MASTER SERVICES AGREEMENT

MSA- **xxxxxx**

This master services agreement ("**Agreement**") between **AETNA LIFE INSURANCE COMPANY**, a Connecticut corporation, located at 151 Farmington Avenue, Hartford, Connecticut ("**Aetna**"), and City of San Marcos, with headquarters located at 630 E Hopkins, San Marcos, Texas 78666("**Customer**") is effective as of January 1, 2027 ("**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"**. The schedules may provide for different start and end dates for certain Services.

2. SERVICES

Aetna shall provide the Services described in the attached schedules.

3. STANDARD OF CARE

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

4. SERVICE FEES

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

Aetna shall provide the Customer with a monthly statement indicating the Service Fees owed for that month. The Customer shall pay Aetna the Service Fees no later than 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) **Third-Party Vendor Services -** In the event Customer elects to retain or engage a third party to perform or supplement any of the services provided by Aetna under this Agreement (e.g., core services, programs or operational components), or requests Aetna to coordinate with a third party for services related to the Plan ("Third-Party Services"), Customer must provide Aetna at least 120 days prior written notice. Aetna will have 60 days following receipt of such notice to determine whether Aetna can agree to the Third-Party Services and to inform the Customer of its decision. Third-Party Services introduce clinical, operational, network, compliance, and/or member experience risks, which require additional coordination or support by Aetna. Any Third-Party Services elected by Customer are expressly excluded from the scope of Services provided by Aetna under this Agreement. Customer agrees to release and hold Aetna harmless from any liability or expense related to the Third-Party Services, including but not limited to, claim processing errors or delays (including duplicate payments and overpayments) and failure to meet performance guarantees. If Aetna agrees to coordinate with a party for Third Party Services, Aetna will charge Customer (or the third-party vendor) to recover the cost of Aetna's administration, support or coordination of the Third-Party Services.

(E) **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.

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

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

8. RECORDS

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

9. CONFIDENTIALITY

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

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

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

(B) **Plan Participant Information -** Each party will maintain the confidentiality of Plan Participant-identifiable information, in accordance with applicable law and, as appropriate, the terms of the HIPAA business associate agreement associated with this Agreement. The Customer may identify, in writing, certain Customer employees or third parties, who the Plan has authorized to receive Plan Participant-identifiable information from Aetna in connection with Plan

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

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

10. AUDIT RIGHTS

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

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 employment from Aetna within the past 12 months, or (iii) is employed or engaged in a contract 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 virtual 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. Any claim audit in addition to the annual audit described above is subject to mutual agreement of the parties, including, but not limited to, a separate written agreement that details the audit scope and guidelines, and will be subject to an additional charge.

11. RECOVERY OF OVERPAYMENTS

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

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

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

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

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

12. INDEMNIFICATION

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

(B) 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.

(D) 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.

(E) 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.

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

13. DEFENSE OF CLAIM LITIGATION

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

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

14. REMEDIES

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

15. BINDING ARBITRATION OF CERTAIN DISPUTES

The parties agree that disputes shall be resolved as follows:

(A) Actions seeking injunctive relief or contract reformation remedies shall be filed in Federal District Court for the District of Connecticut. The parties agree that Federal Court in the District of Connecticut shall be the proper and exclusive forum for any action seeking injunctive relief or contract reformation.

(B) Except as provided in (A) above, the parties expressly agree that any and all disputes, controversies or claims arising out of or relating in any way to this Agreement or the breach, termination, or validity thereof, will be exclusively settled by binding arbitration in Hartford, CT, administered by the American Arbitration Association ("AAA") and conducted by a sole arbitrator in accordance with the AAA's Commercial Arbitration Rules ("Rules"). The arbitrator shall have exclusive authority at the outset of any proceeding to resolve any dispute relating to the interpretation, scope, applicability, enforceability or

formation of the agreement to arbitrate disputes arising under this contract. This includes but is not limited to disputes over the scope, applicability, enforceability or interpretation of any part of this Agreement. The parties further expressly agree that any dispute or question regarding whether a particular demand, claim or matter is subject to confidential arbitration (including questions of arbitrability, jurisdiction or nature of the relief sought) shall be submitted in the first instance exclusively to the arbitrator, and not to any court, for a decision. In the event the arbitrator determines that any provision of this Agreement to arbitrate is invalid for any reason, such provision shall be stricken, and all remaining provisions will remain in full force and effect.

The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. Except as may be required by law or to the extent necessary in connection with a judicial challenge, or enforcement of an award, neither a party nor the arbitrator may disclose the existence, content, record or results of an arbitration. Fourteen (14) calendar days before the hearing, the parties will exchange and provide to the arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) pre-marked copies of all exhibits they intend to use at the hearing. Depositions for discovery purposes shall not be permitted. The arbitrator may award any relief that is available under applicable law, including any relief pursuant to statutory rights, other than any relief providing injunctive relief or contract reformation as detailed above. Any provision herein may be waived or amended by mutual agreement of all parties.

16. COMPLIANCE WITH LAWS

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

17. TERMINATION

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

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

(B) Termination by Aetna and Suspension of Claim Payments –

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

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

wire requests or pay the applicable Service Fees in full within five (5) business days of written notice by Aetna.

