reconcile this guarantee annually.

Penalty and Measurement Criteria:
If we miss the Engaged of Reached Rate target, we will reduce our compensation as follows up to a maximum reduction of $0.20 PEPM:

- $0.04 PEPM if we miss the target by ≥ 2 percent
- $0.10 PEPM if we miss the target by ≥ 5 percent
- $0.20 PEPM if we miss the target by ≥ 10 percent

Inpatient Admission Outreach

Guarantee:
We will guarantee that 95 percent of members meeting the criteria for 1:1 support for an admission will receive 1 attempt to engage them prior to their scheduled admission. For members at high risk for readmission will receive a minimum of 1 outreach attempt post discharge. Outreach attempts can be defined as telephonic, omni channel campaigns, etc. This assumes adequate notification at least 9 business days prior to the scheduled admission and a notification of the discharge timeline (defined as within 48 hours of discharge or 1 business day, whichever is sooner.) This guarantee excludes maternity, newborns, behavioral health, coordination of benefits (COB), Medicare, skilled nursing facility (SNF), rehabilitation admissions, transplants (members managed through the National Medical Excellence Program®) or any member being managed by another CVS Health clinical program.

Aetna One® Flex book of business results will be used to reconcile this guarantee annually.

Penalty and Measurement Criteria:
If we miss the Inpatient Admission Outreach target, we will reduce our compensation as follows up to a reduction of $0.20 PEPM:

- $0.04 PEPM if we miss the target by ≥ 2 percent
- $0.10 PEPM if we miss the target by ≥ 5 percent
- $0.20 PEPM if we miss the target by ≥ 10 percent

High Cost Claimant Screening

Guarantee:
We will guarantee that 95 percent of members with claims in excess of $125,000 will be screened for case management.

Aetna One® Flex book of business results will be used to reconcile this guarantee annually.

Penalty and Measurement Criteria:
If we miss the High Cost Claimant Screening target, we will reduce our compensation as follows up to a reduction of $0.20 PEPM:

- $0.04 PEPM if we miss the target by ≥ 2 percent
- $0.10 PEPM if we miss the target by ≥ 5 percent
- $0.20 PEPM if we miss the target by ≥ 10 percent

Utilization Management Touch Rate Guarantee:
We will guarantee that 90 percent of all inpatient stays, excluding non-high risk maternity stays, will be touched by at

least one Utilization Management (UM) program.

Note: We offer several utilization management programs for members who have been (or will be) admitted to a hospital. A patient may have any, all or none of the programs extended based on a variety of criteria. Despite the possibility of having more than one program administered for a single inpatient stay, the utilization management touch rate only reflects a single program or "touch" by our nurses. For example, if member 1 had concurrent review, member 2 had concurrent review and discharge planning, and member 3 had no programs, then the touch rate would be 2 touched members divided by 3 inpatient stays, or 66.7 percent.

Aetna One® Flex book of business results will be used to reconcile this guarantee annually.

Penalty and Measurement Criteria:
If we miss the UM Touch Rate target, we will reduce our compensation as follows up to a reduction of $0.20 PEPM:

- $0.04 PEPM if we miss the target by ≥ 2 percent
- $0.10 PEPM if we miss the target by ≥ 5 percent
- $0.20 PEPM if we miss the target by ≥ 10 percent

Depression Screening

Guarantee:
We will guarantee that 90 percent or more of members 18 years or older that agree to engage in the Case Management program will be screened for depression.

Aetna One® Flex book of business results will be used to reconcile this guarantee annually.

Penalty and Measurement Criteria:
If we miss the Depression Screening target, we will reduce our compensation as follows up to a reduction of $0.20 PEPM:

- $0.04 PEPM if we miss the target by ≥ 2 percent
- $0.10 PEPM if we miss the target by ≥ 5 percent
- $0.20 PEPM if we miss the target by ≥ 10 percent

Member Satisfaction Surveys

Guarantee:
We will guarantee an overall positive response rate of 90 percent or better on the following medical management program survey(s) administered during the Guarantee Period. The survey assumes a 5-point scale with the top 3 responses viewed as positive. The survey(s) are based on a statistically valid, randomly selected sample size of participants ages 18 to 64. The survey(s) will be administered on a book of business basis. Results are available on a calendar year basis only.

- Aetna One® Flex
- 24-Hour Nurse Line
- Aetna Enhanced Maternity Program

Member satisfaction surveys will be administered for each individual program and then averaged equally across the surveys to derive one overall member satisfaction survey result (for instance, for a customer offerings 3 surveys each result would be blended equally 33.3 percent.

A minimum of two member satisfaction surveys must be administered. The survey results must be blended together to derive one member satisfaction rate that will apply to all surveys administered. For example: The Aetna Maternity survey generates a 92 percent satisfaction level and the 24 hour nurse line survey generates an 88 percent satisfaction level. The guarantee would be considered “Met”, as the blended average is 90 percent.

Customer specific surveys are available for an additional charge. A statistically valid number of responses is required to guarantee customer specific results (usually at least 100 completed surveys). If a statistically valid response is not achieved, the guarantee will default to the book of business result.

Penalty and Measurement Criteria:
If we miss the member satisfaction target, we will reduce our compensation as follows up to a maximum reduction of $0.10 PEPM:

- $0.02 PEPM if we miss the target by ≥ 2 percent
- $0.05 PEPM if we miss the target by ≥ 5 percent
- $0.10 PEPM if we miss the target by ≥ 10 percent

Aetna Enhanced Maternity Program

Participation Rate

Guarantee:
We will guarantee a participation rate of 90 percent or better in our Aetna Enhanced Maternity Program. The calculation will be determined as follows:

$$\frac{\text{Participating members*}}{\text{All members identified and confirmed as pregnant}}$$

* Cumulative unique members who are participating in the program. (Includes members enrolled in any level of the program: case managed, fulfillment only and unable to reach).

The numerator includes those members who are unable to be reached via phone, as they will continue to receive program materials. The denominator includes all members who are confirmed as being pregnant.

Results are calculated on a book of business basis.

Penalty and Measurement Criteria:
If we miss the Participation Rate target, we will reduce our compensation as follows up to a maximum reduction of $0.25 PEPM:

- $0.05 PEPM if we miss the target by ≥ 2 percent
- $0.13 PEPM if we miss the target by ≥ 5 percent
- $0.25 PEPM if we miss the target by ≥ 10 percent

Engagement Rate

Guarantee:
We will guarantee an engagement rate of 85 percent or better in our Aetna Enhanced Maternity Program. The calculation will be determined as follows:

$$\frac{\text{Engaged members*}}{\text{All members stratified for appropriate risk levels **}}$$

* The numerator includes all cumulative unique members who are actively working with a case manager for the following stratification levels: 1. High Risk, 2. At Risk, 3. Supportive.
** The denominator includes all members who have completed the enrollment process for the following stratification levels: 1. High Risk, 2. At Risk, 3. Supportive.

Results are calculated on a book of business basis.

Penalty and Measurement Criteria:
If we miss the Engagement Rate target, we will reduce our compensation as follows up to a maximum reduction of $0.25 PEPM:

- $0.05 PEPM if we miss the target by ≥ 2 percent
- $0.13 PEPM if we miss the target by ≥ 5 percent
- $0.25 PEPM if we miss the target by ≥ 10 percent

Postpartum Depression Screening

Guarantee:
We will guarantee that 88 percent of cases managed in our Aetna Enhanced Maternity Program where participants meet criteria for postpartum outreach, will have an outbound member call (success or attempt) completed for postpartum depression following the member's delivery date.

Results are calculated on a book of business basis.

Penalty and Measurement Criteria:
If we miss the Postpartum Depression Screening target, we will reduce our compensation as follows up to a maximum reduction of $0.25 PEPM:

- $0.05 PEPM if we miss the target by ≥ 2 percent
- $0.13 PEPM if we miss the target by ≥ 5 percent
- $0.25 PEPM if we miss the target by ≥ 10 percent

We guarantee that your allowed guarantee period claims will not exceed your prior (base) year claims by the trend percentages shown below.

Allowed claims are the portion of the providers' billed amount considered eligible for benefits determination after discount. This amount is prior to application of any benefits provisions such as copays, deductibles, etc.

