Approved at 10-9-19 Work Study Session
Affirm on

Meeting Date: 10-14-19

Agenda Item No:

Kitsap County Board of Commissioners

Office/Department: Human Resources
Staff Contact: Nancy Buonanno Grennan
Agenda Item Title: KC-541-19 – Aetna Life Insurance Company

Recommended Action: Move that the Board of County Commissioners approve contract with AETNA Life Insurance Company to provide administration of the County's preferred provider option. KC-541-19 - Aetna Life Insurance Company

Summary:

In 2018, the County launched a request for proposal for an administrator of the County's self-funded preferred provider option (PPO) plans. After a lengthy evaluation process, Aetna was selected as the County's new administrator beginning in January 2020. The administrative costs under this new contract represent a substantial savings (over 39% reduction in administrative fees) over the County's current PPO administration costs. Additionally, Aetna is bringing some enhanced programs to help County employees and their dependents navigate healthcare decision making. Aetna has also agreed to guarantee certain performance standards and if those standards are not met, agreed to reduce their administrative charges. The costs are estimated based upon the number of employees and per employee per month paid for administration of the plan, as follows:

Plan	Projected Enrollment	01/01/2020	01/01/2021	01/01/2022	01/01/2023	01/01/2024
Choice POS II	553	$41.60	$43.20	$44.85	$47.11	$49.46
Vision Hardware	78	$1.00	$1.03	$1.06	$1.10	$1.15

The contract amount shall commence on January 1, 2020 and terminate on December 31, 2024. The contract amount shall not exceed $1,506,194.16

Attachments:

1. Contract Review Sheet
2. Master Services Agreement
3. Attachment A - Business Associate Agreement

Fiscal Impact for this Specific Action

Expenditure required for this specific action:	$1,506,194.16
Related Revenue for this specific action:	$0.00
Cost Savings for this specific action:	$0.00
Net Fiscal Impact:	$ 1,506,194.16
Source of Funds:	Benefit Fund

Fiscal Impact for Total Project

Project Costs:	$ 1,506,194.16
Project Costs Savings:	$0.00
Project Related Revenue:	$0.00
Project Net Total:	$ 1,506,194.16

Fiscal Impact (DAS) Review

Office/Departmental Review & Coordination

Office/Department	Elected Official/Department Director	
Human Resources	Nancy Buonanno Grennan	

Contract Information			
Contract Number	**Date Original Contract or Amendment Approved**	**Amount of Original Contract Amendment**	**Total Amount of Amended Contract**
KC-541-19	Pending	$1,506,194.16	

Kitsap County
CONTRACT REVIEW SHEET
(Chapter 3.56 KCC)

A. CONTRACT INFORMATION

1. Contractor: Aetna Life Insurance Company
2. Purpose: provide administration of the County's preferred provider option
3. Contract Amount: 1,506,194.16 Disburse [x] Receive [ ]
4. Contract Term: January 1, 2020 through December 31, 2024
5. Contract Administrator: Nancy Buonanno Grennan Phone: 360-337-4824

Approved: _____ **Date** _____
Department Director

B. AUDITOR – ACCOUNTING INFORMATION

1. Contract Control Number: KC-541-19
2. Fund Name: Benefit Fund
3. Payment from-Revenue to CC/Account Nbr: 5061.5419
4. **Encumbered By** Susanne Yost **Date** 10/01/2019

C. AUDITOR'S ACCOUNTING – GRANTS REVIEW
Signature required only if contract is grant funded

1. [ ] Approved [ ] Not Approved
Reviewer N/A **Date** N/A
2. Comments:

D. ADMINISTRATIVE SERVICES DEPARTMENT – RISK MANAGER REVIEW

1. [X] Approved [ ] Not Approved
Reviewer Timothy M. Perez **Date** 10/1/2019
2. Comments:

E. ADMINISTRATIVE SERVICES DEPARTMENT – BUDGET MANAGER REVIEW
Signature required only if contract is for $50,000 or more, OR it will be signed by board of commissioners (regardless of dollar amount)

1. [X] Approved [ ] Not Approved
Reviewer Aimée Campbell **Date** 10/01/2019
2. Comments:

F. PERSONNEL DEPARTMENT – PERSONNEL DIRECTOR REVIEW
Signature required only if union or employment contract

1. [ ] Approved [ ] Not Approved
Reviewer _____ **Date** _____
2. Comments:

G. PROSECUTING ATTORNEY

1. [X] Approved as to Form [ ] Not Approved as to Form
Reviewer Jacquelyn M. Aufderheide **Date** 10/02/2019
2. Comments: Comments provided to the Contract Administrator

H. CERTIFICATION BY CONTRACT ADMINISTRATOR: THIS CONTRACT IS READY FOR CONSIDERATION BY THE AUTHORIZED CONTRACT SIGNER.
(For contract signing authority, see KCC 3.56.075)

Date Approved by Authorized Contract Signer: **Date** _____

RETURN SIGNED ORIGINALS TO: Lee Reyes @ MS- 7

MASTER SERVICES AGREEMENT

MSA -142539

This master services agreement ("**Agreement**") between **AETNA LIFE INSURANCE COMPANY**, a Connecticut corporation located at 151 Farmington Avenue, Hartford, Connecticut ("**Aetna**"), and **COUNTY OF KITSAP DBA KITSAP COUNTY**, a Washington corporation, located at 619 Division Street, Port Orchard, WA, 98366 ("**Customer**") is effective as of January 1, 2020 ("**Effective Date**").

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

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

The parties therefore agree as follows:

1. TERM

The initial term of this Agreement will be one year beginning on the Effective Date. This Agreement will automatically renew annually unless otherwise terminated pursuant to section 17 (Termination). The initial term and each successive one year renewal shall be considered an "**Agreement Period**". Pursuant to Kitsap County Code, in no event shall the term of this Agreement with renewals exceed five (5) years. The schedules may provide for different start and end dates for certain Services.

2. SERVICES

Aetna shall provide the Services described in the attached schedules.

General Administration Schedule;

Medical Service and Fee Schedule to the Master Services Agreement;

Prescription Drug Service and Fee Schedule;

Medical Services Schedule to the Master Services Agreement;

Rx Drug Services Schedule to the Master Services Agreement; and

Exhibit 1 – Health Coverage Plan of Benefits to the Master Services Agreement.

This Master Services Agreement, including incorporated schedules listed above and attached hereto, constitute the complete and exclusive contract between the parties ("Agreement") and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein.

3. STANDARD OF CARE

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

standard of care and diligence required of a fiduciary under applicable state law.

4. SERVICE FEES

The Customer shall pay Aetna the fees according to the Service and Fee Schedule(s) ("**Service Fees**"). Aetna may change the Services and the Service Fees annually by giving the Customer 90 days' notice before the changes take effect. Changes will take effect on the anniversary of the Effective Date unless otherwise indicated in the applicable Service and Fee Schedule(s).

Aetna shall provide the Customer with a monthly statement indicating the Service Fees owed for that month. The Customer shall pay Aetna the Service Fees no later than 31 calendar days after the first calendar day of the month in which the Services are provided (the "**Payment Due Date**"). The Customer shall provide with their payment either a copy of the Aetna invoice, modified to reflect current eligibility, or a copy of a pre-approved invoice which meets Aetna's billing requirements. The Customer shall also reimburse Aetna for certain additional expenses, as stated in the Service and Fee Schedule(s).

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

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

5. BENEFIT FUNDING

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

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

In the event that Aetna has exercised its right to suspend claim payments or terminate this Agreement as stated in section 17(B) (Termination), Aetna may place a stop payment order on all of the Customer's outstanding benefit checks.

6. FIDUCIARY DUTY

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

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

Claim fiduciary responsibility is identified in the applicable Schedule.

7. CUSTOMER'S RESPONSIBILITIES

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

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

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

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

(E) **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

Business Confidential Information - Neither party may use "Business Confidential Information" (as defined below) of the other party for its own purpose, nor disclose any Business Confidential Information to any third party. However, a party may disclose Business Confidential Information to that party's representatives who have a need to know such information in relation to the administration of the Plan, but only if such representatives are informed of the

confidentiality provisions of this Agreement and agree to abide by them. The Customer shall not disclose Aetna's provider discount or payment information to any third party, including the Customer's representatives, without Aetna's prior written consent and until each recipient has executed a confidentiality agreement reasonably satisfactory to Aetna.

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

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

Except for records and information already in the public domain, and that does not fall within any statutory exceptions to disclosure, in the event the County receives a public records request pursuant to chapter 42.56 RCW, the County will notify Aeta of such request, and if there is a disagreement between Aetna and the County on whether some or all of the requested records are subject to inspection and copying, the County agrees to give Aetna notification of such request and allow Aetna a reasonable time, but in no event less than fifteen (15) business days from the date the County provides written notice to Aetna of the request, to secure a court order to block release of records in accordance with RCW 42.56.540.

(A) **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.

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

10. AUDIT RIGHTS

The Customer may, at its own expense, audit Plan claim transactions upon reasonable notice to Aetna. The Customer may conduct one audit per year and the audit must be completed within 2 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 performed for the purpose of assessing the accuracy of benefit determinations must be performed at the location where the Customer's claims are processed. Customer may be provided with a copy of the claim and payment information offsite for financial statement audits of fifty (50) claims or less.

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.

In addition, pursuant to WAC 200-110-100, the state auditor, the state risk manager, or their designees, may enter Aetna's premises to inspect or conduct an 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 listed in Section 2 of this Agreement.