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

(D) Responsibilities on Termination –

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

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

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

18. GENERAL

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

(B) **Intellectual Property -** Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under this Agreement (the "Aetna IP"). Aetna has granted the Customer a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in this Agreement. Customer agrees not to modify, create derivative product from, copy, duplicate, decompile, disassemble, reverse engineer or otherwise attempt to perceive the source code from which any software component of the Aetna IP is compiled or interpreted. Nothing in this Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent or otherwise transfer or convey, the Aetna IP to the Customer.

(C) **Notice -** Notices from Aetna to the Customer under this agreement are valid when delivered, in writing, to the Customer's email address provided at the time this contract was entered into (or such subsequent email address as the Customer has provided to Aetna by notice). Notices from the customer to Aetna are valid when delivered, in writing, to the Customer's Aetna account representative.

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

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

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

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

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

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

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

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

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

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

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

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

City of San Marcos	**Aetna Life Insurance Company**
By:	By:
Name:	Name: Katerina Guerraz
Title:	Title: Executive Vice President, Chief Operating Officer of Aetna Life Insurance Company

GENERAL ADMINISTRATION SCHEDULE
TO THE MASTER SERVICES AGREEMENT- xxxx
EFFECTIVE January 1, 2027

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.

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

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

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

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

(K) Medicare Section 111 Reporting - Aetna will facilitate and submit mandatory Medicare Section 111 reporting on behalf of the Plan. In the event of a reporting deficiency due to incorrect or missing information from Customer, any penalties in connection with such deficiency will be the responsibility of Customer.

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 comply with all of the applicable terms of Aetna's Network Provider contracts.

(B) Aetna has value-based contracting ("**VBC**") arrangements with Network Providers. These arrangements reward providers based on indicators of value, such as, effective population health management, efficiency and quality care. Contracted rates with Network Providers may be based on fee-for-service

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

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

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

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

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

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

(H) Aetna's Network Provider contract with Sutter Health, a health system in Northern California, requires that the Customer agrees to be bound by the terms of the contract including, but not limited to, the dispute

resolution and binding arbitration provisions. The Customer may request a copy of the Sutter contract to review the terms upon completion of a confidentiality agreement.

5. NON-DIRECT NETWORKS

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

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

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

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

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

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

6. LEGAL RECOVERY SERVICES AND AUTHORIZATIONS

(A) Periodically, Aetna may identify an opportunity to pursue certain recoveries related to the Plan, including, but not limited to, recoveries associated with: governmental and/or Aetna investigations, class action litigation, private mediation, arbitration and/or litigation, and/or settlements or judgments reached in any of the foregoing ("Legal Recoveries"). As part of the administrative services provided by Aetna to the Plan, the Customer authorizes Aetna to determine whether to pursue such Legal Recoveries on the Customer's behalf (including, without limitation, filing litigation and opting the Customer out of class action litigation related to the Plan).

(B) Customer grants Aetna authority over all aspects of the Legal Recovery process, including, but not limited to, the right to: select and retain outside counsel and other third parties (e.g., experts, consultants, etc.), determine matter strategy, opt-out of or participate in a class action (including signing opt-out forms on the Customer's behalf), initiate litigation, and approve or reject any settlement offers.

(C) Aetna's authorizations to pursue Legal Recoveries on the Customer's behalf are retroactive to the effective date of this Agreement and explicitly apply to all claims related to the Plan, whether or not they may have accrued prior to the date of the Legal Recovery Services and Authorization services amendment. To the extent Aetna has already taken such actions on the Customer's behalf consistent with the Legal Recovery Services and Authorization services amendment's terms, Customer retroactively ratifies all such actions.

(D) Aetna will apportion any recovered amounts pro-rata among any impacted customers, based on a reasonable allocation methodology, after taking into account Aetna's cost of recovery.

(E) Upon request, the Customer agrees to cooperate in good faith with Aetna regarding pursuit of Legal Recoveries and to maintain the confidentiality of any information provided by Aetna.

(F) Upon request, Aetna will provide the Customer with a general explanation of any amounts recovered for its Plan.

(G) The Customer acknowledges and agrees that Aetna's efforts are not a guarantee of any Legal Recovery.

(H) Notwithstanding any provisions to the contrary, all authorizations to perform Legal Recoveries will be considered effective unless and until Aetna receives written notice of termination of those authorizations from the Customer.

MEDICAL
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT- xxxxxx
EFFECTIVE January 1, 2027

The Service Fees and Services effective for the period beginning January 1, 2027 and ending December 31, 2031 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

For purposes of this document, Aetna may be referred to using 'we', 'our' or 'us' and Customer may be referred to using 'you' or 'your'.
Customer-specific fees and caveats will be incorporated from the customer's finalized proposal documents in this section.

The following standard programs/services are also included:

Care Management Services	
▪ Inpatient and Outpatient Precertification	Included
▪ Utilization Management Concurrent Review	Included
▪ Utilization Management Discharge Planning	Included
▪ Utilization Management Retrospective Review	Included
▪ Case Management Program	Included
▪ Aetna's Compassionate Care℠ Program	Included
▪ ACCP Enhanced Hospice Benefits Package	Included
▪ National Medical Excellence/ Institutes of Excellence	Included
▪ Informed Health Line Nurseline 1-800# Only	Included
Behavioral Health Services	
▪ Managed Behavioral Health	Included
▪ Behavioral Health Condition Management	Included
Technology/Web Tools	
▪ Online Provider Directory	Included
▪ Secure Member Portal	Included

Aetna Subrogation Program	Included, **37.50** % of recovered amount will be retained

National Advantage Program (NAP)		National Advantage Access Fee:
National Advantage - Facility Charge Review (NAP-FCR)	Included	50.00% of Aggregate Savings –
National Advantage– Itemized Bill Review (IBR)	Included	Fee will be included in Plan Benefit Funding Request from Bank

Claim Wire Billing Fees

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

Value-Based Contracting

A. 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.

B. 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.

C. 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 and percentage of paid capitation dollars; number of members; percentage of member months.