Year One (January 01, 2024 - December 31, 2024)		
Proposed Aetna enrollment of 4,153 subscribers / 7,924 members in Projection for the Guarantee Period (2024)		Factors
Base Year Medical Incurred Claims (per member per year)		
Trend Factor	X	[redacted]
Year 1 Projected Claim Target (per member per year)	=	
Net Effective Trend		

Outlined below are the definitions of the items in the table(s) above.

We guarantee your net effective trend for the 12 month guarantee period from January 01, 2024 through December 31, 2024 and processed through July 01, 2025. Your active, COBRA, pre-65 retiree, and disabled subscribers are included in this guarantee. Dollar amounts shown are for clarifying purposes only.

Base Year medical incurred claims: The base year medical incurred claims for year 1 are for the period January 01, 2023 through December 31, 2023 and paid through July 01, 2024.

We will finalize your base year medical incurred claims using the data in our system.

To ensure that we are comparing the base and projection years on the same basis, we adjust base year claims for:

- Differences in member to employee ratios from the baseline period to the projection period
- Changes in demographics and geography
- The increase in medical costs that comes with increases in your COBRA, pre-65 retiree, and disabled enrollment
- We reserve the right to adjust base period claims used to develop the target claims PMPM to account for the anticipated impact of novel conditions as noted in the conditions for the guarantee. These adjustments would be applied to normalize the base period for the projected impact of these conditions.

If Aetna medical trends for group plans increase by more than two percentage points, we adjust the base period claims in each guarantee period by this difference.

We reserve the right to adjust the reconciliation period claims to account for the impact of novel conditions as noted in the conditions for this guarantee.

Trend factor: Your trend factor is guaranteed at the time of quotation.

	Actual Claims PMPY vs. Projected Claims PMPY	Fee Adjustment	Maximum Period Adjustment
Our Payout	> 100%	2.0% fee reduction to the per-employee, per month fee for each full 1.0% of difference of actual claims above the target claims plus the corridor	25%
Risk Free Corridor	< =100%	No Adjustment	N/A

Claim Target Guarantee Maximum

The maximum Claim Target Guarantee adjustment will be equal to 25 percent of the actual collected administrative for the applicable guarantee period. Administrative service fees exclude:

- Care Management program fees at risk
- Allowance(s)
- Fee Credit
- Any charges for services performed, which are not included on the monthly administrative service fee bill

Financial Assumptions

We reserve the right to revise or remove the guarantee if any of the following benefit plan conditions are not met. Your plan design includes:

- Steerage from emergency room to urgent care facilities and/or walk in clinics
- Steerage from hospital based services to free standing facilities
- Steerage to more cost effective radiology providers through our Enhanced Clinical Review program

You include the following Medical Management Program(s):

- Aetna Concierge
- MedQuery
- Aetna One® Flex
- Personal Health Record

You provide financial incentives to encourage subscribers and eligible family members to take part in yearly health risk assessments and have biometric screenings that are right for them. We'll provide you with the tools. Our online health assessment model is part of your offering. We'll even help you organize onsite biometric screenings and manage the incentives that you choose to offer your subscribers.
You can choose to use an outside vendor for health risk assessment or biometric screenings. However, that vendor must share the results with us through data feeds and support programs such as disease management and MedQuery. Additional charges may apply.

Conditions for the guarantee

We reserve the right to revise or remove the guarantee if any of the following conditions are not met:

- Novel Conditions and Circumstances: This offer does not contemplate the changes in costs, utilization, risk or any form or type of testing associated with novel conditions or circumstances affecting broad populations that place a significant strain on the health care system and/or your plan(s). These conditions include but are not limited to COVID-19. We reserve the right to adjust the terms and factors of this guarantee in response to these conditions and/or circumstances if necessary.
- Accurate Information: We rely on information from you and your representatives in creating and reconciling the terms of this guarantee. If any of this information is inaccurate, it may have an impact on the net effective trend.
- Full Replacement: We are the full replacement vendor for medical and pharmacy coverage,
- Minimum Enrollment: A minimum of active employees are enrolled in the quoted Aetna self-funded medical products.
- Group Size Variation: A total of 4,153 active, cobra, and retiree employees are expected to be enrolled in the quoted medical products. Aetna may revisit the structure or conditions of this guarantee if the enrollment varies by more than 10 percent from the assumed enrollment during the contract year; or if the assumed enrollment by plan varies by more than 10 percent during the contract year.
  Of this assumed enrollment, the combined enrolled COBRA, pre-65 retirees, and disabled employees does not vary by more than two percent of the total Aetna covered group from the originally assumed enrollment.
  In addition, we assume that the combined enrolled COBRA, pre-65 retirees, and disabled employees will not comprise more than five percent of the total Aetna covered group.
- Cost Factor Variation: The change in the projected cost factors related to the combination of geography, age, and gender in any site with at least 100 employees enrolled is less than 5 percent.
- Minimum Contribution Percentage: You contribute at least 50 percent of the total cost at each tier rate and your

Claim Target Guarantee	Effective Date: January 01, 2024

contribution percentage does not decline by more than 5 percentage points from the base plan year, 2023, by product.

- Employee Contribution Rates: You set employee contribution rates for each plan according to its benefit value relative to all other plans offered.
- Minimum Plan Participation: At least 75 percent of eligible employees must participate in your plan or at least 50 percent when excluding those providing proof of enrollment in a spouse's plan.
- Large Claims: Claims per member per year paid in excess of $100,000 are excluded from the total incurred claims of both the base year and the guarantee period.
- Benefit Plan Changes: There are no changes to the products, programs, current or proposed benefit plans, and there is no change in government laws or regulations that have a material impact on claim cost. Plan design options should provide a suitable number of plan designs that are equal to or less rich than the plan designs offered in the base year.
- Group Composition: You do not have any acquisitions or divestitures.
- Involuntary Terminations: We do not include subscribers whose continuation in Aetna's benefit options stems from an involuntary termination occurring after the effective date in this guarantee.
- In-Network Utilization: Your Aetna medical plans maintain a minimum in-network claim dollar utilization of 90 percent during the guarantee period.
- Out of network reimbursement: You continue to offer the same out of network reimbursement strategy for the base year and the guarantee year.
- Pharmacy Claims: Pharmacy and Specialty Pharmacy claims are excluded.
- Subrogation: Our subrogation services through a third party vendor are included.
- We cannot Offer this guarantee with Aggregate Stop Loss Coverage.
- Other Included Guarantees: We cannot offer this guarantee with Aggregate Stop Loss coverage.
- Coverage Termination: The Medical Claim Target Guarantee is considered met if our medical coverage is terminated by you prior to December 31, 2024.

APPENDIX II
ONSITE HEALTH COACH/ONSITE HEALTH CONCIERGE

1. AETNA'S RESPONSIBILITIES:

(A) Employment status: The
a. Onsite Support Technician (OST); or
b. Onsite Health Concierge (OHC)
is a full-time employee of Aetna, and is not an employee of the Customer. Aetna shall be liable for providing all wages and benefits, including health insurance that meets at least the minimum requirements of the Affordable Care Act. Aetna warrants that it shall comply with all federal and state employment laws, and shall indemnify the Customer for Aetna's failure to comply with any such employment laws. In the event the Customer is deemed an employer of an OST or OHC under Federal or State law by a Federal or State agency or court of law, Aetna shall indemnify the Customer for all such claims, actions, damages, fees, fines, penalties, defense costs, suits or liabilities which arise out of or are connected to such determination.

(B) Replacement of OST or OHC: If after the OST/OHC begins providing on-site support services, the OST/OHC fails to provide services required under the Agreement, or fails to abide by Polk County's rules and civility requirements, the Customer shall notify Aetna. Any such failure shall be deemed a breach of this Agreement. If the breach is not rectified within three (3) business days, Aetna shall remove the OST/OHC and a new OST/OHC shall be provided. An interim OST/OHC will be provided if a full-time OST/OHC is not on-site within two weeks.

(C) Service hours: Aetna shall provide on-site support services through an OST/OHC during the normal day shift hours of operation, Monday through Friday, excluding Aetna-observed holidays and mutually agreed off-site service periods, for a total of forty (40) service hours per week. Aetna may have the OST/OHC perform other duties as requested by the Customer and agreed upon by Aetna within the limits of time (40 hours a week) and responsibilities for one Aetna employee.