11. RECOVERY OF OVERPAYMENTS

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

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

Any requested payment from Aetna relating to an overpayment must be based upon documented findings or direct proof of specific claims, agreed to by both parties, and must be due to Aetna's actions or inactions. Indirect or inferential methods of proof – such as statistical sampling, extrapolation of error rate to the population, etc. – may not be used to

determine overpayments. In addition, use of software or other review processes that analyze a claim in a manner different from the claim determination and payment procedures and standards used by Aetna shall not be used to determine overpayments.

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

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

12. INDEMNIFICATION AND INSURANCE

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

(B) The Customer shall indemnify Aetna, its affiliates and their respective directors, officers, and employees for that portion of any Losses caused directly by (i) any material breach of this Agreement by the Customer including a failure to comply with the standard of care in section 3; (ii) the Customer's negligence, willful misconduct, fraud, or breach of fiduciary responsibility; (iii) the release or transfer of Plan Participant-identifiable information to the Customer or its designee, or the use or further disclosure of such information by the Customer or such designee; or (iv) in connection with the design or administration of the Plan by the Customer or any acts or omissions of the Customer as an employer or Plan Sponsor.

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

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

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

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

(F) Insurance – Throughout the Term of this Agreement, Aetna shall, at Aetna's sole cost and expense, maintain the minimum amounts of insurance coverage specified below:

(1) If required by law, Workers' Compensation Insurance with statutory limits and Employers' Liability coverage with a limit of not less than $2,000,000 per occurrence.

(2) Commercial General Liability Insurance, including contractual coverage, products and completed operations coverage with a limit of not less than $5,000,000 per occurrence in combination with an Excess Umbrella Liability coverage.

(3) Automotive Liability Insurance with a combined single limit of $5,000,000, alone or in combination with an Excess Umbrella Liability coverage.

(4) Professional liability insurance protecting Aetna and Customer from errors and omissions of Aetna in connection with the performance of Services, with minimum limits of $5,000,000 per claim.

(5) Network and Privacy Liability (Cyber Risk) coverage for unauthorized access of systems, theft of data, denial of service attacks, introduction of malicious code and regulatory fines and penalties with minimum limits of $10,000,000 per claim and aggregate.

A certificate of insurance evidencing such coverage shall be provided prior to commencement of operations or performance or at Customer's request. Aetna shall provide for thirty (30) days prior written notice to Customer in the event of cancellation, non-renewal or adverse material change in coverage if not immediately replaced.

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. RESOLUTION OF CERTAIN DISPUTES

Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, , may be brought and maintained only in the U.S. District Court for the Western District of Washington. If for any reason the U.S. District Court for the Western District of Washington lacks or rejects jurisdiction, the claim, action, or proceeding may be brought and maintained in the Superior Court of the State of Washington, pursuant to the venue provisions applicable to Kitsap County.

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**"), Chapter 70.02 RCW. No conflict of interest prohibited by RCW 48.62.121 or WAC 200-110-150 exists.

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 four (4) months' prior written notice of when such termination will become effective.90

(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 four (4)months' prior written notice of when such termination will become effective.

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

(C) **Legal Prohibition** - If any jurisdiction enacts a law or 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, the Customer may request that Aetna continue processing 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. In such event, the parties shall mutually agree upon a fee for such runoff services, which shall be paid by the Customer prior to the commencement of the runoff services. 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. Nothing in this Agreement shall be deemed to grant any additional ownership rights in the Aetna IP to the Customer.

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

If to Aetna:
Aetna
600 University Street
Seattle
WA
98101

If to the Customer:
Nancy Buonanno Grennan
619 Division Street
Port Orchard
WA
98366

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

(E) **Governing Law** - The Agreement shall be governed by and interpreted in accordance with applicable federal law. To the extent such federal law does not govern, the Agreement shall be governed by Washington State 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**.** Pursuant to WAC 200-110-060, no amendments to Participant benefits, procedures, or Plan documents shall be made without written notice to Participants at least thirty days in advance of the effective date of the change unless exigent circumstances can be demonstrated. Customer shall notify Aetna of any amendment pursuant to section 7 (Customer Responsibilities).

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

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

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

(O) **Subcontractors** -The work to be performed by Aetna under the Agreement may, at its discretion, be performed directly by it or wholly or in any part through a subsidiary, an affiliate, or under a contract with an organization of its choosing. Aetna will remain liable for Services under the Agreement. Upon request, Aetna shall provide a written list of Tier 1 subcontractors to the Customer. Tier 1 subcontractors are defined as a subset of Aetna suppliers for whom a portion of the Services provided may include direct Plan Participant contact or significant access to Plan Participant-identifiable data. Not all Aetna suppliers on the list provided are utilized in providing services to all customers or plan participants. Aetna shall make an updated Tier 1 subcontractor list available to the Customer for informational purposes, as requested by the Customer, but no more frequently than once annually, during the term of the Agreement. For the avoidance of doubt, neither Aetna's obligation to provide, nor the Customer's right to receive a Tier 1 subcontractor list under this paragraph, shall constitute a right of the Customer to pre-approve any Aetna subcontractor or a right to require Aetna to terminate any agreements (or services under any agreements) with any Aetna supplier.

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

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

COUNTY OF KITSAP DBA KITSAP COUNTY	**Aetna Life Insurance Company**
	By:
Edward E. Wolfe, Chair	Name: Karen S. Lynch
	Title: President, Aetna Life Insurance Company
Charlotte Garrido, Commissioner	
Robert Gelder, Commissioner	
ATTEST:	
Dana Daniels, Clerk of the Board	

GENERAL ADMINISTRATION SCHEDULE
TO THE
MASTER SERVICES AGREEMENT-
EFFECTIVE January 1, 2020

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

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. The Customer agrees to be bound by all of Aetna's provider agreements as amended from time to time.

(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.

MEDICAL
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2020

The Service Fees and Services effective for the period beginning January 1, 2020 and ending December 31, 2020 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement

Administrative Service Fees

Based on the package of services selected and enrollment awarded to Aetna, the per employee per month administrative services fees by plan for each of the three contract periods, as revised and quoted May 2019, are:

Plan	Projected Enrollment	01/01/2020	01/01/2021	01/01/2022	01/01/2023	01/01/2024
Choice POS II	553	$41.60	$43.20	$44.85	$47.11	$49.46
Vision Hardware	78	$1.00	$1.03	$1.06	$1.10	$1.15

- We have provided a fee guarantee for each of the first five contract periods from January 1, 2020 through December 31, 2024 for the self-funded coverages included in this proposal (each a "Guarantee Period"). The mature fees are guaranteed according to the per-employee, per-month fees as illustrated on the financial exhibit(s). If you place the products and services included in this multi-year fee guarantee out to bid, this guarantee is nullified.

- Our proposed fees are contingent upon Aetna Pharmacy being included.

- Retained Rebate Program - We have offered an alternative to our standard rebate share. Your monthly year one - year five medical fees have been reduced by $11.72 PEPM. Please note that the offsets for years four and five are shown on an illustrative basis and will be finalized in year three. This fee offset is for the period(s) January 1, 2020 through December 31, 2024.

Self Funded Fees include:

Included Services / Programs in Above Administrative Fees
Implementation, Account Management & Plan Administration

Designated Account Management Team
Designated Implementation Manager
Designated Service Center
Onsite Open Enrollment Meeting Preparation
Open Enrollment Marketing Material (Standard) Onsite Meeting Preparation
Standard ID Cards
Summary of Benefits and Coverage (SBC)
Claim Fiduciary Option 1
Aetna provides External Review
Vision Hardware Benefit
Weekly Stockpiling (Thursday ACH)
Network Services
Network Access
Institutes of Quality® (IOQ) Program
National Medical Excellence Program® - Transplant Coordination
Care Management
Aetna Maternity Management
Aetna Compassionate Care℠ Program
MedQuery Member Messaging
Preventive Care Considerations (Electronic)
Personal Health Record
Aetna In Touch Care℠ Premier – Designated
Utilization Management
Transitional Care Management
Member Resources
Aetna Health Member Website
Aetna Health Mobile App
Enhanced Customer Service Framework

Designated Service Center
Extended Service Center Hours (3 additional hours)
Aetna Concierge (includes First Impression Treatment)
MindCheck℠

Wellness
24/7 Nurse Line - Informed Health® Line
Simple Steps to Healthier Life® Health Assessment
Allowances
Implementation/Communication Allowance (Year 1) - $20,000
Communication Allowance (Ongoing) - $10,000
Reporting and Integration
Weekly Eligibiliy File Feed to Workday
Monthly Stop Loss Integration
Behavioral Health
Managed Behavioral Health
Behavioral Health Condition Management Program
AbleTo Network - subject to member cost share

Services included through the claim wire:

Claim Wire Billing Programs	***Charged through the claim wire. Not included in the PEPM fees above.***
National Advantage™ Program	We will retain 50% of savings
Standard Facility Charge Review	We will retain 50% of savings
Itemized Bill Review	We will retain 50% of savings

Teladoc General Medical Administrative Fee (PMPM)	$0.25 PMPM
Teladoc Behavioral Health Administrative Fee (PMPM)	$0.07 PMPM
Teladoc Dermatology Administrative Fee (PMPM)	$0.25 PMPM
Teladoc Per Consultation Administrative Fee	$3.00 per each Teladoc consultation
Subrogation	37.5% or recovered amount will be retained.
Coordination of Benefits and other contracted services	Up to 37.5% of recovered amounts will be retained.
Third Party Claim and Code Review Program	Up to 37.5% of recovered amounts will be retained.
Enhanced Clinical Review Program– High Tech Imaging (PMPM)	$0.35 PMPM
Enhanced Clinical Review Program – Diagnostic Cardiac (PMPM)	$0.10 PMPM
Enhanced Clinical Review Program – Sleep Management (PMPM)	$0.05 PMPM
Enhanced Clinical Review Program – Cardiac Implantable Devices (PMPM)	$0.05 PMPM
Enhanced Clinical Review Program – Interventional Pain (PMPM)	$0.00 PMPM
Enhanced Clinical Review Program – Hip and Knee Arthroplasties (PMPM)	$0.05 PMPM

Performance Guarantees – Medical

In total, we will put **15.0%** of our applicable guarantee period administrative service fees at risk through Performance Guarantees. The guarantee period administrative service fees will be calculated at the end of each guarantee period and will be based on the total number of employees actually enrolled in the plans listed below.