Examples

1. Pay for Performance. Percentage of allowed claims dollars and percentage of paid capitation dollars: Achieving agreed upon clinical and efficiency performance goals by comparing performance year end to performance year baseline or an industry standard.
    a. Provider earns $100,000 performance-based compensation for the 12-month period January to December;
    b. All plan sponsors, combined incurred $8,500,000 in claims with the provider for the 12-month period January to December;
    c. Plan sponsor incurred $150,000 in claims with the provider for the 12-month period January to December;
    d. 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);
    e. 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.

2. 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.
    a. Provider earns $100,000 performance-based compensation for the 12-month period January to December;
    b. All plan sponsors, combined had 100,500 member months with the provider for the 12-month period January to December;

c. Plan sponsor had 9,500 member months (for 850 unique members) attributed to the provider for the 12-month period January to December;
d. Plan sponsor's share of the member months is (9,500/100,500) = 9.4527%. Formula: (Plan sponsor member months/All plan sponsors months);
e. 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.

3. 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.
    a. We determine the attributed patients for the provider for the quarter April through June;
    b. Plan sponsor had 850 members attributed to the provider for the quarter April through June;
    c. ACP and FFS payments are incorporated into the final analysis of provider performance against the medical claims target;
    d. 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;
    e. Plan sponsor's calculated share is $5,100 ($6.00 * 850), which would be processed as a claim through ordinary self-funded banking channels.

D. 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.

Late Payment Charges

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

The current charges are outlined below:

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

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

In addition, we'll charge to recover costs of collection including reasonable attorney's fees.
We will notify you of any changes in late payment interest rates.

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

COALITION PHARMACY SERVICE AND FEE SCHEDULE
MASTER SERVICES AGREEMENT MSA- xxxx
EFFECTIVE January 1, 2027 ("Schedule Effective Date")

Pharmacy Discounts & Fees

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

Pricing Arrangement	xxx
Network	xxx
Employees	xxx

Customer-specific fees and caveats will be incorporated from the customer's finalized RX proposal documents in this section.

Additional Disclosures

This pricing has an effective date of January 1, 2027 and is contingent upon signing a five-year agreement. In order for Aetna to implement the pricing as set forth above by the effective date, acceptance of the pricing must be given (120) days prior to the effective date. A legal document must be signed by Customer and returned to Aetna sixty (60) days prior to the effective date.

Charges or services not identified in this SFS and/or changes in financial terms resulting from a change in the scope of services shall be quoted upon request.

Discount and dispensing fee guarantees apply to all paid Claims with the exception of the following exclusions: 340B Claims; Compound drug Claims; Paper or Member submitted Claims; Coordination of Benefits (COB) or secondary payor Claims; Claims paid at government required amounts; Vaccine and vaccine administration Claims.

Pricing guarantees are measured and reconciled as four separate components with the components defined as retail network, Aetna mail pharmacy, CVS Specialty mail pharmacy, and rebates. Retail network, Aetna mail pharmacy, and CVS Specialty mail pharmacy Pricing guarantees will be reconciled separately for each Participating Group, and any underperformance, dollar for dollar, will be paid to the Participating Group. AWP discounts and MAC, if applicable, are managed to achieve pricing guarantees within each component. If selected, Maintenance Choice will be reconciled as part of the mail pharmacy channel.

Pricing in this proposal is based upon Aetna as the exclusive provider to Customer for each of the Services quoted in this proposal, including without limitation, retail pharmacy network contracting, pharmacy claims processing, mail and specialty pharmacy services, utilization management and formulary and rebate administration services.

The amount billed to the Client will be equal to the amount paid to the participating pharmacies. The retail networks proposed are based on the number of participating pharmacies at the time of the proposal and may vary from time to time.

The pricing in this document assumes the use of the Caremark Cost Saver™ program, under which Aetna may compare the price available under the Aetna contracted network with the price available through a non-Aetna contracted network if available for that pharmacy. If the price is lower through a non-Aetna contracted network (including an administrative fee paid to the third-party that contracts the network), the Claim will be processed through that network. These Claims are included in the reconciliation of all financial guarantees. In these instances, the generic drug prescription through retail may be less than the same generic drug, dosage form, and dose through mail on the same day of adjudication.

The National Network is a managed network that includes most major chains and independents and may not include some regional chains. The composition of this network may differ from Customer's existing National Network composition. While member disruption is expected to be minimal, if a member disruption report has not been provided to Customer, a report can be provided upon request.

Retail 90 Network

The Aetna Retail-90 Network is a subset of the National Network which provides the flexible option of a nationwide network of retail pharmacies that can fill up to a 90 days' supply of medications. Aetna Retail-90 Network pricing is applicable for non-specialty claims equal to or greater than an 84 days' supply filled by a participating Aetna Retail-90 Network pharmacy. Claims up to the Customers' qualified retail days' supply plan design limits can be filled at any participating pharmacy. Claims greater than the Customers' qualified retail plan design limits shall only be filled by a Aetna Retail-90 Network pharmacy. Implementation of Maintenance Choice and/or a mandatory plan design may limit the implementation of this offering.