(D) Emergency Activation: From time to time, the Customer may declare an "Activation" due to a hurricane, tropical storm, or other natural disaster. Under an Activation, on-site OST service hours can be extended by the Customer until the Activation is concluded. Aetna will make reasonable efforts to meet the on-site OST/OHC service hours to the extent the Customer declares an Activation and it extends OST on-site service hours, the OST/OHC on-site service hours during the week following conclusion of the Activation shall be reduced by the commensurate on-site service hours that OST/OHC were provided during the Activation, if the number of on-site service hours exceeded forty (40) hours during the week(s) the Activation was in effect.

(E) Site Specific Responsibilities and Scope:

The Onsite Support Technician (OST) will be a dedicated Aetna employee assisting the customer in the area of targeted health and wellness initiatives, implementation and participation by members in Aetna medical management programs and collaboration with the informatics consultant to provide trend analysis.

The OST will have the following roles and responsibilities:

- Assist the Customer's staff in navigating through the Aetna organization in regard to programs and services available to them.
- Assist the Customer's staff with member eligibility issues and updates, as needed.
- Communicate/discuss identified trends that need to be addressed by the organization in regard to disease prevalence.
- Assist the Customer in developing targeted wellness initiatives based upon needs of the organization. Avoid the one size fits all approach and drill down to most immediate need by year.
- Work with existing wellness director/ network of ambassadors in accomplishing established wellness goals.
- Assist the Customer with wellness educational programs.
- Work with Customer to customize communication materials related to clinical and wellness initiatives, including social media.
- Assist the Customer with operations of Customer's fitness facilities, as needed.
- May provide outreach to the Customer's employees identified on data analysis who would benefit from certain Aetna programs but are not engaged, i.e. maternity management, disease management. OST will coach employee regarding program benefits, etc.
- OST, in conjunction with AetInfo, will assist with the analysis of monthly/quarterly reporting and will participate in onsite customer meetings.
- OST will participate in all projects related to the implementation of the Customer's initiatives to provide clinical insight and assure seamless implementation of these initiatives.

- OST will act as a subject matter expert for all associates in regard to any Aetna clinical program.
- OST will work with the account management team to facilitate clinical pre-authorizations for services, when necessary.
- OST will work in conjunction with the account management team on monitoring activity and trends within the Customer's population to ensure a positive working relationship with customer.

The OHC will have the following roles and responsibilities:

- OHC will assist Customer's staff with escalated member issues and questions.
- OHC will work directly with Customer's membership to resolve claim issues, billing questions, and general medical and dental benefit inquiries.
- OHC will work with the account management and customer service teams to identify trends in member calls and assist with problem resolution.
- OHC will attend Open Enrollment meetings and health fairs to assist in explaining member's health benefits.
- OHC will attend monthly new hire trainings to explain benefit plan offerings and answer questions.

(F) Workplace Policy Compliance: All Aetna employees shall comply with the following policies while at the Customer's workplace:

(1) Smoking – Smoking is not permitted inside any Polk County facility. Smoking is restricted to designated smoking areas outside a facility.

(2) Parking – Aetna employees shall abide by all parking restrictions. Aetna employees' vehicles are subject to the same restrictions, limitations, fines and tickets as posted for any other vehicle. Where time limit restrictions exceed the required time to provide services, arrangements shall be made in advance.

(3) Alcohol/Drugs – Aetna employees under the influence of alcohol and/or non-prescription drugs are not permitted to work in the Customer facilities. Any person known or thought to be under these influences will be escorted off the Customer property.

(4) Security - Aetna employees must adhere to all of the Customer's security procedures. Each Aetna employee must be legally authorized to perform work in the United States.

2. CUSTOMER'S RESPONSIBILITIES:

a. Work Environment: During the term of the Agreement, the Customer shall commit to the following:

(1) Provide a clean, business type atmosphere for the OST and OHC to work in with appropriate work accommodations and office equipment and furniture.

(2) Provide free access to telephone equipment and long distance when used strictly for purposes of calling for additional support or information in resolution of a County problem or condition.

(3) Use of an administration type desktop workstation on the system being supported for administrative type duties, licensed with the appropriate software. (Aetna will supply the OST and OHC with a current model laptop for all other computer operations and mobile support).

SCHEDULE C
MEDICAL SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA-811370 (MEDICAL)
EFFECTIVE January 1, 2024

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

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

I. CLAIM FIDUCIARY

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

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

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

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

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

III. ADDITIONAL AUDIT GUIDELINES

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

IV. CARE MANAGEMENT SERVICES

1. Utilization Management:

a. Inpatient and Outpatient Precertification:

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

b. Concurrent Review:

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

c. Discharge Planning:

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

d. Retrospective Review:

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

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

2. Case Management Programs:

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

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

Aetna targets two types of case management opportunities:

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

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

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

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

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

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

3. Specialty Case Management Programs:

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

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

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

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

4. National Medical Excellence Program®/Institutes of Excellence™ /Institutes of Quality®:

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

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

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

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

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

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

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

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

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

process. The Aetna CareEngine-Powered PHR also offers personalized messaging and alerts based on medical claims, pharmacy claims, and demographic information, and lab reports.

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

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

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

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

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

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

with RedBrick Health®. Through RedBrick Health, there is also an alternative health assessment option called RedBrick Compass™.

11. Aetna Healthy Actions℠:

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

12. Get Active℠ Program:

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

13. Enhanced Clinical Review:

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

14. Aetna Oncology Solutions℠:

The Aetna Oncology Solutions program works with medical oncologists/hematologists, either directly or through a vendor relationship, to identify factors that can make cancer care more effective, more affordable and safer for the Plan Participant. Plan Participants utilize providers who use tools and technology (data analysis and decision-support tools) to assist them with treatment using the most current medical guidelines and drug therapies considered to be best practices.

15. Lifestyle and Condition Coaching:

Lifestyle and Condition Coaching is part of a population health solution for Employees and their dependents which delivers a holistic, person-centric experience designed to promote healthier and more engaged employees, which in turn, drives improved organizational performance and cost savings.

The total health and well-being of each participant is monitored and analyzed using sophisticated and integrated clinical, consumer, behavioral and predictive analytics. A multi-disciplinary care team and digital toolset, helps participants to achieve their health and well-being goals with personalized support, and education.

The standard Lifestyle and Condition Coaching program offering includes lifestyle and condition management coaching. However, customers who choose to focus on lifestyle only or chronic conditions only may purchase standalone options including:

- Lifestyle and Condition Coaching: Lifestyle coaching
- Lifestyle and Condition Coaching: Condition coaching
- Lifestyle and Condition Coaching: Tobacco cessation

Lifestyle and Condition Coaching uses the Aetna Health Index to quantify the difference between the current and optimal health state for an individual or population. The difference between the current to the optimal health state is then scored and used to spot health improvement opportunities across an integrated health profile (e.g., unresolved Care Considerations, nonadherence to chronic medications, uncontrolled diabetes, at-risk for stroke, low-perception of health, etc.). With this approach, Plan Participants achieve a healthier lifestyle and better manage conditions like heart disease, type 2 diabetes, hypertension and obesity.

16. Member Engagement Platform:

Aetna's member engagement platform provides well-being related digital tools, programs and resources in a new comprehensive online experience designed to promote participant engagement, and includes visuals and graphics that prompt participants' interest and enthusiasm. The platform includes device integration and an online scheduling tool. Optional tools are also available, including the Rewards Center that coordinates incentive administration, and the ActiveChallenges that promote better nutrition, physical activity and weight management through team challenges.

The member engagement platform combines the following components:

- Comprehensive, proprietary health assessment
- Health Report and Health Actions
- Online digital coaching
- Personal Health Record
- Health Decision Support
- Health Trackers
- Health-related videos and online content
- Engaging tools and resources
- Social Communities
- Rewards Center
- ActiveChallenge program (buy-up option)

17. Aetna One® Care Management Programs:

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

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

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

Aetna One® Advisor is a high-touch, high tech engagement model focused on driving optimal Plan Participant health performance. The data Aetna has about each Plan Participant such as medical claims, lab values, pharmacy data, precertification requests and provider relationships is combined with information from Plan Participants regarding their preferred method of communication (i.e. phone calls, emails, text messages) to transform the health care experience and guide each Plan Participant on their path to better health. This proactive model integrates clinical support and member service. The advocate team is made up of co-located nurses, EAP/Work-life consultants, designated, concierge-level member Advocates, provider network specialists, and a care management associates. This fully integrated service and clinical team reduces the need for transfers and provides members a single point of contact who can address their needs and ambitions, while keeping them engaged over their long-term health care journey.