The guarantees described herein will be effective from January 1, 2020 to December 31, 2020 (hereinafter "guarantee period").

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

Performance Category	Target	Proposed Penalty
Implementation - Overall	Average score on evaluations of 3.0	2.0%
Implementation - ID Cards	97% within 15 business days of receiving file	2.0%
Account Management - Overall	Average score on evaluations of 3.0	2.0%
Claims Administration - Turnaround Time	14 calendar days for 90.0% of processed claims	2.0%
Claims Administration - Financial Accuracy	99%	2.0%
Claims Administration - Total Claim Accuracy	95%	2.0%
Member Services - Average Speed of Answer	30 seconds	1.5%
Member Services - Abandonment Rate	2.5%	1.5%
Total		**15.0%**

Medical Claim Target Guarantee

We guarantee Kitsap County's Net Effective Trend for the 12-month guarantee period from January 1, 2020 through December 31, 2020. Outlined below is an illustration of the calculation for the guarantee period. *Dollar amounts are shown for illustrative purposes only*.

Choice POS II		
Year One (January 01, 2020 - December 31, 2020)		
Proposed Aetna enrollment of 550 subscribers / 1331 members in Choice POS II		**Factors**
Projection for the Guarantee Period (2020)		
Base Year Medical Incurred Claims (per member per year)		$3,880
Unit Cost Relativities	X	1.0000
Medical Management and Integration Savings Factor	X	0.9674
Trend Factor	X	1.0920
Year 1 Projected Claim Target (per member per year)	=	$4,099
Net Effective Trend		5.6%

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, 2020 through December 31, 2020 and paid through July 01, 2021. Your active 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, 2019 through January 01, 2020 and paid through July 01, 2020.

We will finalize your base year medical incurred claims using the data provided to us by your prior carrier(s).

Please refer to the Addendum for the data needed.

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 plan design from baseline period to projection period
- Changes in demographics and geography
- The increase in medical costs that comes with increases in your COBRA, retiree and disabled enrollment

Unit cost relativities: The unit cost relativities refer to the differential between Aetna's and the incumbent carrier's discount (1-Aetna Discount %) / (1- Incumbent Carrier Discount %). We guarantee the unit cost relativities at the time of quotation.

Medical management and integration savings factor: The medical management and integration savings factor accounts for the decrease in medical cost due to:

- Integration of our medical, radiology, behavioral health and pharmacy programs for you; as well as the savings opportunity for pharmacy integration with your Pharmacy Benefits Manager (PBM), if applicable.
- Our clinical and cost management programs (relative to your current vendors and programs)

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

We guarantee the process and the factors for developing the projected claims as noted. We will reconcile the Claim Target Guarantee annually. Any adjustments will be determined based on the table below. The maximum penalty adjustment will be equal to 20% of actual base service fees. In no event will fees be adjusted by more than 30% due to results of the claim-based performance guarantee and all other performance guarantees combined.

	Actual Claims PMPY vs. Projected Claims PMPY	Fee Adjustment	Maximum Period Adjustment
Our Payout	> 101%	3.0% 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	20%
Risk Free Corridor	< =101%	No Adjustment	N/A

The Claim Target ASC Guarantee section of the Self-Funded Financial Package provided as Attachment A provides additional information and the caveats that are associated with claim target guarantee.

Value-Based Contracting

Introduction to Value-Based Contracting

We have a variety of different value-based contracting (VBC) arrangements with many of our Network Providers. These arrangements compensate providers to improve indicators of value such as, effective population health management, efficiency and quality care.

Value-Based Contracting Models

We have VBC arrangements ranging from bundled payments and pay-for-performance approaches to more advanced forms of collaborative arrangements that include integrated technology and case management, aligned incentives and risk sharing. Our VBC models include:

Pay for Performance (P4P). Under P4P programs, we work together with providers (doctors and hospitals) to develop and agree to a set of quality and efficiency measures and their performance impacts their total compensation.

Bundled Payments. In a Bundled Payment model, a single payment is made to doctors or health care facilities (or jointly to both) for all services associated with an episode-of-care. Bundled payment rates are determined based on the total expected costs for a particular treatment, including pre- and post-treatment services, and are set to incentivize efficient medical treatment.

Patient Centered Medical Home (PCMH). In a PCMH, a primary care doctor leads a clinical team that oversees the care of each patient in a practice. The medical practice receives data about their patients' quality and costs of care in order to improve care delivery. Financial incentives can be earned based upon performance on specific quality and efficiency measures.

Accountable Care Organizations (ACOs). In an ACO, we team up with systems of doctors, hospitals and other health care providers to help these organizations manage risk, improve clinical care management, and implement data and technology to connect providers, health plans and patients. The ACO arrangements include financial incentives for the organization to improve the quality of patient care and health outcomes, while controlling costs.

We will continue to evolve our value-based contracting arrangements over time. We employ a broad spectrum of different reimbursement arrangements with providers to advance the goals of improving the quality of patient care and health outcomes, while controlling costs.

Value-Based Contracting Example Calculations

A customers' financial responsibility under many VBC arrangement is determined based on provider performance, using an allocation method appropriate for each particular performance program. These methods include: percentage of allowed claims dollars; number of members; percentage of member months.

Examples

Pay for Performance. Percentage of allowed claims dollars:

Achieving agreed upon clinical and efficiency performance goals by comparing performance year end to performance year baseline or an industry standard.

Provider earns $100,000 performance-based compensation for the 12-month period January to December;

All plan sponsors, combined incurred $8,500,000 in claims with the provider for the 12-month period January to December;

Plan sponsor incurred $150,000 in claims with the provider for the 12-month period January to December;

Plan sponsor's share of claims costs is ($150,000/$8,500,000) = 1.7647 %. Formula: (Plan sponsor incurred claims/All plan sponsors incurred claims);

Plan sponsor's share of the $100,000 performance-based compensation is 1.7647 % * $100,000) = $1,764.70, which would be processed as a claim through ordinary self-funded banking channels.

Patient Centered Medical Home and Accountable Care Organization. Percentage of member months:

Achieving agreed upon clinical and efficiency goals as measured by performance year end to performance year baseline or an industry standard.

Provider earns $100,000 performance-based compensation for the 12-month period January to December;

All plan sponsors, combined had 100,500 member months with the provider for the 12-month period January to December;

Plan sponsor had 9,500 member months (for 850 unique members) attributed to the provider for the 12-month period January to December;

Plan sponsor's share of the member months is (9,500/100,500) = 9.4527 %. Formula: (Plan sponsor member months/All plan sponsors months);

Plan sponsor's share of the $100,000 performance-based compensation is (9.4527 % * $100,000) = $9,452.73, which would be processed as a claim through ordinary self-funded banking channels.

Patient Centered Medical Home and Accountable Care Organization. Number of Members:

In addition to Example 2 above, a quarterly Accountable Care Payment (ACP) may be made to the provider to fund activities necessary to meet the financial and clinical objectives. These are paid quarterly either during, or after the end of each quarter. The financial impact is considered in the total financial package negotiated with the provider.

We determine the attributed patients for the provider for the quarter April through June;

Plan sponsor had 850 members attributed to the provider for the quarter April through June;

ACP and FFS payments are incorporated into the final analysis of provider performance against the medical claims target;

We apply the agreed upon rate to the attributed patients; i.e. $2.00 per-member, per-month (PMPM) = $6.00 per quarter per member, to determine funding to the provider;

Plan sponsor's calculated share is $5,100 ($6.00 * 850), which would be processed as a claim through ordinary self-funded banking channels.

General

We will process any payments in accordance with the terms of each VBC arrangement. In each of the VBC models, self-funded plan sponsors reimburse us for any payment attributable to their plan when the payments are made. Each customer's results will vary. It is possible that payments paid to a particular provider or health system may be required even if the plan sponsor's own population did not experience the same financial or qualitative improvements. It is also possible that payments will not be paid to a provider even if the customer's own population did experience financial and quality improvements. A report of VBC charges to a plan sponsor will be available on a quarterly basis.

Upon request, we will provide additional information regarding our VBC arrangements.

PRESCRIPTION DRUG
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2020

The Service Fees and Services effective for the period beginning January 1, 2020 and ending December 31, 2020 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.

Pharmacy Discounts & Fees

Pricing Arrangement	Traditional
Network	Aetna National Network
Employees	553

RETAIL			
	01/01/2020	**01/01/2021**	**01/01/2022**
Brand Discount	AWP - 17.75%	AWP - 17.85%	AWP - 17.95%
Generic Discount	AWP - 82.00%	AWP - 82.20%	AWP - 82.40%
Dispensing Fee	$1.20 per script	$1.20 per script	$1.20 per script

MAIL ORDER PHARMACY/MAINTENANCE CHOICE			
Mail Benefit Type	Mandatory Maintenance Choice with Opt Out		
	01/01/2020	**01/01/2021**	**01/01/2022**
Brand Discount	AWP - 24.50%	AWP - 24.60%	AWP - 24.70%
Generic Discount	AWP - 84.00%	AWP - 84.20%	AWP - 84.40%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

AETNA SPECIALTY PHARMACY			
Network	Aetna Performance Specialty Network		
Price List	Not Applicable		
	01/01/2020	**01/01/2021**	**01/01/2022**
Discount	AWP – 18.00%	AWP – 18.10%%	AWP – 18.20%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

This offer assumes that Discounts and Dispensing Fees above are part of a 5-year guarantee (1/1/2020-12/31/2024). Guarantees for 2023 and 2024 will assume a 10-basis point increase for Retail and Specialty and a 20-basis point increase for Generics in years 4 and 5.