Rebate Terms

Customer will receive the greater of the aggregate minimum rebate guarantees quoted herein or 100% of total rebates plus manufacturer administrative fees collected by Aetna in its capacity as a group purchasing organization on behalf of Customer, that are attributable to the utilization of prescription drugs by Customer's members.

Rebates guarantees are conditioned upon alignment with one of the formulary options in the pricing grid above, and the claims utilization mix and volume available at the time of pricing negotiations remaining consistent through the term of the agreement. Specialty Rebate Guarantees are contingent upon the Customer adopting a Plan Design that allows up to 90-day supply at Specialty. When remitting and reconciling minimum Rebate guarantees, Aetna may add "Rebate Credit" value to the total Rebates remitted to Customer for each respective Rebate component. "Rebate Credits" shall consist of (i) the differential between the Wholesale Acquisition Cost (WAC) of a lower net cost Brand Covered Product, including but not limited to a Biosimilar ("Low Cost Brand"), claim processed and the WAC of the reference Brand Drug,

subject to the below cap, and/or (ii) the value of price reductions for rebateable products that have experienced a WAC decrease, measured as the differential between the Baseline WAC of the product and the WAC of the product when the Claim is adjudicated, subject to the below cap. The "Baseline WAC" will be the WAC of the product prior to a reduction in WAC or, as applicable, for Biosimilars, the Baseline WAC will be the WAC of the reference Brand Drug at the time of Claim processing.

In no way will the Rebate Credit exceed the Baseline Rebate less the earned Rebates on either the Low Cost Brand Claim or the rebateable product that has experienced a WAC decrease. "Baseline Rebate" is calculated as follows: in the year the price reduction occurred, Baseline Rebate will be the Rebate available for coverage of the product prior to the WAC reduction or, as applicable, for Low Cost Brands the Baseline Rebate will be the Rebate available for coverage of the reference Brand Drug on the date of claim processing. For a product experiencing a WAC reduction in subsequent years, the Baseline Rebate will increase over the prior year Baseline Rebate at the WAC inflation rate of the GPI subclass (GPI-6) of the applicable product. Aetna will notify Customer of any applicable Covered Product that qualifies for Rebate Credits. Aetna shall provide reporting upon Customer request demonstrating the net-cost impact in the therapeutic category. A Covered Drug Claim will only be eligible for application of a Rebate Credit if a minimum Rebate guarantee reduction has not already been made by Aetna for the same WAC reduction or change in reference Brand Drug placement event.

Rebates are paid quarterly for each channel and reconciled 120 days after year end in the aggregate. Additional 340B reconciliation and true-up may occur post annual minimum Rebate guarantee reconciliation.

Rebate guarantees will apply to all paid Brand Drug Claims, with the exception of the following exclusions; however, any Rebates collected by Aetna for such Claims will be passed to Customer in accordance with the rebate terms described herein: 340B Claim; Compound drug Claims; Paper or Member submitted Claims; Coordination of Benefits (COB) or secondary payor Claims; Vaccine and vaccine administration Claims; COVID treatment claims; any other Claim identified as having received 340B program pricing and therefore ineligible for a Rebate; Over the Counter (OTC) product Claims; Claims approved by formulary exception; Limited distribution and exclusive distribution drugs.

Rebate are paid quarterly for each channel and reconciled annually in the aggregate across all groups within the coalition. If a group has greater than 20,000 members and has elected group-specific rebates, those rebates will be reconciled at the group level. Additional 340B reconciliation and true-up may occur post annual minimum Rebate guarantee reconciliation.

The proposed Aetna Standard formulary includes certain preferred brand drugs where the Tier 1 cost share shall be assessed to members.

CVS Specialty mail pharmacies, including through the Specialty Connect program, will be the exclusive provider of specialty pharmacy services. Claims for specialty products will not be processed through the retail network, except for those specialty drugs that CVS Specialty mail pharmacies are unable to dispense.

In order to encourage coalition growth, Aetna will evaluate group-specific rebate guarantees for any group of 20,000 lives or greater upon request.

Aetna reserves the right to adjust rebate guarantees if aggregate rebate performance is less than 5% of Aetna projections on annual basis. This could occur if a subset lives in the coalition results in significantly different mix than assumed in this RFP.

The Overall Effective Discount (OED) offer is conditioned on Aetna being the exclusive provider of Specialty Services and Customer implementing and maintaining a generics first plan design for specialty. Aetna may amend the individual Specialty Drug discounts to manage the financial guarantee. The financial guarantee is measured and reconciled annually across all Specialty Drugs dispensed from CVS Specialty mail pharmacy, including through the Specialty Connect program, with the exception of the following exclusions (in addition to the discount and dispensing fee exclusions). Note: New to market and existing Biosimilars are included in the discount guarantees.

New to Market Brand Drugs

For the items notes here, the following quoted rates shall apply.

- New to Market Brand Drugs: xxx
- New to Market Generic Drugs: xxx
- New to Market Limited and exclusive distribution drugs: xxx

It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, the following Allowance(s) shall constitute and shall be treated as a discount against the purchase price of drugs dispensed under the Agreement within the meaning of 42 U.S.C. §1320a-7b(b)(3)(A).