Aetna One® Advocate is a high-touch, high-tech customer service model that combines data driven processes with the expertise of highly-trained advocates. The data that Aetna has about each Plan Participant such as medical claims, lab values, pharmacy data, precertification requests and provider relationships is combined with information from Plan Participants regarding their preferred method of communication (i.e. phone calls, emails, text messages), and the Plan Participant is paired up with an advocate team. Advocate teams may include concierge-level benefits specialists, nurses, wellbeing professionals, and provider network experts, and are all cross-trained to provide support from benefit questions to complex care management. Advocates also work directly with other internal resources or programs, external vendors and network providers to support Plan Participant and their families.

Aetna One Basics program is a utilization management and precertification only model that carves care/case management out to the plan sponsor. With our Aetna One Basics program, we ensure each Plan Participant gets the care they need from network providers, avoid unnecessary treatment and use benefit dollars wisely. Our nurses work together to get each Plan Participant the care they need. Aetna One Basics includes coverage and eligibility reviews for precertification and utilization management including concurrent review, discharge planning and retrospective review.

18. Healing Better:

Healing Better is a coordinated program for everything members need across provider and facility selection, medication guidance, home care expectations, covered Durable Medical Equipment (DME), and support services in order to recover quickly and without complications. Eligible members will receive an initial care package that includes information related to their condition and support to order supplies on a curated CVS site specific to their recovery needs.

This program includes:

Predictive modeling to identify members early in their journey

Care Package and Product Bundle to surprise and delight our members

Digital Support Center with stories from peers that have had the procedures

Pain management support materials

Concierge Service to support higher risk members

19. Aetna Enhance

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

20. Cirrus MD

CirrusMD's text-first, anything next platform connects members directly to a live, licensed doctor. Encounters can also seamlessly shift to include video, voice and images when needed. Members consult with board-certified physicians by in-platform secure text, telephone or video via vendor website or mobile app. Members can access these services for the same cost as an office visit with a network physician in under a minute without having to schedule an appointment. This setup means members can easily access care when their PCP is not available. They do not need to travel, take time off from work or make childcare arrangements. CirrusMD's Platform Includes: Care Delivery Platform, Member online portal ("platform") with easy registration, available both on desktop and in a mobile application ("app"). On-demand consults available by in-platform text, phone, online video and mobile app Integrated visit history and visit notes. Dedicated customer support team that assists members that are having issues with the platform (web and mobile). Customer support is available for live chat messaging during business hours. Support inquiries received outside of business hours receive a reply within 24 hours. General Medical Physicians: Instant, barrier-free access to a physician. There is no chat bot or paywall in the user experience delaying care. CirrusMD's partner organization CMDPN, LLC. directly contracts with a network of licensed professionals. The number of physicians changes as membership grows. CirrusMD's licensed contracted physicians are in all 50 states and the District of Columbia.
Per consultation fee includes 7 continuous days of access to a physician at no extra charge.
No time limits on consults, allowing your employees to get care on their schedule.

To enroll on the CirrusMD platform, a member will register through the CirrusMD website or app.

V. BEHAVIORAL HEALTH SERVICES

1. Managed Behavioral Health:

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

- Inpatient Care Management provides phone-based utilization review of inpatient behavioral health (mental health and chemical dependency) admissions intended to contain confinements to appropriate lengths, assure medical necessity and appropriateness of care, and control costs. Inpatient Care Management provides precertification, concurrent review and discharge planning of inpatient behavioral health admissions. These services also include identification of Plan Participants for referral to a Behavioral Health Condition Management program.

- Outpatient Care Management includes precertification on a limited number of selected services. Where precertification is required, the request for services is reviewed against a set of criteria established by clinical experts and administered by trained staff, in order to determine coverage of

the proposed treatment. Where precertification is not required, cases are identified for Outpatient Case Management through the application of clinical algorithms.

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

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

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

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

VI. TECHNOLOGY/WEB TOOLS

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

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

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

   Health Decision Support has two options for customers. Both options offer programs for treatment, procedure and surgery decision support.
   - **Basic --** Offers 30 programs. It is available to all secure member portal registered users at no additional cost to customers or employees.
   - **Premium –** (optional additional purchase) Offers over 200 programs and plan sponsor-specific engagement reporting. Aetna Healthy Actions[SM] incentive tracking is available for program completion in the premium option.

4. **Metabolic Health in Small Bytes:**
   Metabolic Health in Small Bytes is a program promoting metabolic syndrome risk reduction and reversal. This program targets the root cause of obesity by using a holistic approach (mental, emotional, and physiological) to help Employees identify underlying reasons for their weight and what barriers may exist which impede weight loss. Classes are taught live in an online virtual classroom. The program is available in multiple formats for convenience and engagement.

5. **Aetna Second Opinion:**
   Aetna Second Opinion, powered by 2nd.MD is a virtual program that provides access to skilled medical specialists who are under contract with our vendor 2nd.MD, to provide advice and second opinions. 2nd.MD has a dedicated 1-800 telephone number, online portal and integrated app. The medical specialists made available through the 2nd.MD program are independent contractors and are neither employees nor agents of 2nd.MD or Aetna. 2nd.MD supports a Plan Participant by onboarding the Plan Participant and assigning them a nurse coordinator, vetting the appropriateness of their second opinion request, connecting the Plan Participant with a 2nd.MD medical specialist based on the Plan Participant's condition, obtaining all relevant medical records and digitizing, and coordinating the consultation and follow-up. On average, 2nd.MD can provide a plan participant with a second opinion within three days.

6. **2nd.MD Reach:**
   A comprehensive proactive outreach program that uses a plan sponsor's claims data and 2nd.MD predictive model algorithms to engage members who are on the path to a high-cost or high-impact medical event before it happens. It's a best-in-class solution that uses proven strategies to engage members who could benefit the most from a consultation with an elite specialist physician who specializes in their condition.

VII. OTHER SERVICES

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

2. **CVS Health Solutions-PLLC:**
   CVS Health Solutions-PLLC is a vendor that provides access to clinicians who are under contract with CVS Health Solutions PLLC, to provide consultations for non-urgent care and mental health needs via synchronous audio/video using web browsers. The providers made available through the CVS Health Virtual Care benefit are independent contractors and are neither employees nor agents of Aetna.

   Virtual Primary Care (VPC):
   If elected by Customer as indicated on the Medical Service and Fee Schedule, Virtual Primary Care (VPC) allows plan participants 18 and older to receive eligible in-network services through a contracted VPC telemedicine provider with a copay as low as a $0 (members enrolled in qualified high-deductible health plans must meet their deductible before receiving covered non-preventive for as low as $0).

3. **Aetna Concierge:**
   Aetna Concierge is a level of customer service that provides a dedicated team of Aetna employees to support the delivery of high-touch, tailored service for Customers. The dedicated Aetna Concierges obtain Customer-specific training in order to serve as a single point of contact across the full-spectrum of plan and benefit offerings available to Plan Participants, even if such offerings are external to Aetna.

The dedicated team is staffed with more customer service representatives than Aetna's traditional Customer Service Model, without call handle time guidelines, thereby allowing for longer, more relevant Plan Participant interactions. Aetna Concierges use their skills and training to listen for opportunities to educate and empower Plan Participants by sharing insights, providing useful information, and offering guidance through the use of Aetna tools and resources so that Plan Participants become more informed health care consumers. Aetna Concierge include a dedicated team, individual Aetna Concierges can serve as an extension of the Customer benefits team, and as an available single point of contact for Plan Participants via a dedicated, toll-free 800-number, as well as via live web chat through Aetna's secure member portal.

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

5. **Mindfulness at Work:**
   Aetna's Mindfulness at Work program is an evidence-based mind-body solution that targets Employees with stress. The program teaches evidence-based stress management skills, including mindfulness awareness, breathing techniques and emotions management. Classes are taught live in an online virtual classroom. The program is available in multiple formats for convenience and engagement.