Rebates

REBATES (3 Tier Qualifying)			
Formulary	Aetna Standard Formulary		
Rebate Terms	Plan sponsor will receive the following guaranteed rebates:		
Retail	$103.50 Per Brand Script	$114.75 Per Brand Script	$128.75 Per Brand Script
Mail Order / Maintenance Choice	$344.50 Per Brand Script	$382.50 Per Brand Script	$427.75 Per Brand Script
Specialty Non-Hepatitis C	$742.25 Per Brand Script	$786.75 Per Brand Script	$834.00 Per Brand Script
Specialty Hepatitis C	$9,497.00 Per Brand Script	$9,497.00 Per Brand Script	$9,497.00 Per Brand Script

REBATES (2 Tier)			
Formulary	Aetna Standard Formulary		
Rebate Terms	Plan sponsor will receive the following guaranteed rebates:		
Retail	$89.75 Per Brand Script	$99.25 Per Brand Script	$111.50 Per Brand Script
Mail Order / Maintenance Choice	$328.00 Per Brand Script	$364.25 Per Brand Script	$407.25 Per Brand Script
Specialty Non-Hepatitis C	$705.75 Per Brand Script	$748.25 Per Brand Script	$793.00 Per Brand Script
Specialty Hepatitis C	$9,497.00 Per Brand Script	$9,497.00 Per Brand Script	$9,497.00 Per Brand Script

This offer assumes a 5 year guarantee. Rebates for 2023 and 2024 will be determined in 2022.

Terms & Conditions

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

- To the extent the pricing and services outlined in this document are part of a proposal to the Customer, the pricing set forth herein is valid for 90 days from the date of such offer.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Prescriptions dispensed by a Participating Retail Pharmacy shall be processed at the lower of the pharmacy's submitted Usual & Customary Retail Price, MAC (where applicable) plus a

Dispensing Fee, or discounted AWP cost plus a Dispensing Fee.

- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
    - Discount and Dispensing Fee guarantees are measured individually and reconciled in the aggregate; surpluses in one or more component guarantees may be used to offset shortages in other component guarantees.
    - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within one hundred eighty (180) days following the guarantee period.
    - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant copay and include zero balance due claims.
    - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein: compound drug claims, direct Plan Participant reimbursement / out-of-network claims, over-the-counter products, in- house pharmacy claims, and vaccines. In addition, we do not identify or administer any claims for 340B.
    - Retail pricing guarantees include claims that reflect the Usual & Customary Retail Price.
    - Single Source Generic Drugs are excluded from the Generic Discount guarantees.
    - Brand Drug Discount guarantees include Single Source Generic Drugs.
    - Prescriptions dispensed by Aetna Specialty Pharmacy are included in the Aetna Specialty Pharmacy Discount guarantee listed above.
    - Aetna has assumed 0% in-house pharmacy utilization. Aetna reserves the right to re- evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.
- Pricing and terms in this proposal assume the Customer has elected the Aetna Standard Formulary and the Choose Generics program.
- Aetna Performance Specialty Network means that Plan Participants are required to use the Aetna Specialty Pharmacy (no fills at retail allowed).
- Three-tier qualifying plan design maintains a plan design with the first tier comprised of Generic Drugs, the second tier comprised of preferred Brand Drugs, and the third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a $15.00 co-payment differential between preferred and non-preferred Brand Drugs, at least a $15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).
- Rebate guarantees may be subject to:
    - The adoption of utilization management edits for Specialty Products, including for example, Prior Authorization (PA) and Quantity Limits.
    - The adoption and maintenance of a biosimilar first plan design for Specialty Products.
    - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
    - Rebate guarantees assume that products that are not Specialty Products will not be subject to precertification or step therapy requirements, and that all drug classes included on the Aetna Standard Formulary be covered.

- The above rebate guarantees exclude:
    - OTC Claims
    - 340B Claims
    - Limited Distribution Drugs
    - The Specialty Drug category Lipid Disorder-PCSK9
    - New to Market Biosimilars
- For the purposes of rebate guarantee calculations, HIV therapeutic category will receive the Retail rebate guarantee.
- Specialty rebates will apply to specialty brand claims, excluding HIV therapeutic category, regardless of distribution channel. Specialty rebates are based on the assumption that (i) utilization management programs for the hepatitis C class, which are aligned with the product label, are implemented and maintained; and (ii) the estimated utilization mix and volume remain consistent through the term of the Agreement.
- A separate rebate guarantee applies for the specialty brand drug claims within the Hepatitis C therapeutic class for the Commercial and Exchange lines of business. Hepatitis C Minimum Rebate Guarantees are conditioned upon Harvoni, Epclusa, and Vosevi as the preferred formulary brand drugs for Hepatitis C treatment with at least 80% brand drug claim share, all other brand drugs are excluded or non-preferred, coverage is provided for all fibrosis scores (F0/F1-F4), utilization management criteria aligns with drug labeling, and client is not utilizing starter or split fill programs.
- A mailing to impacted members moving to the Aetna Standard formulary is included if a claim file is provided at least 70 days prior to the effective date.

Additional Disclosures

The Customer acknowledges that the Retail Discounts and Dispensing Fees contained in this Agreement reflect a Traditional or Lock-In pricing arrangement. Traditional or Lock-In Pricing means that the amount charged to the Customer and Plan Participants for retail network claims may differ from the amount paid to Participating Retail Pharmacy and/or Aetna's PBM subcontractor and Aetna retains the difference, in addition to any other fees or charges agreed upon by Aetna and Customer, as compensation for the pharmacy benefit management services provided to the Customer.

Aetna reserves the right to make appropriate changes to these price points if any event materially impacts Aetna's net income derived under this Agreement. Such events include (i) the termination or material modification of any material manufacturer Rebate contract, (ii) any significant changes in the composition of Aetna's pharmacy network or in Aetna's pharmacy network contract compensation rates with its pharmacy network subcontractor, CVS Health, (iii) a change in government laws or regulations,
(iv) a change in the Plan that is initiated by Customer, (v) AWP is discontinued or modified in whole or in part, or (vi) a greater than 15% change in enrollment or a material change, as defined by Aetna, in the drug utilization, plan design, geographic mix or demographic mix of the covered population from what was assumed at the time of underwriting. Aetna shall provide the Customer with at least sixty (60) days written notice of such changes together with a sufficiently detailed explanation supporting these price point changes. If sixty (60) days written notice is not practicable under the circumstances, Aetna shall provide written notice as soon as practicable.

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

Rebate Payment Terms

Rebates will be distributed on a quarterly basis by claim wire credit. Rebate allocations will be made within 180 days from the end of each calendar quarter, with payments issued to customers in the month following allocation. Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

The rebate schedule will be as follows:

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

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

Formulary Management

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

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

Other Payments

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

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with plan sponsors, including without limitation, Customer.

Aetna's PBM subcontractor may also receive network transmission fees from its network pharmacies for services it provides for them. These amounts are not considered Rebates and are not shared with plan sponsors. These amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees.

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

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

Early Termination

In the event Customer terminates the Agreement prior to December 31, 2024 (an "Early Termination") Aetna shall retain any earned but unpaid rebates as of the Early Termination date subject to any exception there to provided herein. If there is a loss of enrollment greater than 15% after year 1, Aetna may retain the earned but unpaid rebates on this enrollment loss by taking the total rebates divided by the total number of employees multiplied by the number of employees that have left Aetna. This calculation of Rebate retention is applicable to subsequent losses of enrollment and not subject to a one-time event. Termination for purposes of this condition is defined as 50 percent or greater membership reduction from the membership we assumed in this Service and Fee Schedule.

The pharmacy guarantees agreed to between the Customer and Aetna, if any, shall be considered null and void for the Plan year prior to an early termination subject to any exception thereto provided herein. In addition, there will not be any partial-year reconciliation of guarantees with loss of enrollment as outlined above.

Late Payment Charges

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

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

ii. Late payments of Service Fees: 12.0%, annual rate

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

Pharmacy Audit Rights and Limitations

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the pharmacy services schedule.

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

between the Customer and Aetna.

Aetna Specialty Pharmacy

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

Limited Distribution Specialty Products

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

Pharmacy Performance Guarantees

In total, Aetna agrees to place **$55,000** at risk through the Performance Guarantees outlined herein. Our offer assumes 553 employee lives. Aetna reserves the right to revisit the guarantees if there is a change in enrollment of more than 15%.

The guarantees described herein will be effective from January 1, 2020 to December 31, 2020 (hereinafter "guarantee period").

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

Performance Guarantee Category	Minimum Standard	Proposed Penalty
Account Management		
• Quarterly Pharmacy Utilization Reports	Within 45 days after the end of the calendar quarter	$5,000
Claim Administration		
• Claim Processing Accuracy	99.0%	$5,000
Retail Claim Administration		
• Turnaround Time – Paper Claims	97.0% within a weighted average of 5 business days of receipt and 99.5% within a weighted average of 10 business days of receipt	$5,000
Mail Order Claim Administration		
• Turnaround Time – Clean Claims	98.0% within an average of 2 business days of receipt	$5,000
• Turnaround Time – Claims Requiring Intervention	95.0% within an average of 5 business days of receipt	$5,000
• Mail Order Dispensing Accuracy	99.98%	$5,000
Member Services		
• Average Speed of Answer	30 seconds or less	$5,000
• Abandonment Rate	3.0%	$5,000
• Pharmacy First Call Resolution	95.0**%** successfully resolved on the first call	$5,000
• TAT Response of Internet Inquiries	Initial response 98.0% within 24 hours and provide a resolution to 94.0% within 3 calendar days	$5,000
• Member Satisfaction	90% or better	$5,000
Total		**$55,000**

MEDICAL SERVICES SCHEDULE
TO THE
MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2020

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

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

I. CLAIM FIDUCIARY

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

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.