General Allowance

Aetna agrees to provide Customer an annual Allowance in the amount up to xxx per member which will be available during the term of the Agreement. The number of members shall be based on the information provided by Customer during this process. This Allowance may be used to offset certain expenses incurred by Customer in the administration of Customer's prescription benefit plan or the services provided by Aetna during the term. The Allowance, for example, may be applied to offset legitimate implementation expenses, communication expenses, member I.D. cards, postage, special programming charges, or applied to clinical programs offered by Aetna. Customer will be requested to provide reasonable documentation of expenses incurred that are to be applied to this Allowance. If Customer terminates this Agreement prior to the expiration of its Initial Term for any reason other than Aetna breach, or if Aetna terminates the agreement as a result of Customer's breach, Customer shall repay Aetna a pro rata portion of the applied general Allowance amount based upon the number of months remaining in the Initial Term.

Implementation Allowance

Aetna shall provide Customer with a one-time implementation Allowance up to xxx Per Net New Member to defray certain transition costs associated with moving Customer's business to Aetna. This Allowance can be used to offset typical and/or mutually agreed upon implementation costs in transferring from the current provider to Aetna. Customer shall be responsible for all transition and implementation expenses in excess of the implementation Allowance provided to Customer as set forth above. Examples of transition and implementation

expenses include costs of customized Member I.D. cards, postage expense for direct mail of I.D. cards and other communication materials to Members, and special programming required by Aetna or Customer's prior prescription benefit manager to provide data to Aetna. Identification of the costs shall occur no later than six (6) months after the effective date of the Agreement. Customer shall provide Aetna with documentation of eligible expenses directly incurred by Customer in the form of an invoice, an account statement, or other detailed documentation. For agreed upon implementation or transition services provided by Aetna towards this allowance, Aetna shall provide expense detail for such items. If Customer's Agreement with Aetna is terminated prior to the expiration of the Initial Term for any reason (other than Aetna's uncured breach), or if Aetna terminates the Agreement as a result of Customer's uncured breach, Customer will repay Aetna a pro rata portion of the applied implementation allowance amount based upon the number of months remaining in the Initial Term. The parties acknowledge and agree that the implementation allowances provided by Aetna are commercially reasonable and necessary services related to the implementation of this Agreement and represent fair market value for the services provided.

Third Party Payment

Aetna will bill the Participating Groups an administrative fee of xxx per Claim and will collect and remit this amount to the Coalition, after the Effective Date of the Agreement.

Market Check

Annually, during the 2nd quarter of each contract year, at Coalition's reasonable request, Aetna and Coalition or Coalition's representative may review the financial terms of Customer compared to financial offering presented to similar Customers in the marketplace as deemed appropriate. A third party selected and engaged by Customer shall execute Aetna's form confidentiality agreement prior to conducting the market check. The parties agree for the purpose of this market check that the parties will compare, among other things, the following factors to determine whether Coalition is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable Coalition of comparable size, inclusive of the program savings, the retail pricing for brand and generic drugs, pricing for specialty drugs, administrative fees, rebates and guarantees; (ii) the services provided by Aetna to such Coalition; and (iii) the plan design of such Customers, which may include plan formulary, brand/generic utilization information and mail and retail utilization information, available to Aetna. Coalition, or its representative, shall provide Aetna with a report to substantiate its findings. Should the comparison demonstrate that the current market conditions would yield a savings of 1% or more in net costs (i.e. gross costs net of administration fees and rebate guarantees), then the parties will discuss in good faith a revision to the current pricing terms and other applicable contract provisions. If Coalition and Aetna agree to any revisions to the financial terms as a result of this review (i) the agreement shall be amended and (ii) shall be effective January 1 of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the contract year as to which of the revisions are to apply. A legal document must be signed by Customer and returned to Aetna 60 days prior to pricing effective date.

Termination Rights

Subject to the terms of the Agreement either party may terminate the Agreement without cause, anytime, with xxx days prior written notice.

This document is a summary of Aetna offer, and is not intended to be all-inclusive. Other standard Aetna terms, conditions and pricing may apply. Specific contract language will be provided upon request. Shipping fees and/or postage may not be increased if Aetna's third party carrier increases its charges to Aetna.

The financial provisions in the offer are based upon information available to Aetna during the pricing request process. Upon thirty (30) days prior written notice to Customer, Aetna reserves the right to modify or amend the financial provisions in the offer in a manner designed to account for the impact of events identified below. Such notice will include Aetna’s explanation of the manner in which the modification accounts for the impact of the event.

1. Greater than 15% change in total membership or claims volume (83,000 members will be used as the baseline member count for total membership);

2. Customer-initiated change to pharmacy benefit program, plan design, or formulary alignment. Adding, deleting, or modifying member choice or incentives to enroll in pharmacy benefit options (e.g., Exchanges, Medicare Part D plans);

3. Product offering decisions by drug manufacturers that result in a reduction of rebates, including the introduction of a lower cost alternative product which may replace an existing rebatable brand product; an unexpected launch of an interchangeable version of a brand product; or a branded product converted to OTC status, recalled or withdrawn from the market; or a material reduction in Wholesale Acquisition Cost (WAC); or

4. Any government imposed or industry-wide change, including any prohibition or restriction on Aetna’s ability to receive rebates or discounts from pharmaceutical manufacturers; changes to methodology, availability, or publication of AWP; changes to tax laws; or changes in CMS guidelines for government regulated programs, if applicable.