6. **eM Life™:**
   The eM Life platform offers daily, live short-form classes, an on-demand library of audio and video content, working memory game, well-being articles, meditation timer, and an annual engagement campaign. Available via web browser and mobile devices.

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

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

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

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

   Aetna has the exclusive discretion to: (a) decide whether to pursue potential recoveries on subrogation/reimbursement claims; (b) determine the reasonable methods used to pursue recoveries

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

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

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

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

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

10. NATIONAL ADVANTAGE PROGRAM (NAP)

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

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

Through the Contracted Rates component of NAP, Aetna either contracts with third-party vendors to access their contracted rates with providers (a "**Vendor Accessed Rate**"), or directly contracts with providers (a "**Directly Contracted Rate**") (collectively, a "**Pre-Negotiated Contracted Rate")** for (i) medical claims paid under non-network indemnity plans, (ii) claims covered under the out-of-network portion of network-based plans ("**Voluntary Out-of-Network Claims**"), and (iii) claims from out-of-network providers covered as in-network benefits under the Plan because the claims are for emergency services, because the services are provided by out-of-network providers at in-network facilities, or because Aetna otherwise determines that the Plan Participant received the services out-of-network because of circumstances outside the Plan Participant's control ("**Involuntary Out-of-Network Claims**"). An Aetna Directly Contracted Rate is applied to a claim first, if available (for example, a Directly Contracted Rate is typically applicable for indemnity plans and narrow-network arrangements). If a Directly Contracted

Rate is not available, an external vendor looks for a Vendor Accessed Rate, based on a preset hierarchy of vendor contracted networks. Providers with Pre-Negotiated Rates are collectively referred to as "**NAP Providers**."

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

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

For certain eligible out-of-network claims, Aetna or its external vendor, will use a methodology for pricing professional claims that is based on typical competitive charges and/or payments for a service, adjusted for the geography in which the service was provided ("**Professional Claims Repricing**"). In the event Professional Claims Repricing is applied and a Plan Participant receives a balance bill from a provider, patient advocacy services are available to assist in order to minimize balance billing. For Voluntary Out-of-Network Claims for Professional services, the Plan Participant may be responsible for charges in excess of the re-priced rate. For Involuntary Out-of-Network Claims for Professional services, the provider may be paid up to billed charges to ensure the Plan Participant is held harmless.

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

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

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

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

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

D. **Terms and Conditions**

(i) NAP Fees

(a) The Customer's fees for the NAP program are charged as a percentage of the Savings achieved for a claim paid under NAP ("**NAP Fee**"), as described in the Service and Fee

Schedule. For purposes of calculating the NAP Fee, the following definitions shall apply:

- "**Savings**" means the difference between (i) the Reference Price, and (ii) the NAP priced amount.
- "**Reference Price**" means (i) for a facility service, the amount billed by the provider (other than where Itemized Bill Review applies); (ii) for in-network facility services where Itemized Bill Review applies, the rate for the facility service prior to removal of any non-payable charges identified as part of the claim review; (iii) for a Professional service paid using an Ad Hoc Rate negotiated by Aetna for an Involuntary Out-of-Network Claim, the amount billed by the provider; and (iv) for all other Professional services, the lesser of the billed charge or the 80th percentile of the applicable FAIR Health database, *provided* that from time to time Aetna may elect to substitute another reference database or methodology reasonably comparable to FAIR Health.

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

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

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

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

(ii) Plan Participant Information Regarding NAP

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

(iii) Customer Acknowledgements

Customer acknowledges that:

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

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

- Claims involving Medicare when Aetna is the secondary payer

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

(iv) General Provisions

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

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

SCHEDULE D
REIMBURSEMENT SERVICES
SERVICE AND FEE SCHEDULE
Flexible Spending Account (FSA)

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

Services	Service Fees
Annual Fee*	Waived
Monthly Administration Fee Per Member	[redacted]
Minimum Monthly Billing	$150 per employer per month

*Annual Fee includes upon written request: standard enrollment materials, limited to the number of eligible employees; and an electronic sample of plan document and summary plan description.

Participants, as used in this Service and Fee Schedule are defined as:

An employee in an active status

A terminated employee with a balance greater than $10.00 (Billing for terminated employees continues for three billing cycles after termination, or until the participant's balance drops below $10.)

The fees listed below are only charged if the services are applicable/performed for the Customer.

Optional Services	Fee
Onsite Enrollment Meeting Support (Less than 500 eligible or more than one meeting for groups with 500 plus eligible)	$500 per day, based on availability
Customized participant materials, co-branded debit card, and other customer communication requests	$150 per hour Statement of Work required
Customized Reporting	$150.00 per hour Statement of Work required
Election Confirmation (Reimbursement products) Lead-time: Done at the time of implementation/renewal	$0.12 Per Member Per Month
Takeover Administration (previous Plan year)	$1,000.00
Rejected/NSF Customer Funding ACH Transactions	$50 per occurrence of any Customer funding ACH pull that is rejected
Non-discrimination testing	TBD based on testing requirements

Failure to Fund Released Claims	Any funding due to PayFlex for claims paid on behalf of Company that remains unpaid after twenty (20) banking days shall be subject to a fee ("Failure to Fund Fee"). The Failure to Fund Fee shall be calculated as one-hundred twenty five (125) basis points above the three (3) month United States Dollar London Interbank Offered Rate. If such Failure to Fund Fee shall be calculated at a rate not to exceed regulatory rates, based on the average daily balance outstanding across all non-funded days.

In general, the number of Plan Participants on which the per-Participant-per-month fee is based for any month is the sum of (1) the number of Plan Participants on the first day of the Plan Year plus (2) the number of Plan Participants that have been added during the Agreement Period. This number is determined as of the first day of each month of the Agreement Period. Plan Participants who terminate during a month are included in the Plan Participant count for purposes of determining that month's per-Participant fee.

The fees shown above are based on administrative services selected. Aetna may adjust the Service Fees effective as of the date on which any of the following occurs:

(a) If, for any Service, there is a 30 % change in the number of employees participating from the number assumed in Aetna's quotation or from any subsequently reset assumptions.
(b) Change in Plan – A material change in the Plan is initiated by the Customer or by legislative action.
(c) Change in Administration – A material change in claim payment requirements or procedures, account structure or any other change materially affecting the manner or cost of paying benefits.

Late Payment Charges: In addition to any termination rights under the Agreement which may apply, if the Customer fails to provide funds on a timely basis to cover Plan benefit payments, and/or fails to pay Service Fees on a timely basis as provided in the Agreement, Aetna will assess a late payment charge in accordance with Section 218.74, Florida Statutes, Florida Local Government Prompt Payment Act. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Agreement or at law or in equity for failure to pay.
The late payment charge percentage specified above is subject to change annually upon written notice to the Customer in accordance with the Agreement.

SCHEDULE E
REIMBURSEMENT SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA-811370 (MEDICAL)
EFFECTIVE January 1, 2024

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

I. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, or state law, as applicable, the Customer will be the "appropriate named fiduciary" for the purpose of reviewing denied claims under the reimbursement account(s). It is also agreed that Aetna's responsibilities under this schedule are ministerial and Aetna has no fiduciary responsibility under this schedule.

II. CUSTOMER RESPONSIBILITIES:

1. The Customer shall provide Aetna with the necessary records of the Plan Participants covered under this reimbursement schedule, and promptly notify Aetna of any changes or corrections of such Plan Participants.

2. The Customer shall be solely responsible for the collection and administration of contributions to the Plan Participants' account.

3. The Customer shall maintain a supply of forms, which, upon the Customer's request, will be provided by Aetna, and the Customer shall distribute or make such forms available to the Plan Participants for the filing of claims for benefits or to report changes in participation.

4. The Customer shall be solely responsible for satisfying any and all reporting and disclosure requirements imposed on the reimbursement account under applicable law. When requested by the Customer, Aetna will assist Customer with such requirements.

5. The Customer shall be responsible for the final proper preparation and timely filing of the following documents, and performance and compliance with the following tests in connection with the Plan:

   (a) "Plan Document" and "Summary Plan Description";

   (b) Corporate resolution approving and adopting the Plan;

   (c) IRS Form 5500; and

   (d) Non-discrimination testing and compliance.