In addition, pursuant to WAC 200-110-100, the state auditor, the state risk manager, or their designees, may enter Aetna's premises to inspect or conduct an audit.

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
        - 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. **Aetna In Touch Care[SM] Programs:**

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

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

These services are the basis for National Accounts Aetna In Touch Care[SM] Solutions and Aetna In Touch Care[SM] Premier offerings.

4. **Specialty Case Management Programs:**

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

  ACCP Enhanced Hospice Benefits Package - The enhanced hospice benefits package includes the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    The range of available service components options include:

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

11. **Healthy Lifestyle Coaching:**
    - **Healthy Lifestyle Coaching –** This program provides online educational materials, web-based tools and telephonic coaching interventions with a primary health coach. The program is designed to help Employees quit smoking, manage their weight, deal more effectively with stress and learn about proper nutrition and physical fitness. Support is provided through one-on-one telephonic coaching and group coaching. Additionally, Plan Participants or Employees can receive peer-to-peer support through clinically moderated online communities.
    - **Healthy Lifestyle Coaching Lite –** This program provides online educational materials, web-based tools and group coaching interventions designed to help Employees quit smoking, manage their weight, deal more effectively with stress and learn about proper nutrition and physical fitness. Support is provided through group coaching. Additionally, Employees can receive peer-to-peer support through clinically moderated online communities
    - **Healthy Lifestyle Coaching Tobacco Free -** This program provides support to Employees and dependents (18 and older) who want to stop using Tobacco. Employees work with a tobacco cessation specialist to examine

the pros and cons of kicking the habit, set a quit date, understand the mental, physical and social aspects of using tobacco, develop strategies to overcome their urges and create a plan for staying tobacco free.

- **Healthy Weight** – This program drives employee engagement, encourages healthier lifestyle choices and helps create lasting behavioral changes. The program targets the risk factors associated with being overweight so Employees and their families can change before disease develops or complications arise.

12. Simple Steps To A Healthier Life®:

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

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

13. Aetna Healthy Actions℠:

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

14. Get Active℠ Program:

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

15. Enhanced Clinical Review:

This radiology program is designed, through a clinical prior authorization process, to promote appropriate and effective use of outpatient diagnostic imaging services and procedures. Aetna will provide these services nationally and/or regionally, and interact with, free-standing radiology and/or outpatient network facilities that provide the following services: Computed Tomography/Coronary Computed Tomography Angiograph (CT/CTA), Magnetic Resonance Tomography, Magnetic Resonance Angiography (MRIs/MRAs), Nuclear Medicine and Positron Emission Tomography (PET) and/or PET/CT Fusion, Stress Echocardiography (Stress Echo), and Diagnostic Cardiac 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.

16. Newtopia

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

17. 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.

18. 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.

19. 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)

20. Aetna One® Advocate

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.

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, emergency room ("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 (in coordination with eMindful):

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.

VII. OTHER SERVICES

1. Teladoc

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

2. ALEX® Benefits Advisor

ALEX Benefits Advisor ("ABA") is an interactive, online decision support tool designed to assist employees in making their benefits elections during open enrollment. A virtual host ("ALEX") begins the session by learning about the employee so that he can tailor his approach and content to the needs of the individual. ALEX uses plain language to ask questions about topics such as family status, dependents, health care needs, lifestyle, financial status and risk tolerance – all the while avoiding insurance jargon often associated with choosing a benefits plan. The online and mobile-friendly experience includes audio, on-screen text and animations to ensure an engaging, personalized interaction.

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** (in coordination with eMindful Inc.):
   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™** (in coordination with eMindful)**:**

   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. **Peerfit®:**
   Aetna has contracted with a vendor, Peerfit®, to provide a fitness program. Customers buy access to the platform for their employees by sponsoring the program. The program would give each employee a designated amount of standard fitness classes per month in the form of a credit allowance. These credits would be distributed to Employees via the Peerfit site. These Employees would sign in to the site and look for classes or

fitness activities within a network of boutique fitness studios in their area, which would be paid for with the program credit allowance. Employees can try fitness classes without the burden of a long term commitment or contract. Any unused credits are forfeited at the end of the month, but are replenished to the designated number of credits for use in the next month.

7. ID Cards:

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

8. Subrogation Services:

Aetna will provide subrogation/reimbursement services 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.

9. National Advantage Program (NAP):

The National Advantage Program includes three components, Contracted Rates, Facility Charge Review and Itemized Bill Review. Unless otherwise agreed in writing, only the NAP components selected by the Customer in the Service and Fee Schedule will be provided by Aetna. In order to elect the Facility Charge Review or Itemized Bill Review components, the Contracted Rates component must be selected.

A. Contracted Rates Component

Through the Contracted Rates component of NAP, Aetna either contracts with third-party vendors to access their contracted rates with providers, or directly contracts with providers (collectively "**NAP Providers**") for (i) medical claims paid under non-network indemnity plans, (ii) claims covered under the out-of-network portion of network-based plans ("**Voluntary Out-of-Network Claims**"), and (iii) claims from out-of-network providers covered as in-network benefits under the Plan because the claims are for emergency services, because the services are provided by out-of-network providers at in-network facilities, or because Aetna otherwise determines that the Plan Participant received the services out-of-network because of circumstances outside the Plan Participant's control ("**Involuntary Out-of-Network Claims**").

When Aetna accesses rates through direct contracts or third-party vendors, the Provider is contractually bound not to balance bill Plan Participants. To limit balance billing for Plan Participants, contracted rates will apply even if the contracted rate exceeds the amount determined by the benefit level under the Plan.

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

B. Facility Charge Review ("FCR") Component

FCR applies to inpatient and outpatient facility claims for which a contracted rate is not available and for which the claim amount exceeds a certain threshold as determined by Aetna. Through the FCR component, Aetna establishes a reasonable charge for a Plan benefit in the geographic area where such benefit was provided to the Plan Participant ("**Reasonable Charge Amount**"). The Reasonable Charge Amount is based on the Provider's estimated cost, including an anticipated profit margin. The claim will be paid based on the Reasonable Charge Amount.

C. Itemized Bill Review ("IBR") Component

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

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

D. Terms and Conditions

(i) Access Fees

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

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

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

(ii) Plan Participant Information Regarding National Advantage Program

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

(iii) Definitions applicable to the National Advantage Program:

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

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

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

"Reference Price" means (i) for 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 charge as reported by 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.

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

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

(iv) Customer Acknowledgements

Customer acknowledges that:

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

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

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

(v) General Provisions

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

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

Rx DRUG SERVICES SCHEDULE
TO THE
MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2020

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

I. SCHEDULE TERM

The initial term of this Schedule shall be one year beginning on the Schedule Effective Date (referred to as an "Agreement Period"). This Schedule will automatically renew for additional Agreement Periods (successive one-year terms) unless otherwise terminated pursuant to the Agreement Pursuant to Kitsap County Code, in no event shall the term of this Agreement with renewals exceed five (5) years.

II. CLAIM FIDUCIARY

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

III. EXTERNAL REVIEW

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

The Customer delegates the sole discretionary authority to make the determination regarding the eligibility for external review, under the Plan, to Aetna. If an appeal is denied through the final level of internal appeal, Aetna will determine if it is eligible for ERO. Then Aetna will inform the Plan Participant of the right to appeal through

ERO. If the appeal is upheld, Aetna will inform the Plan Participant the reason for the denial. If the appeal is not eligible for ERO, Aetna will inform the Plan Participant of the reasons for the ineligibility.

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

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

IV. DEFINITIONS

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

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

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

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

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

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

"Calculated Ingredient Cost" means the lesser of:

a) AWP less the applicable percentage Discount;
b) MAC; or
c) U&C Price.

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

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

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

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

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

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

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

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

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

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

"Generic Drug" means a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that (a) is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and

interchangeable with drugs having an identical amount of the same active ingredient, or (b) is deemed by Aetna to be pharmaceutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

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

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

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

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

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

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

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

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

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

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

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

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

“Rebates” shall mean certain monetary distributions made to the Customer by Aetna under the pharmacy benefit and funded from retrospective amounts paid to Aetna (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (ii) in consideration for the inclusion of such manufacturer’s drug(s) on Aetna’s Formulary, and (iii) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain Prescription Drugs by Plan Participants.

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

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

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

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

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

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

for coverage is obtained.

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

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

V. ADMINISTRATIVE SERVICES

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

1. General Responsibilities and Obligations

a. Exclusivity

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

2. Pharmacy Benefit Management Services

a. Pharmacy Claims Processing

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

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

such DMR Claim; or (ii) the amount the Plan Participant is entitled to be reimbursed for such claim pursuant to the description of Plan benefits.

b. Pharmacy Network Management

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

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

- Aetna shall adjudicate each On-Line Claim for services rendered by a Participating Retail Pharmacy at the applicable Discount and Dispensing Fee negotiated between Aetna and the Customer. For the avoidance of doubt, the Benefit Cost paid by the Customer in connection with On-Line Claims for services rendered by Participating Retail Pharmacies may or may not be equal to the Discount and Dispensing Fees negotiated between Aetna and such pharmacies. This is considered "traditional" or "lock in" pricing.