By accepting this proposed pricing for review, Customer acknowledges and agrees that the information included is confidential, proprietary and trade secret to Aetna and will agree to protect

MEDICAL SERVICES SCHEDULE
TO THE MASTER SERVICES AGREEMENT- xxxxxx
EFFECTIVE January 1, 2027

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 the Customer not otherwise covered under products provided under the 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, or applicable state law as appropriate, 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, or applicable state law as appropriate, 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 virtual audit is completed within five days, and (ii) the sample size is no more than 250 claims. Aetna will notify the Customer prior to the audit, if an audit request would require an additional payment from the Customer for any audits in excess of the aforementioned thresholds.

IV. CARE MANAGEMENT SERVICES

1. Utilization Management:

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

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

c. Discharge Planning:
This is an interdisciplinary process that assists Plan Participants as their medical condition changes and they transition from the inpatient setting. Discharge planning may be initiated at any stage of the patient management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences upon identification of post discharge needs during precertification or concurrent review. This program may include evaluation

of alternate care settings and identification of care needed after discharge. The goal is to provide continuing quality of care and to avoid delay in discharge due to lack of outpatient support.

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

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

2. Case Management Programs:
The Aetna Case Management program is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs in accordance with the Plan through communication and available resources to promote quality, cost-effective outcomes.
Those Plan Participants with diagnoses and clinical situations for which a specialized nurse, working with the Plan Participant and their physician, can make a material impact to the course or outcome of care and/or reduce medical costs will be accepted into the program at Aetna's discretion. Case management staff strives to enhance the Plan Participant's quality of life, support continuity of care, facilitate provision of services in the appropriate setting and manage cost and resource allocation to promote quality, cost-effective outcomes in accordance with the Plan. Case Managers collaborate with the Plan Participant, family, caregiver, physician and healthcare provider community to coordinate care, with a focus on closing gaps in the Plan Participant's care.

Aetna targets two types of case management opportunities:

- Complex Case Management targets Plan Participants who have already experienced a health event and are likely to have care and benefit coordination needs after the event. The objective for Case Managers is to identify care or benefit coordination needs which lead to faster or more favorable clinical outcomes and/or reduced medical costs.

- Proactive Case Management targets Plan Participants, from Aetna's perspective, who are misusing, over-using or under-utilizing the health care system, leading them towards avoidable and costly health events. This program's objective is to confirm gaps in Plan Participants' care leading to their

over-use, misuse, or under-use, and to work with the Plan Participant and their physician to close those gaps.

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

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

- **Dedicated Units, Designated Units and Care Advocate Teams -** These services were created to help coordinate care, support and resources for Plan Participants under one Care Unit.

    - Aetna's Dedicated Unit provides centralized care management services for pre-certification, utilization management and Case Management.
    - Aetna's Designated Unit is a unit team that provides centralized care management services for pre-certification, utilization management, condition 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, and
        - Support the Plan Participant throughout their treatment and recovery by making follow-up calls and helping them get the support they need.

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

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

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

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

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

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

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

5. 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. Paper copies of a PCC, delivered via U.S. Mail, are also available as an additional purchase option.

6. Personal Health Record:

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

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

messaging and alerts based on medical claims, pharmacy claims, and demographic information, and lab reports

7. **Aetna Healthy Chapters:**
Our expanded family care program goes beyond traditional maternity benefits to deliver inclusive, personalized care – meeting the evolving needs of members across all life stages, for women and men:
- Complex reproductive conditions
- Contraception and sexual health
- Family building and maternal health
- Healthy aging and midlife support

By integrating virtual care, an expanded network and always-on support, we close gaps, reduce medical costs and empower healthier outcomes.

8. **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.
Available service components include:

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

9. **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.

10. Aetna Oncology Solutions[SM]:

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.

11. 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.

12. Aetna Health Your Way™:

Aetna Health Your Way 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. This includes a health assessment, dynamic MyHealth100 health score, well-being content, and personalized and curated whole health pathways. The platform also offers flexibility to design a strategy that is unique for each customer including the ability to add device integration, activity tracking, incentive administration and challenges.

13. Aetna One® Care Management Programs:

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

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

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

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

single point of contact who can address their needs and ambitions, while keeping them engaged over their long-term health care journey.

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

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

14. Aetna Enhance:

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

15. Cirrus MD:

CirrusMD’s text-first, anything next platform connects members directly to a live, licensed doctor. Encounters can also seamlessly shift to include video, voice and images when needed. Members consult with board-certified physicians by in-platform secure text, telephone or video via vendor website or mobile app. Members can access these services for the same cost as an office visit with a network physician in under a minute without having to schedule an appointment. This setup means members can easily access care when their PCP is not available. They do not need to travel, take time off from work or make childcare arrangements. CirrusMD’s Platform Includes: Care Delivery Platform,

Member online portal (“platform”) with easy registration, available both on desktop and in a mobile application (“app”).
On-demand consults available by in-platform text, phone, online video and mobile app Integrated visit history and visit notes. Dedicated customer support team that assists members that are having issues with the platform (web and mobile). Customer support is available for live chat messaging during business hours. Support inquiries received outside of business hours receive a reply within 24 hours.
General Medical Physicians: Instant, barrier-free access to a physician. There is no chat bot or paywall in the user experience delaying care. CirrusMD’s partner organization CMDPN, LLC. directly contracts with a network of licensed professionals. The number of physicians changes as membership grows. CirrusMD’s licensed contracted physicians are in all 50 states and the District of Columbia.
Per consultation fee includes 7 continuous days of access to a physician at no extra charge.
No time limits on consults, allowing your employees to get care on their schedule.
To enroll on the CirrusMD platform, a member will register through the CirrusMD website or app.