   The Customer acknowledges that it has the responsibility to review and approve all Plan documents 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 regardless of the role Aetna may have played in the preparation of such documents.

6. The Customer agrees to verify all deductions and annual elections and notify Aetna in writing of any changes or corrections within thirty (30) days following delivery of the Election Report (as defined below) by Aetna.

III. AETNA RESPONSIBILITIES:

1. Aetna shall assign an 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.

2. Aetna shall provide customer service support for Plan Participants by toll free telephone in accordance with its then-current policies.

3. Aetna shall provide Plan Participants with current account balance and activity information via electronic means, including web portal and call center. Periodic balance information shall be provided with Aetna's responses to submitted claims. Aetna shall not produce or mail separate periodic statements to Plan Participants.

4. Aetna shall make available to the Customer, an account history showing the name of the Plan Participant, name of payee, and amount of benefit payable based on Aetna's initial determination of the claim.

5. Upon request, Aetna shall provide the Customer with the then current administration manual for the orderly operation of the Plan as relates to the Services. Such manual may be modified by Aetna from time-to-time.

6. Aetna shall provide the Customer with forms or comparable electronic means for the enrollment and maintenance of a Plan Participant's records and for the Plan Participant's submission of claims for payment of benefits provided under the Plan.

7. Upon request, Aetna may assist the Customer, or its designated agent, by providing information relating to the preparation and filing of any report, form or document required by any state or federal agency with respect to the Plan. Aetna will also assist the Customer by providing the following:

   (a) Electronic sample of the "Plan Document" and "Summary Plan Description," when requested by the Customer;

   (b) Available information requested by the Customer in connection with the filing of the IRS Form 5500; and

   (c) Available information requested by the Customer in connection with conducting non-discrimination testing.

   Aetna shall have no responsibility or liability for the information provided or the content of any of the Customer's Plan documents regardless of the role Aetna may have played in the provision of such information or the preparation of such documents.

8. Aetna shall make the following standard reports available to the Customer at no additional cost:

(a) **Ledger Summary Report (Monthly)** – List of deposits, payments and account balances by Plan Participant account for the period and plan year to date.

(b) **Election Report (Beginning of Plan Year)** – List of elections by Plan Participant account.

(c) **Funding Notification Reports (Settlement and Production)** – Voucher-style report sent each time funding transactions are initiated.

(d) **Production and Settlement Payment Registers** – Supporting detail for the Funding Notification Report referenced above, which lists Plan Participant reimbursements by account type, plan year and division (if applicable).

Custom reports may be provided subject to feasibility and data availability for an additional cost as mutually agreed to by the parties in writing. The Customer shall be billed for programming time in accordance with the Service and Fee Schedule.

9. Where applicable and upon request of the Customer, Aetna shall provide debit cards to all Plan Participants. Debit card use shall be bound by and subject to the terms of the "Card Association Rules" as described in the "Cardholder Agreement" that Aetna provides to each Plan Participant upon card issuance.

IV. CLAIM SERVICES:

A. Claim Services:

1. Aetna shall process each claim for reimbursement made by a Plan Participant after determining that the claim for benefits is consistent with the terms of the Plan, and will make the initial determination of the amounts due and payable pursuant to the Plan.

2. Aetna shall arrange for the payment of all approved claims from funds made available by the Customer. The claim checks shall be made payable to the Plan Participant, their assignee or to such other person designated by the Plan Participant not otherwise restricted or prohibited by the Plan. The Customer authorizes Aetna to prepare and issue checks signed by Aetna from an Aetna account funded by the Customer for the purpose of paying claims. Any interest generated on such funds shall be used to pay the fees of the financial institution with respect to such account. To the extent that such interest is not sufficient to pay such fees, Aetna shall pay such fees. To the extent that such interest is in excess of such fees and it does not exceed LIBOR plus 2-percent, Aetna shall be entitled to retain such interest. Aetna will return interest in excess of these permissible amounts to the Customer and the Customer agrees that it will use such amounts consistent with applicable law. Aetna shall request payment from the Customer on a periodic basis for the total amount of reimbursements representing payment of claims. Funding shall take the form of an ACH debit that Aetna will initiate against the Customer's designated bank account. This may be the same account designated for Aetna administration fees and expense reimbursements, or may be a unique account, at the Customer's discretion. Aetna reserves the right to not release claim reimbursements until current funds are received by Aetna from the Customer. The Customer shall advise the Plan Participant of any delays in payment of any claim due to the failure of the Customer to fund a claim payment and the effect of such delay on the payment of the claim processed pursuant to this schedule. In the event that claims are released prior to funds receipt by Aetna, the Customer shall be subject to a "Failure to Fund Claims" fee as referenced in the Service and Fee Schedule.

3. All debit card transactions posted to the account, regardless of final disposition, are deemed to be claims and shall be the responsibility of the Plan and shall be funded by the Plan. Funding shall take the form of an ACH debit that Aetna will initiate against the Customer's designated bank account on each day that transactions post, which may be up to daily.

4. Following an adverse benefit determination of a claim during its initial submission, Aetna shall issue a written notification of its decision to the Plan Participant consistent with Department of Labor ("DOL") regulations or other prevailing law, which shall include: the basis for the adverse benefit determination; reference to the specific Plan provisions on which the determination is based; a description of additional information which may be required in order to perfect the claim; how to formally appeal the claim; and a general statement of rights under the Plan or prevailing law.

5. Upon receipt of an initial appeal by a Plan Participant, Aetna will evaluate the appeal and advise the Customer of Aetna's recommendation as to the determination of the claim. The Customer shall be responsible for, and has otherwise reserved unto itself, final discretionary authority to render benefit determinations, including interpreting the terms of the Plan, during the review on appeal. The Customer shall issue written notice of any adverse benefit determination to the Plan Participant and Aetna, which shall include all the requirements of applicable law.

V. ADDITIONAL ADMINISTRATION INFORMATION:

1. Billing and Payment of Administration Fees.

Administrative Fees are payable via an ACH debit which shall be initiated by Aetna thirty-one (31) days after the invoice is delivered to the Customer. Aetna shall initiate the ACH debit against an account designated for this purpose by the Customer. This may be the same account designated for contributions, or may be a unique account, at the Customer's discretion. Alternate funding methods may be available.

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'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 Agreement; or (ii) waive or release any claim or cause of action arising out of Aetna's performance or non-performance of this Agreement. Aetna shall be and will always remain liable to the Customer in accordance with applicable law for all damages to Customer caused by Aetna's negligent or wrongful performance or nonperformance of any of the services to be furnished under this Agreement.

The Customer shall promptly review and verify the accuracy of each invoice and notify Aetna in writing of any inaccuracy or discrepancy with respect to any amount referenced therein within sixty days after receipt of such invoice, failing which such invoice shall be deemed final, complete and correct for all purposes. Any payments which are not timely paid shall be subject to Late Payment Charges as indicated in the Service and Fee Schedule. In determining applicable Administrative Fees Aetna will be entitled to rely on current enrollment information provided by the Customer.

2. Communications. Any notices related to the administration of the reimbursement accounts should be directed to PayFlex Systems USA, Inc., 10802 Farnam Drive, Suite 100, Omaha, Nebraska, 68154, Attention: Chief Operating Officer.

3. **Subcontractors.** Aetna may subcontract reimbursement administration services, or may assign its obligations under this schedule to its subsidiaries or affiliates at any time without notice to the Customer.

4. **Termination.** If this schedule is terminated by either party, other than for the Customer's failure to pay Administrative Fees, Aetna agrees to continue to perform Services hereunder for up to three months thereafter in exchange for a fee paid by the Customer equal to three times the amount of the invoice for the last month prior to the effective date of termination. Such fee (and all other amounts owed to Aetna hereunder) shall be paid in full prior to further performance by Aetna.

SCHEDULE F
COBRA ADMINISTRATIVE SERVICES
SERVICE AND FEE SCHEDULE
PER OCCURRENCE
MASTER SERVICES AGREEMENT MSA- 811370 (MEDICAL)
EFFECTIVE January 1, 2024

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 4 of the Agreement.