(ii) Aetna Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Aetna Mail Order Pharmacy on its internet website and via its member services call center. The Aetna Mail Order Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Aetna Mail Order Pharmacy generally will require that medications and supplies be dispensed in quantities not to exceed a 90-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable law do not prohibit substitution of a Generic Drug equivalent, if any, for the prescribed drug, or if the Aetna Mail Order Pharmacy obtains consent of the Prescriber, the Aetna Mail Order Pharmacy

shall require that the Generic Drug equivalent be dispensed to the Plan Participant. Certain Specialty Products, some acute drug products or certain compounds cannot be ordered through the Aetna Mail Order Pharmacy. The Aetna Mail Order Pharmacy shall make refill reminder and on-line ordering services available to Plan Participants. Aetna and/or the Aetna Mail Order Pharmacy may promote the use of the Aetna Mail Order Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Aetna Mail Order Pharmacy's cost, unless otherwise agreed upon by Aetna and the Customer.

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

c. Clinical Programs

(i) Formulary Management. Aetna offers several versions of formulary options ("Formulary"). The formulary options implemented will be determined and communicated prior to the implementation date. Aetna grants the Customer the right to use the Formulary during the term of this Schedule solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. The Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary for the Plan. The Customer further acknowledges and agrees that the Formulary is subject to change at Aetna's sole discretion as a result of a variety of factors, including without limitation, market conditions, clinical information, cost, rebates and other factors. The Customer also acknowledges and agrees that the Formulary is the Business Confidential Information of Aetna and is subject to the requirements set forth in this Schedule and the Agreement.

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

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

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

(v) Aetna Rx Check Program. If purchased by the Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Aetna Rx Check Program. Aetna Rx Check programs use a rapid Retrospective DUR approach. Claims are systematically analyzed, often within 24 hours of adjudication, for possible physician outreach based on program algorithms. The specific outreach programs are designed to promote quality, cost-

effective care in accordance with accepted clinical guidelines through mailings or telephone calls to physicians and Plan Participants.

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

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

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

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

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

(viii) Aetna Rx Healthy Outcomes. If purchased by the Customer as indicated on the Service and Fee Schedule, Aetna Rx Healthy Outcomes is designed to promote drug adherence

and sustained positive health outcomes for Plan Participants who survive an Acute Myocardial Infarction (heart attack), Coronary Artery Stent Placement or Acute coronary syndrome.

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

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

d. Plan Participant Services and Programs

Internet services including the Secure Member Portal and Aetna Pharmacy Website.

Through the Secure Member Portal, Plan Participants have access to the following:

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

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

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

- Preferred Drug List and Generic Substitution List.
- Step Therapy List.

e. Rebate Administration

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

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

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

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

The Customer further acknowledges and agrees that if it is eligible to receive a portion of Rebates under this Schedule, such eligibility shall be subject to the condition that the Customer, its affiliates, representatives and agents do not contract directly or indirectly with any other person or entity for discounts, utilization limits, Rebates or other financial incentives on pharmaceutical products or formulary programs for Claims processed by Aetna pursuant to this Agreement, without the prior written consent of Aetna. Without limiting Aetna's right to other remedies, failure by the Customer to

obtain Aetna's prior written consent in accordance with the immediately preceding sentence shall constitute a material breach of the Agreement, entitling Aetna to (a) suspend payment of Rebates hereunder and to renegotiate the terms and conditions of this Agreement, and/or (b) immediately withhold any Rebates earned by, but not yet paid to, the Customer as necessary to prevent duplicative Rebates on such drugs.

VI. IMPORTANT INFORMATION ABOUT THE PHARMACY BENEFIT MANAGEMENT SERVICES

1. The Customer acknowledges that Aetna contracts for its own account with pharmaceutical manufacturers to obtain Prescription Drug Formulary Rebates directly attributable to the utilization of certain Prescription Drugs by Plan Participants who receive Covered Services. The Rebate amounts negotiated by Aetna with pharmaceutical manufacturers vary based on several factors, including the volume of utilization, benefit plan design, and Formulary or preferred coverage terms. Aetna may offer the Customer an amount of Rebates on Prescription Drugs that are administered and paid through the Plan Participant's pharmacy benefit. These Rebates are earned when members use drugs listed on Aetna's Formulary and preferred Specialty Products. Aetna determines each customer's Rebates based on actual Plan Participant utilization of those Formulary and preferred Specialty Products for which Aetna also has manufacturer Rebate contracts. The amount of Rebates will be determined in accordance with the terms set forth in the Customer's Pharmacy Service and Fee Schedule.

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

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

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

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

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

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

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

4. The Customer acknowledges that Aetna contracts with Participating Retail Pharmacies directly or through a pharmacy benefit management ("**PBM**") subcontract to provide the Customer and Plan

Participants with access to Covered Services. The prices negotiated and paid by Aetna or PBM to Participating Retail Pharmacies vary among Participating Retail Pharmacies in Aetna's network, and can vary from one pharmacy product, plan or network to another.

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

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

6. The Customer acknowledges that Aetna generally pays Participating Pharmacies (either directly or through PBM) for Brand Drugs whose patents have expired and their Generic Drug equivalents at a single, fixed price established by Aetna (Maximum Allowable Cost or MAC). MAC pricing is designed to help promote appropriate, cost-effective dispensing by encouraging Participating Pharmacies to dispense equivalent Generic Drugs where clinically appropriate. When a Brand Drug patent expires and one or more generic alternatives first become available, the price for the Generic Drug(s) may not be significantly less than the price for the Brand Drug. Aetna reviews the drugs to determine whether to pay Participating Pharmacies (or PBM) based on MAC or continue to pay Participating Pharmacies (or PBM) on a discounted fee-for-service basis, typically a percentage discount off of the listed Average

Wholesale Price of the drug (AWP Discount). This determination is based in part on a comparison under both the MAC and AWP Discount methodologies of the relative pricing of the Brand and Generic Drugs, taking into account any Rebates Aetna may receive from Prescription Drug manufacturers in connection with the Brand Drug. If Aetna determines that under AWP Discount pricing the Brand Drug is less expensive (after taking into account manufacturer Rebates Aetna receives) than the generic alternative(s), Aetna may elect not to establish a MAC price for such Prescription Drugs and continue to pay Participating Pharmacies (or PBM) according to an AWP Discount.

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

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

VII. AUDIT RIGHTS

1. General Pharmacy Audit Terms and Conditions

a. Subject to the terms and conditions set forth in the Agreement and disclosures made in the Service and Fee Schedule, the Customer shall be entitled to have audits performed on its behalf (hereinafter **"Pharmacy Audits"**) to verify that Aetna has (a) processed Claims submitted by participating pharmacies or a pharmacy benefits manager under contract with Aetna, (b) paid Rebates in accordance with this Schedule and the Service and Fee Schedule. Pharmacy Audits may be performed at Aetna's Minnetonka, MN or Hartford, CT location. In addition, pursuant to WAC 200-110-100, the state auditor, the state risk manager, or their designees, may to enter Aetna's premises to inspect and conduct an audit.

b. Additional Terms and Conditions

(i) Auditor Qualifications and Requirements specific to Pharmacy Audits

All Pharmacy Audits shall be performed solely by third party auditors meeting the qualifications and requirements of the Agreement, this Schedule and the Service and Fee Schedule. In addition the requirements set forth in section 11, Audit Rights of the Agreement, the auditor chosen by the Customer must be mutually agreeable to both

the Customer and Aetna. Auditors may not be compensated on the basis of a contingency fee or a percentage of overpayments identified, in accordance with the provisions of Section 8.207 through 8.209 of the International Federation of Accountant's (IFAC) Code of Ethics For Professional Accountants (Revised 2004).

(ii) Auditor Qualifications and Requirements specific to Rebate Audits

Any audit of Aetna's agreements with pharmaceutical manufacturers will be conducted by (a) one of the major public accounting firms (currently the "Big 4") approved by Aetna whose audit department is a separate stand alone function of its business, or (b) a national CPA firm approved by Aetna whose audit department is a separate stand alone function of its business.

(iii) Closing Meeting

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

2. Additional Claim and Rebate Audit Terms and Conditions

a. Rebate Audits

Subject to the terms and limitations of this Schedule, the Agreement, and the Service and Fee Schedule including without limitation the general Pharmacy Audit terms and conditions set forth in this section VII, the Customer shall be entitled to audit Aetna's calculation of Rebates received by the Customer as set forth below. Aetna will share the relevant portions of the applicable formulary rebate contracts, including the manufacturer names, drug names and rebate percentages for the drugs being audited. The drugs to be audited will be selected by mutual agreement of the parties. The parties will reasonably cooperate to select drugs for each audit that (a) represent the fewest unique manufacturer rebate contracts required for audit so that the selected drugs represent a maximum of 15% of the Customer's Rebates; which are attributable to the drugs most highly utilized by Plan Participants (b) shall be limited to (two) 2 consecutive quarters and (c) are subject to manufacturer rebate agreements that do not contain restrictions prohibiting Aetna from disclosing to the Customer portions of such contracts

concerning the rebates, payments or fees payable there under. Aetna will also provide access to all documents reasonably necessary to verify that Rebates have been invoiced, calculated, and paid by Aetna in accordance with this Schedule. The Customer is entitled to only one annual Rebate audit. Prior to the commencement of such audit, the Customer and auditor shall enter into a rebate audit confidentiality agreement acceptable to Aetna. In addition, pursuant to WAC 200-110-100, the state auditor, the state risk manager, or their designees, may to enter Aetna's premises to inspect and conduct an audit.

b. Pharmacy Claim Audits. Claim audits are subject to the above referenced audit standards for Rebates in the case of a physical, on-site, Claim-based audit. In the case of electronic Claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of Claims is requested and processed off-site, the Customer may elect to audit 100% of claims. The Customer is entitled to only one annual Claim audit. In addition, pursuant to WAC 200-110-100, the state auditor, the state risk manager, or their designees, may to enter Aetna's premises to inspect and conduct an audit.