16. **Aetna Back and Joint Care™ :**
    Includes Aetna predictive analytics and care management coordination and digital MSK therapy programs from Hinge Health.

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

    CVS Medication-Nutrition Management ™, formerly called Deprescribing for Diabetes or DeRX, is buy-up to Aetna’s Transform Diabetes Care Program. It provides members with type 2 diabetes access to a comprehensive nutrition program, led by Registered Dieticians and backed by

providers, capable of developing personalized nutrition plans for members and titrating medications with oversight from Endocrinologist.

CVS Weight Management™ provides members with access to a comprehensive nutrition program, led by Registered Dieticians and backed up by providers, capable of developing personalized nutrition plans for members as well as adjusting medications when appropriate

18. **Mind Companion**
    Mind Companion helps members to navigate to behavioral health benefits, product and services available via their plan sponsors and to identify the next best step to manage their primary mental health or substance use condition or need. Members will access Mind Companion via an app or website and will first be asked to complete a quick mental health check-in, which will help identify the condition for which a member is seeking support as well as the acuity of that condition. Mind Companion will capture details on all behavioral health benefits and products available to an Aetna medical member, regardless of whether those benefits or products were contracted through Aetna or contracted directly by the plan sponsor. Mind Companion also offers condition-specific self-guided programs that a member can work through on their own time. While the product is designed to be a digital-first model, members who still have questions about the best next step in their mental health journey will have telephonic access to a "navigator" that will be able to help them understand the differences in the care options presented to them. If the digital + coaching version of the product is purchased, 1:1 chat-based coaching will be made available to members. Additionally, members will be offered a telephonic onboarding session with their coach to discuss care goals and needs after opting into the coach discuss care goals and needs after opting into the coaching program. This is the only meaningful difference between the two versions of Mind Companioning program.

19. **Aetna Personal Health Solutions**
    Members can access a single, centralized hub to utilize point solutions for condition networks focused on weight management, diabetes prevention, tobacco cessation, mental well-being, musculoskeletal health, digestive health, cardiometabolic health and women's health.
20. **Cylinder™**
    Cylinder is a virtual digestive healthcare platform that provides personalized, clinician-backed care for gastrointestinal (GI) issues. Cylinder offers a comprehensive approach to digestive health through its digital platform, which includes services from Registered Dietitians and Health Coaches.

    The platform aims to reduce healthcare costs, wait times, and frustrations associated with traditional GI care by offering immediate, expert-led virtual care. Cylinder's services are designed

to improve overall health by addressing the root causes of GI issues and providing ongoing support to create sustainable behavior changes.

Cylinder's patient-centered approach provides:
Personalized Care Plans: Cylinder offers individualized care plans tailored to each member's specific needs. These plans are designed by a team of Registered Dietitians, and Health Coaches.
Immediate, Virtual Access: Members can access care immediately through the platform, reducing wait times and the need for in-person visits. This includes symptom tracking and virtual consultations.
Ongoing Support: The platform provides continuous support to help members manage their digestive health. This includes dynamic content and care plans aimed at creating long-term, sustainable behavior changes.
Cost Reduction: By offering virtual care, Cylinder helps reduce healthcare costs, emergency room visits, and duplicative doctor visits. This approach also improves medication adherence and decreases absenteeism.
Integrated Care: Cylinder integrates with existing in-person care, ensuring that the entire care team is in sync and that members receive coordinated care.
Member Empowerment: The platform empowers members to take control of their digestive health, leading to improved overall well-being and satisfaction.
Key features include:
Microbiome tests: which provides a snapshot of a member's gut bacteria to identify imbalances
Personalized nutrition plan: Guided support for planning meals, avoiding trigger foods, and establishing healthy eating habits
Stool imaging: Clinically validated AI-powered stool imaging
Diet & lifestyle coaching via phone or live chat with a dedicated clinical team that includes Registered Dietitians and Health Coaches
24/7/365 Nurse support: Immediate assistance to help members find relief or determine if emergency medical care is needed, thereby reducing costly ER visits.

21. Aetna Over-the-Counter Health Solution (OTCHS)

Aetna Over-the-Counter Health Solution (OTCHS) is a program that provides the covered individual with a quarterly retail allowance for selected over-the-counter medical related items pain relievers, first aid supplies, allergy relief, feminine care products etc.) through OTC Health Solutions, a CVS Health company.
There are 3 easy ways to redeem the allowance:

- In a CVS store - Visit at any CVS Pharmacy store and select items from the catalog. At the register, the covered individual will supply the cashier with their name and month/day of birth to access the allowance.
- Order online - Register online using the member ID to order products at aet.na/myallowance
- By phone - by calling 1-888-628-2770

22. **Aetna Custom Connections™:**
Aetna Custom Connections creates one integrated benefits experience, helping customize the existing Aetna member website and mobile app with third-party programs, services, and benefits. This in turn makes our member website and app the “one-stop-shop” for members, guiding them to the right solutions — whether from Aetna or third-party providers — to help increase awareness, access, and navigation.