Annual Fees	
Annual Fees	Waived
Ongoing Service Fees	
Qualifying Event Notification	[redacted]
New Hire COBRA/HIPAA General Rights Notice and Renotification	[redacted]
Late Payment Notice	[redacted]
COBRA Participant Termination Notice	[redacted]
Minimum Monthly Billing	$150.00 per month
Optional Service Fees - NOTE: **Only applicable** if the service is requested by the Customer and performed by Aetna. Optional Service Fee pricing is fixed during the Initial Term of the Agreement and are listed below for transparency.	
Annual Open Enrollment Services (*Per package with a $300.00 minimum plus postage, available after Aetna has been providing administration for a minimum of 90 days.)	$15.00 per package plus postage
Annual Open-Enrollment Election Form Processing (Service offered if the Plan Sponsor administers the open-enrollment but wants the Open Enrollment form returned to Aetna for processing.)	$5.00 per form processed
Custom Mailings (Non-Standard Notices)	$5.00 per notice
Custom Mailings (Set Up Fee)	$150.00 per hour
Manual Notification Form Processing	$10.00 per form
Summary of Benefits and Coverage Form	$0.60 per page plus postage
Non-Commencement Notice	$3.00 per notice
Optional Government Mandated Notice	$10.00 per notice
Custom Letter Fee	$250.00 flat charge (cannot be waived or reduced)
Premium Disbursement to Carriers (No Fee for remittance to Aetna)	$50.00 per carrier per remittance
Customized Reporting and Web Development	$150.00 per hour - $2,500 Minimum
Special Requests	As mutually agreed upon by the Plan Administrator and Aetna
Rejected/NSF Customer Funding ACH transactions	$50.00 per occurrence of any Customer funding ACH pull that is rejected
By the 5th working day of each month, Aetna will provide a bill for all administration from the prior month. Reports detailing the prior month's activity will also be provided for your records. PFS shall retain the 2% administrative fee on the total premium administered for COBRA Participants.	

SCHEDULE G
COBRA SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA-811370 (MEDICAL)
EFFECTIVE January 1, 2024

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

SECTION 1 - DUTIES OF THE PARTIES

Aetna Responsibilities

1.1 The Customer hereby appoints Aetna, and Aetna agrees to provide, administrative services as agreed to between the parties and as further described in this Schedule G, COBRA Services Schedule, (the "Services"). Such Services shall be performed in a good and workmanlike manner consistent with industry standards.

1.2 Aetna shall, at its expense, maintain adequate and necessary records on each Participant related to the Services. The Customer shall furnish Aetna with all information necessary for the preparation of such records. Aetna shall not be responsible for verifying the accuracy or completeness of the information provided by the Customer and the Customer shall indemnify and hold Aetna harmless from and against any claim, damage, loss or expense arising out of the inaccuracy or incompleteness of such information.

1.3 At no time shall Aetna provide legal, tax or accounting advice or services in connection with the Services. The Customer shall be responsible for obtaining any legal, tax or accounting advice they deem advisable in connection with any Customer-sponsored employee benefits from their counsel or advisor.

1.4 Aetna shall hold all funds received from the Customer, Participant or on behalf of a Participant as applicable, in an account established for such purpose at a financial institution of Aetna' choosing. Aetna shall pay all fees associated with said account.

Customer's Responsibilities

1.5 The Customer shall be responsible for any delay in the performance of the Services caused by the failure of the Customer to promptly furnish information or funds, as required, to Aetna.

1.6 The Customer shall provide Aetna with complete and accurate information including, but not limited to, proper accounting of all Participants for whom Services are provided, specific coverages and changes and corrections thereto. Aetna shall not be liable for (and Customer releases and discharges Aetna and agrees to defend, indemnify and hold Aetna harmless from and against) any and all claims, damages, losses or expenses suffered or incurred as a result of any inaccurate or incomplete information furnished by Customer to Aetna.

1.7 The Customer is responsible for maintaining reasonable internal control mechanisms as they relate to the Services that Aetna provides, including, but not limited to:

(a) The Customer having its own administration functions and controls so users are removed promptly when they no longer need access to system resources.

(b) The Customer having controls to ensure that all Aetna-generated reports and information received from Aetna are reviewed for accuracy and Participant activity on a timely basis, with any inaccuracies or discrepancies being communicated in writing to Aetna no later than thirty (30) days after such report or information is first generated by Aetna.

(c) The Customer having controls to ensure that any erroneous data is re-submitted to Aetna within thirty (30) days from the time it is first inputted erroneously.

(d) The Customer shall reconcile all cash activity to Aetna-generated reports as soon as reasonably possible (and in any event within ten (10) days after such report is first delivered by Aetna to the Customer). Customer shall advise Aetna in writing of any discrepancies or inaccuracies in connection with such reconciliation within twenty (20) days thereafter.

SECTION 2 - PAYMENTS

2.1 The Customer agrees to pay Aetna the amounts set forth in the Fee and Expense Exhibit.
Such amounts are payable via an ACH debit which shall be initiated by Aetna thirty-one (31) days after the invoice is delivered to the Customer. Aetna shall initiate the ACH debit against an account designated for this purpose by the Customer. This may be the same account designated for ACH funding, or may be a unique account, at the Customer's discretion.

Customer shall promptly review and verify the accuracy of each invoice and notify Aetna in writing of any inaccuracy or discrepancy with respect to any amount referenced therein within sixty (60) days after receipt of such invoice, failing which such invoice shall be deemed final, complete and correct for all purposes. Any payments which are not timely paid hereunder shall, at the option of Aetna, be subject to a late payment charge in accordance with Section 218.74, Florida Statutes, Florida Local Government Prompt Payment Act. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Agreement or at law or in equity for failure to pay..

2.2 If, during the term of this Agreement, any tax (other than taxes based on the net income of Aetna) or any other assessment or premium charge, shall be assessed against Aetna with respect to the Services or this Agreement, Aetna shall report the payment of such amount to the Customer and the Customer shall pay such amount directly (or reimburse Aetna for the same, at Aetna' option).

2.3 Nothing in this Schedule shall prohibit Aetna from performing any service not enumerated in this Agreement for a reasonable fee. Any such service and corresponding fee shall be provided only if agreed to by the Customer and Aetna in writing, in advance of such performance.

2.4 If the Customer, for any reason whatsoever, fails to make a required payment on a timely basis, Aetna may (in addition to its other rights and remedies), suspend the performance of the Services until such time as the Customer makes the proper remittance and otherwise delivers adequate assurance to Aetna, as reasonably determined by Aetna, concerning the Customer's performance hereunder. Aetna shall use reasonable efforts to provide the Customer with up to three (3) days prior written notice of its intention to take such action.

SECTION 3 – UNDERTAKING OF OBLIGATIONS AT DIRECTION OF CUSTOMER

3.1 Aetna shall undertake its obligations hereunder as directed by (and in accordance with instructions provide by) the Customer. Aetna shall at no time exercise any discretionary authority or control respecting the management or administration of the Plan(s), or the management or disposition of any Plan assets. On all matters involving the exercise of discretion, Aetna shall seek direction from the Customer and shall be fully protected, held harmless, and indemnified in so acting consistent with such direction. The Customer acknowledges that the timeliness of providing information and direction to Aetna is critical to the successful completion of the Services. All employee data and other relevant information will be supplied to Aetna in a timely and accurate manner using a pre-approved Aetna format. Aetna is not responsible for the actions of the Customer in processing or interpreting data provided by the Customer or the Customer's failure to provide the necessary data.

Aetna agrees to provide the following services and Customer agrees to provide all information and data as needed.

SECTION 4 - INITIAL/GENERAL COBRA NOTICE

4.1 Customer will notify Aetna in writing within thirty (30) days of new enrollees in a group health plan subject to COBRA, which notice will specify:

(a) the date and type of enrollment;

(b) the names and addresses of each new qualified beneficiary(ies), and

(c) the names and addresses of family members of qualified beneficiary(ies).

4.2 Within ten (10) business days after Aetna receives the notice described in paragraph 4.1 above, Aetna will send with proof of mailing, a letter notifying the appropriate qualified beneficiary(ies) of their right to COBRA continuation coverage upon the occurrence of a qualifying event.