TEMPORARY EXHIBIT 1 –HEALTH COVERAGE
PLAN OF BENEFITS
TO THE
MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2020

The Plan(s) described in this Temporary Exhibit are benefit plans of the Customer. These benefits are not insured with Aetna but will be paid from the Customer's funds. Until this Temporary Exhibit is otherwise modified or replaced in its entirety by agreement between Aetna and the Customer:

1. Aetna will provide certain administrative services to the Plan as outlined in the Letter of Understanding signed by Aetna.
2. Aetna will use the description of covered benefits, services and programs outlined in the Plan Design(s), including any subsequent changes agreed to by Aetna and the Customer, in the administration of the Plan(s).
3. Further, in the administration of the Plan(s), Aetna will use Aetna's standard plan General Exclusions and standard Glossary definitions of terms.

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

COUNTY OF KITSAP dba KITSAP COUNTY
ATTACHMENT A
BUSINESS ASSOCIATE AGREEMENT

HIPAA Business Associate Agreement

End of ATTACHMENT A

ATTACHMENT A
HIPAA BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement ("Agreement") is made part of the Contract between Kitsap County ("Covered Entity") and Aetna Life Insurance Company, on behalf of itself and those of its affiliates providing services in connection with this Agreement ("Business Associate") as a condition of the Contract. The parties agree as follows:

SECTION 1. PURPOSE

The Contract for Services may require the Covered Entity to make certain information available to the Business Associate for business purposes, some of which may constitute Protected Health Information ("PHI"). Accordingly, the Covered Entity is required to enter into a Business Associate Agreement with the Business Associate to protect the privacy and security of PHI pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as modified by the American Recovery and Reinvestment Act of 2009, Sec. 13400-13424, H.R. 1 (2009) and 45 CFR Part 160 and Part 164.

SECTION 2. DEFINITIONS

2.1 Business Associate means the "Contractor" and shall have the same meaning as the term "business associate" at 45 CFR 160.103. Any reference to Business Associate in this Agreement includes the Business Associate's employees, Subcontractors, independent contractors, and representatives.

2.2 Covered Entity means the "County" and shall have the same meaning as the term "Covered Entity" in 45 CFR 160.103.

2.3 HIPAA means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as modified by the American Recovery and Reinvestment Act of 2009 (ARRA), Sec. 13400-13424, H.R.1 (2009).

2.4 HIPAA Rules means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

2.5 Subcontractor means, in addition to the Contract definition, a Business Associate that uses, creates, receives, maintains, or transmits PHI on behalf of another Business Associate.

2.6 Catch-All Definition. The following capitalized terms used in this Agreement shall have the same meaning as those terms have been defined by the HIPAA Rules unless otherwise provided herein: Breach, Covered Entity, Designated Record Set, Disclosure, Electronic Protected Health Information ("EPHI"), Health Care Operations, Individual(s), Minimum Necessary, Notice of Privacy Practices,

Protected Health Information ("PHI"), Required by Law, Secretary, Security Incident, Subcontractor, Unauthorized Use, Unsecured PHI, and Use.

SECTION 3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

3.1 Compliance. Business Associate shall perform all Contract duties, activities, and tasks in compliance with HIPAA, the HIPAA Rules, and all applicable law. Business Associate acknowledges that this Agreement is intended to supplement other federal and state laws and regulations. To the extent not preempted by HIPAA, Business Associate acknowledges its obligation to comply, where applicable, with all such laws and regulations, including, without limitation, breach notification laws and laws requiring the safeguarding of such information.

3.2 Use and Disclosure. Business Associate shall Use or disclose PHI only as necessary to perform the Services specified in the Contract and in compliance with this Agreement and as required by state and federal confidentiality and security laws. Business Associate shall not Use or disclose such PHI in any manner that would violate Subpart E of 45 CFR Part 164 (Privacy of Individually Identifiable Health Information) if done by Covered Entity.

3.3 Minimum Necessary Standard. Business Associate shall make reasonable efforts to limit its Use or Disclosure and apply the HIPAA Minimum Necessary standard to any Use or disclosure of PHI as necessary to achieve the lawful purpose of the Contract. See 45 CFR 164.514(d)(1) - (d)(5).

3.4 Duty to Protect PHI. Business Associate shall implement and Use appropriate safeguards to maintain and ensure the confidentiality, privacy, and security of all PHI and comply with Subpart C of 45 CFR Part 164 with respect to EPHI to prevent unauthorized Use or disclosure of EPHI other than as provided for in the Contract or as Required by Law, for the duration that PHI is within its possession and control, even after the termination or expiration of the Contract. Business Associate shall Use, store, and transmit PHI in an encrypted format as required by the HIPAA Rules.

3.5 Use for Proper Management and Administration. Business Associate may Use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

3.6 Proper Management, Administration, and Disclosure. Business Associate may disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided such disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information shall remain confidential and be Used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in

which the confidentiality of the information has been Breached in accordance with the Breach and Security Incident notifications requirements of this Agreement.

3.7 Remuneration. Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual.

3.8 Communication. Business Associate may Use or disclose PHI to communicate about a product or service, provided that such communication is made in a manner that does not constitute marketing as defined in 45 CFR Section 164.501 or otherwise constitute a use or disclosure that Covered Entity is prohibited from performing itself.

3.9 Data Aggregation. Business Associate may Use PHI to perform Data Aggregation services, consistent with 45 CFR 164.504.

3.10 Reporting Violation of Law. Business Associate may Use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j).

3.11 De-identification. The provisions of this Agreement notwithstanding, Business Associate is permitted to de-identify PHI, provided that it does so in accordance with HIPAA de-identification rules. De-identified information does not constitute PHI, and may be Used and disclosed by Business Associate for its own purposes, including, without limitation, for purposes of developing comparative databases, performing statistical analysis and research, and improving the quality of Business Associate's products and services.

3.12 Obligations. To the extent the Business Associate is to carry out one or more of the Covered Entity's obligations under Subpart E of 45 CFR Part 164 (Privacy of Individually Identifiable Health Information), Business Associate shall comply with all requirements that would apply to the Covered Entity in the performance of such obligation(s).

3.13 Liability. Business Associate bears all responsibility for any penalties, fines, or sanctions imposed against the Business Associate for violations of the HIPAA Rules and for any imposed against its Subcontractors for which it is found liable.

3.14 Business Associate shall :

3.14.1 Provide access directly to an Individual to PHI in a Designated Record Set, at the request of Covered Entity or an Individual within thirty (30) calendar days in accordance with 45 CFR 164.524.

3.14.2 Maintain and provide to an Individual, at the request of Covered Entity or an Individual, an accounting of disclosures of PHI, within forty-five (45) calendar days in accordance with 45 CFR 164.528.

3.14.3 Make any amendment(s) to PHI in a Designated Record Set, at the request of Covered Entity or an Individual, within sixty (60) calendar days pursuant to 45 CFR 164.526.

3.15 Disclosure to Third Parties. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, Business Associate shall require that any Subcontractors, that create, receive, maintain, or transmit PHI on behalf of the Business Associate shall agree in writing to the restrictions and conditions that are no less protective than those apply to the Business Associate under this Agreement. Business Associate shall require that such Subcontractors agree to implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity. Business Associate shall be fully liable to Covered Entity for any acts, failures, or omissions of such Subcontractors providing the Services as if they were Business Associate's own acts, failures, or omissions, to the extent permitted by law. Business Associate further shall require that its Subcontractors shall be specifically advised of, and shall comply in all respects with, the terms of this Agreement.

3.16 Controller of PHI. Business Associate acknowledges that Covered Entity is the controller of PHI for purposes of all applicable privacy laws with rights under such laws to determine the purposes for which the PHI is used and disclosed, and nothing in this Agreement will restrict or limit in any way Covered Entity's rights or obligations as controller of PHI for such purposes.

SECTION 4. AUDIT AND ACCESS TO RECORDS

Audits, Inspection, and Enforcement. Upon reasonable notice and during normal business hours, Covered Entity shall have the right to inspect the facilities, systems, books, records, agreements, policies, and procedures relating to the Use and disclosure of PHI and security safeguards required herein to ensure compliance with this Agreement and HIPAA Rules. The fact that the Covered Entity inspects, or fails to inspect or inspects and fails to notify Business Associate of its deficiencies shall not constitute acceptance of any deficiency or waiver of the Covered Entity's enforcement rights under this Agreement.

4.2 Internal Practices, Books, and Records. Business Associate shall make available its internal practices, books, and records relating to the Use and disclosure of PHI received from, created, or received by Business Associate on behalf of the Covered Entity to the U.S. Department of Health and Human Services or its agents for the purpose of determining the Covered Entity's compliance with the HIPAA Rules, or any other health oversight agency, or to the Covered Entity.

SECTION 5. INDIVIDUAL RIGHTS, ACCOUNTING OF DISCLOSURES

5.1 Business Associate record keeping procedures shall be sufficient to respond to a

request for an accounting under this section for the six (6) years prior to the date on which the accounting was requested.

SECTION 6. IMPROPER USE OR DISCLOSURE OF PHI, SECURITY INCIDENT AND BREACH

6.1 Improper Use or Disclosure. Business Associate shall report to the Covered Entity in writing all Uses or disclosures of PHI not provided for by this Agreement of which it becomes aware, including Breaches of Unsecured PHI as required at 45 CFR 164.410 (Notification by a Business Associate), and any Security Incident of which it becomes aware.