SECTION 5- QUALIFYING EVENT NOTICE

5.1 Customer will notify Aetna in writing within thirty (30) days of a qualifying event occurring, which notice will specify:

(a) the date and type of qualifying event (as set forth in 26 U.S. Code Section 4980B(f)(3)(A) through (F);

(b) the names, social security numbers, addresses and birth dates of all qualified beneficiaries (and the covered Participant if not a qualified beneficiary) and their relationship to each other and to the covered Participant; and

(c) the specific group health plan(s) and combinations of such plans under which the qualified beneficiaries are entitled to COBRA continuation coverage.

5.2 Within fourteen (14) days after Aetna receives the notice described in paragraph 5.1 above, Aetna will send, with proof of mailing, a letter notifying the appropriate qualified beneficiary(ies) of their right to COBRA continuation coverage, along with an election form specifying the group health plan(s) and the cost of coverage thereof to such qualified beneficiaries.

SECTION 6 - NOTICE TO QUALIFIED BENEFICIARIES OF ENROLLMENT

6.1 Within ten (10) business days after Aetna receives a properly completed and signed election form for COBRA continuation coverage and initial payment from the qualified beneficiary(ies), Aetna will send payment coupons or invoice to such qualified beneficiary(ies), provided the election form was returned to Aetna by the qualified beneficiary within sixty (60) days of the date the election form was mailed to the qualified beneficiary, or the loss of coverage date, whichever is later. The initial premium must be postmarked within forty-five (45) days after the COBRA election. Aetna will also provide a method for automatic electronic premium payment from a qualified beneficiary's checking or savings account.

6.2 If Aetna receives an election form for COBRA continuation coverage after such sixty (60) day period has expired, Aetna will provide the affected qualified beneficiary(ies) with a notice of unavailability of coverage. Such notice shall be provided within ten (10) business days after Aetna receives the late election form.

SECTION 7 - NOTICE OF SUBSEQUENT QUALIFYING EVENT

7.1 Qualified beneficiary(ies) must notify Aetna in writing within sixty (60) calendar days after the latest of a subsequent qualifying event, which notice will specify:

(a) Name and address of the COBRA Participant entitled to extend the period of COBRA continuation coverage up to 36 months due to a second qualifying event; and

(b) The type of qualifying event.

7.2 Within ten (10) business days after Aetna receives the notice described in paragraph 7.1 above, Aetna will send, by proof of mailing, a letter notifying the appropriate qualified beneficiary(ies) of their right to such extended COBRA continuation coverage, along with an election form specifying the group health plans and the cost of coverage thereof. Aetna will provide the affected qualified beneficiary(ies) with a notice of unavailability of coverage if the event does not qualify as a subsequent qualifying event.

SECTION 8 - NOTICE OF TOTALLY DISABLED QUALIFIED BENEFICIARIES

8.1 Qualified beneficiaries must notify Aetna within sixty (60) calendar days after the latest of (a) the date of the Social Security Administration's disability, (b) the date of the covered employee's termination of employment or reduction of hours; and (c) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours. Such notice must be provided within (18) eighteen months after the covered employee's termination of employment or reduction of hours. By providing Aetna with this notice, the qualified beneficiary certifies that the qualified beneficiary is entitled to up to 29 months of COBRA continuation coverage.

8.2 Within ten (10) business days after receiving the foregoing letter. Aetna will determine the qualified beneficiary's ability to extend coverage as described in 26 U.S. Code Section 4980B(f)(2)(B)(i). Upon determination, Aetna will send a letter notifying the totally disabled qualified beneficiary of their ability to extend the maximum period of continuation coverage to 29 months. Aetna will also provide notice to the disabled qualified beneficiary of the increase in premiums to 150% for months 19 through 29 if the Customer elects to charge additional premium. Aetna will provide the affected qualified beneficiary with a denial notice if it is determined that coverage cannot be extended.

SECTION 9 - NOTICE OF EXPIRATION OR TERMINATION OF COBRA CONTINUATION COVERAGE

9.1 Aetna will notify COBRA Participants of the date of termination of their COBRA continuation coverage within ten (10) business days following the date Aetna learns of one or more of the following reasons for termination of COBRA continuation coverage:

(a) failure of the COBRA Participant to timely pay the correct premium for COBRA continuation coverage;

i. For purposes of this Schedule "timely pay" means the initial premium payment is made within forty-five (45) calendar days from the date of the COBRA election, thereafter premium payments will be considered timely if they are made within a thirty (30) calendar day grace period after the first day of the coverage period to which the premiums relate.

(b) coverage of the COBRA Participant under another group health plan, if such plan does not contain any exclusions or limitations with respect to the COBRA participant health coverage;

(c) expiration of the maximum period for COBRA continuation coverage;

(d) the Customer ceasing to provide any group health plan to any Customer employees and all of its commonly controlled trades or businesses (within the meaning of Code Section 414);

(e) the qualified beneficiary, after having elected COBRA continuation coverage, becomes eligible for Medicare;

(f) the Social Security Administrator issues a final determination that the qualified beneficiary is no longer disabled; or

(g) any other event that would cause a qualified beneficiary to lose coverage, such as filing fraudulent or false claims, omitting a material fact or making a misrepresentation of a material fact in connection with the group health plans.

9.2 If the reason for notice is the expiration of the maximum period for COBRA continuation coverage, a notice of conversion rights (if available) shall be sent 180 days prior to expiration of COBRA continuation coverage.

SECTION 10 - PREMIUMS FOR COBRA CONTINUATION COVERAGE

10.1 COBRA Participants shall make premium payments, for COBRA continuation coverage and who have made a valid election of COBRA continuation coverage, via mail to Aetna; electronic funds transfer through the Participant's bank to Aetna; or online through the Aetna website. Alternatively, Aetna may accept payments on behalf of the COBRA Participant from other third-parties. Aetna shall deposit such funds received from COBRA Participants into a custodial account established for such purpose at a financial institution of Aetna's choosing. Any interest generated on such account shall generally be at federal funds rates. Such interest shall be used to pay the fees of the financial institution with respect to such account. To the extent that such interest is not sufficient to pay such fees, Aetna shall pay such fees. To the extent that such interest is in excess of such fees,

Aetna shall be entitled to retain such interest as compensation for services provided. Premium payments collected by Aetna belong to the Customer, except that Aetna shall retain the two percent (2%) surcharge administrative fee paid by such COBRA Participants. Aetna shall act solely as an administrative collection agent for the Customer in collecting premium payments and will remit payments to the Customer, appropriate insurance carrier, or other entity directed by the Customer by the 15th day of the month following the month in which payment was received.

10.2 When premium payments are received at Aetna, Aetna will notify the appropriate insurance carriers/administrators of eligibility changes including new enrollees or terminations. When premium payments are received by the Customer, the Customer is responsible to notify appropriate insurance carriers/administrators of eligibility changes including new enrollees or terminations.

10.3 If the premium payment is deficient by an amount that is no greater than $50 or 10% of the COBRA premium amount required for that coverage period, Aetna will notify the qualified beneficiary of the deficient amount and provide him or her with a reasonable period of time (not to exceed thirty (30) days) in which to make the payment as described in 26 C.F.R. §54.4980B-8, Q/A-5(d).

10.4 Aetna will provide the Customer with a monthly summary employer census report, COBRA participant payment and refund report, COBRA participant paid through report, deficient payment report and an address update report. The Customer will notify Aetna of any errors or corrections in such reports within thirty (30) days following delivery by Aetna.

10.5 If Aetna receives written notice from the Customer of an increase in the premium amount for COBRA continuation coverage, and such notice specifies the effective date of the increase (which must be at least thirty (30) days after such written notice to Aetna), Aetna will notify the affected COBRA participants of the amount and effective date of the increase within thirty (30) business days following Aetna's receipt of such written notice from the Customer.

SECTION 11 -ANNUAL OPEN ENROLLMENT SERVICE

11.1 Where agreed upon between Aetna and the Customer, Aetna shall assist the Customer in notifying COBRA Participants of open enrollment rights. Customer shall provide benefit material to Aetna at least sixty (60) days prior to the open enrollment period.

11.2 Aetna will send a letter notifying the COBRA Participant of their open enrollment options. This mailing shall include enrollment forms and benefit communication material as provided by Customer.

11.3 The Customer will provide Aetna with a completed open enrollment document. Upon receipt of the completed open enrollment document from the Customer, Aetna will process the documents and notify the carrier(s) of any change in the enrollment status.