6.2 Security Incident. Business Associate agrees to report to Covered Entity any Security Incident without unreasonable delay, and in no event more than ten (10) calendar days, after becoming aware that such Security Incident affects Covered Entity's information, except that, for purposes of this Security Incident reporting requirement, the term "Security Incident" shall not include inconsequential incidents that occur on a daily basis, such as scans, "pings" or other unsuccessful attempts to penetrate computer networks or servers containing EPHI maintained by Business Associate.

6.3 Mitigation. If Business Associate violates this Agreement or the HIPAA Rules, Business Associate agrees to mitigate, to the extent practicable, any damage caused by such breach.

6.4 "Breach" is defined in the Breach Notification Rule ("Rule"), 45 CFR Sections 164.400-414. The time when a Breach is considered to have been discovered is set forth in the Breach Notification Rule.

6.5 In the event of a Breach of Unsecured PHI or disclosure that compromises the privacy of PHI received from the Covered Entity, or created, maintained, or received on behalf of the Covered Entity, Business Associate shall take all measures required by federal law.

6.6 Business Associate shall notify the Covered Entity both in writing and by telephone within ten (10) calendar days of any Breach of Unsecured PHI, after becoming aware that such Breach affects Covered entity's PHI, and that may potentially compromise the security or privacy of the PHI by the Business Associate or its Subcontractors and is not authorized by this Agreement, the HIPAA Rules, or Required by Law. Such notice shall include a written explanation of the Breach, to include the following: date and time of the Breach, the date the Breach was discovered, location and nature of the PHI, type of Breach, origination and destination of PHI, detailed description of the Breach, anticipated mitigation steps, and the name, address, telephone number, fax number, and e-mail of the individual who is responsible as the primary point of contact. Business Associate shall address communications to the Contract Representative. Business Associate

shall work cooperatively with the Covered Entity and provide a copy of its investigation and any other information requested by the Covered Entity.

6.7 If Business Associate does not have full details at that time, it shall promptly report the information it has, and provide full details within ten (10)calendar days' after becoming aware of such Breach. The initial report may be oral, with a written report to be provided as soon as possible. The Business Association shall promptly provide all information required for notification pursuant to 45 CFR Sections 164.410 and 164.402, and any other information the Covered Entity reasonably requests, as soon as the information becomes available. Business Associate shall promptly notify the Covered Entity if it determines it has or may have an independent notification obligation under any federal breach notification laws and advise the Covered Entity of its intent to give notice.

6.8 If either the Covered Entity or Contractor determines that Business Associate or its Subcontractor(s) is responsible for a Breach within the meaning of the Breach Notification Rule, and notification of is required under the Breach Notification Rule, or other law or rule, then:

6.8.1 The Covered Entity may choose to make any notifications to affected Individuals, the Secretary, the media, and/or governmental agencies, or request the Business Associate to make notifications to affected Individual or the media.

6.8.2 In any case, Business Associate bears the responsibility and costs for: i) notifying the affected Individuals, and media; ii) providing all necessary information, in the format required by the Secretary, to the Covered Entity to facilitate Covered Entity's reporting of the Breach to the Secretary under 45 C.F.R. 164.408;; iii) receiving and responding to questions and requests for additional information from the affected Individuals, and the media; and iv) such other actions reasonably appropriate to protect the information as requested by the Covered Entity or required provided by Law.

6.8.3 Business Associate shall compensate the Covered Entity and others for harm caused to them by the Breach or possible Breach described above.

6.8.4 The Covered Entity will take appropriate remedial measures up to termination of the Contract.

6.9 Failure to Cure. If the Covered Entity learns of a pattern or practice of the Business Associate that constitutes a violation of the Business Associate's obligations under the terms of the Contract and reasonable steps by the Covered Entity do not end the violation, the Covered Entity shall terminate the Contract, if feasible. In addition, If Business Associate learns of a pattern or practice of its Subcontractors that constitutes a violation of the Business Associate's obligations under the terms of the Contract and reasonable steps by the Business Associate do not end the

violation, Business Associate shall terminate the Subcontract, if feasible.

SECTION 7. OBLIGATIONS OF COVERED ENTITY

7.1 Notice of Privacy Practice. Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity's notice of privacy practices agreed to in accordance with 45 CFR Section 164.520(b)(2), to the extent that such limitation(s) may affect Business Associate's Use or disclosure of PHI.

7.2 Notice of Changes. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to Use or disclose PHI, to the extent that such changes affect Business Associate's Uses or disclosures of PHI.

7.3 Notice of Restrictions. Covered Entity agrees that it will not impose special limits or restrictions on the Uses and disclosures of its PHI that may impact in any manner the Use and disclosure of PHI by Business Associate under the Contract and this Agreement, including, but not limited to, restrictions on the Use and/or disclosure of PHI as provided for in 45 CFR Section 164.522(a), unless such restrictions are required by 45 CFR Section 164.522(a). The foregoing notwithstanding, Business Associate agrees to accommodate reasonable requests for alternative means of communications pursuant to 45 CFR Section 164.522(b).

7.4 Notice of Privacy and Security Rules. Covered Entity shall not request Business Associate to Use or disclose PHI in any manner that would not be permissible under the Privacy and Security Rules if done by Covered Entity except that Business Associate may use PHI in its possession (i) for Business Associate's proper management and administrative services, or (ii) to provide Data Aggregation services to the Covered Entity as permitted by 45 CFR Section 164.504(e)(2)(i)(B).

SECTION 8. EFFECTIVE DATE AND TERMINATION

8.1 Term. This Agreement is effective when the Contract is executed by the parties and shall terminate upon expiration or termination of the Contract, unless otherwise provided herein.

8.2 Termination for Cause. The Covered Entity may terminate this Agreement if the Covered Entity determines the Business Associate has violated a material term of this Agreement. The Covered Entity may, at its sole option, offer Business Associate an opportunity to cure a violation of this Agreement before exercising a termination for cause. Termination shall be effective as of the date stated in the notice of termination.

8.3 Failure to Cure. If the Covered Entity learns of a pattern or practice of the Business Associate that constitutes a violation of the Business Associate's obligations under the terms of this Agreement and reasonable steps by the

Covered Entity do not end the violation, the Covered Entity shall terminate this Agreement, if feasible. In addition, if Business Associate learns of a pattern or practice of its Subcontractors that constitutes a violation of the Business Associate's obligations under the terms of this Agreement and reasonable steps by the Business Associate do not end the violation, Business Associate shall terminate the Subcontract, if feasible.

8.4 Return or Destruction. Upon expiration or termination of this Agreement for any reason, Business Associate shall return to the Covered Entity all PHI received from the Covered Entity, or created, maintained, or received on behalf of the Covered Entity that Business Associate still maintains in any form or, if agreed to by the Covered Entity, destroy the same, unless otherwise Required by Law. For purposes of this subsection, to destroy PHI is to render it unusable, unreadable, or indecipherable to the extent necessary to establish it is not Unsecured PHI. The Business Associate shall retain no copies of PHI unless otherwise agreed to by the parties.

8.5 Retained PHI. The Business Associate may retain only that PHI necessary to continue its proper management and administration or to carry out its legal responsibilities. In such an event, Business Associate shall:

8.5.1 Continue to use appropriate safeguards and comply with the terms and conditions of this Agreement and HIPAA Rules;

8.5.2 Not Use or disclose the PHI retained by Business Associate or any Subcontractors other than for the purposes for which such PHI was retained and subject to the terms and conditions of this Agreement; and

8.5.3 Return to the Covered Entity or destroy in compliance with subsection 8.4 the PHI retained by Business Associate when it is no longer needed for its proper management and administration or to carry out its legal responsibilities.

SECTION 9. INDEMNIFICATION

A breach of the terms and conditions of this Agreement shall be deemed a breach of the Contract for purposes of the indemnification provisions of the Contract.

SECTION 10. MISCELLANEOUS PROVISIONS

10.1 Disclaimer. The Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement will be adequate or satisfactory for Business Associate's own purpose. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

10.2 Survival. The obligations of the Business Associate under Section 8.4 and 8.5 of

this Agreement shall survive the expiration or termination of the Contract.

10.3 Regulatory References. A reference in this Agreement to a section in HIPAA, the HIPAA Rules means the section as in effect or as amended.

10.4 Amendment. The parties agree to take all actions to amend this Agreement from time to time as is necessary to remain in compliance with HIPAA, the HIPAA Rules, and applicable law.

10.5 Severability. If any provision in this Agreement is invalid, illegal or unenforceable to any extent, the remainder of this Agreement and the application thereof shall not be affected and shall be enforceable to the fullest extent permitted by law.

10.6 Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with HIPAA and the HIPAA Rules.

10.7 Covered Entity Contact for Reporting and Notification Requirements. Business Associate shall address all reporting and notification communications required in this Agreement to the Covered Entity Representative as identified in the Contract.

10.8 Governing Law. This Agreement shall be governed by and construed in accordance with the governing law provisions of the Contract, subject to applicable federal law.

10.9 Countersignature. This Agreement may be executed in several counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument. In addition, this Agreement may contain more than one counterpart of the signature page and this Agreement may be executed by the affixing of the signatures of Business Associate and Covered Entity, to one of such counterpart signature pages. All of those counterpart signature pages shall be read as though one, and they shall have the same force and effect as though all of the signers had signed a single signature page.

[THIS IS THE SIGNATURE PAGE]

AETNA LIFE INSURANCE COMPANY	**COVERED ENTITY**
	
Authorized Signature	Authorized Signature
Tracey Scraba [Print Name]	[Print Name]
Vice President and Chief Privacy Officer [Title]	[Title]
[Date]	[Date]