23. **Aetna Custom Connection™ Enhanced:**
Aetna Custom Connections creates one integrated benefits experience, helping customize the existing Aetna member website and mobile app with third-party programs, services, and benefits. This in turn makes our member website and app the “one-stop-shop” for members, guiding them to the right solutions — whether from Aetna or third-party providers — to help increase awareness, access, and engagement. With Aetna Custom Connections Enhanced, members receive a comprehensive platform that leverages data insights to deliver personalized recommendations and streamlined access to unique benefits, ultimately fostering greater member engagement and well-being.

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. Metabolic Health in Small Bytes:

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

4. 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.

5. **2nd.MD Reach:**
   A comprehensive proactive outreach program that uses a plan sponsor's claims data and 2nd.MD predictive model algorithms to engage members who are on the path to a high-cost or high-impact medical event before it happens. It's a best-in-class solution that uses proven strategies to engage members who could benefit the most from a consultation with an elite specialist physician who specializes in their condition.

VII. OTHER SERVICES

1. **Teladoc:**
   Teladoc is a vendor that provides access to providers 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.

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

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

   Virtual Primary Care (VPC):
   If elected by Customer as indicated on the Medical Service and Fee Schedule, Virtual Primary Care (VPC) allows plan participants 18 and older to receive eligible in-network services through a contracted VPC telemedicine provider with a copay as low as a $0 (members enrolled in qualified

high-deductible health plans must meet their deductible before receiving covered non-preventive for as low as $0).

3. **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.

4. **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.

5. **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.

6. **Mindfulness at Work:**
   Aetna's Mindfulness at Work program is an evidence-based mind-body solution that targets Employees with stress. The program teaches evidence-based stress management skills, including mindfulness

awareness, breathing techniques and emotions management. Classes are taught live in an online virtual classroom. The program is available in multiple formats for convenience and engagement.

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

8. **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.

9. **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.

10. **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.

11. National Advantage Program (NAP):

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

A. Contracted Rates Component

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

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

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

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

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

B. Facility Charge Review ("FCR") Component

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

C. Itemized Bill Review ("IBR") Component

IBR applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b)

Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology. Aetna refers to these as "**IBR Claims**."

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

D. Terms and Conditions

(i) NAP Fees

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

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

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

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

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

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

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

(ii) Plan Participant Information Regarding NAP

The Customer shall inform Plan Participants of the availability of NAP Providers. Further, the Customer's Summary Plan Description specifying coverage for out-of-network health services must conform to Aetna requirements. Aetna shall provide information regarding NAP

Providers on Aetna's online provider listing, on our website at www.Aetna.com or by other comparable means.

(iii) Customer Acknowledgements
Customer acknowledges that:

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

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

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

(iv) General Provisions

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

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

COALITION PRESCRIPTION DRUG SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA- xxxx
EFFECTIVE January 1, 2027 ("Schedule Effective Date")

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

I. SCHEDULE TERM

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

II. FIDUCIARY

Aetna and Participating Group acknowledge and agree that Coalition shall not be (i) the administrator of any Plan for any purpose; (ii) a named fiduciary with respect to any Plan for purposes of ERISA or any applicable state law; (iii) delegated discretionary authority or responsibility, or exercise discretionary authority or control, with respect to any Plan or its administration; or (iv) deemed a fiduciary with respect to any Plan for purposes of ERISA or any applicable state law. Aetna and Participating Group further acknowledge and agree that Coalition shall not have any control or authority with respect to any assets of any Plan, including but not limited to the investment or disposition thereof.

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 Participating Group acknowledge that neither Plan Participants nor providers will be penalized for exercising their right to an External Review.

Participating Group 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.

Participating Group 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, Participating Group 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.

"Brand Drugs" shall mean drugs or devices for which the Medi-Span Multisource Code field contains "M" (co-branded product), or "N" (single source brand), or "O" (originator). For purposes of adjudication only, in limited circumstances, Aetna may override the M, N, or O indicators and deem the drug to be a Generic Drug through review of additional information including other Medi-Span data, FDA application data (NDA/ANDA) and price.

"Calculated Ingredient Cost" means the lesser of:

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

The Calculated Ingredient Cost does not include the Dispensing Fee or sales tax, if any. The amount of the Calculated Ingredient Cost payable by the Participating Group 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 in accordance with the terms of this Agreement in connection with a Participating Group's Plan.

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

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

"**Cost Share"** means that portion of the charge for a Prescription Drug or device dispensed to a Plan Participant that is the responsibility of the Plan Participant as provided in the applicable Plan, including coinsurance, copayments, deductibles and penalties, and may be a fixed amount or a percentage of an applicable amount. Cost Share will be calculated on the basis of the rates charged to the Participating Group 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 Participating Group and Aetna in consideration of the costs associated with a Participating Pharmacy dispensing medication to a Plan Participant.

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

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

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

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

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

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

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

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

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

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

“National Average Drug Acquisition Cost” or **“NADAC”** means the published NDC-11 specific NADAC as reported by CMS, on the date dispensed. The NADAC for individual Claims will not in any way be calculated, altered, adjusted or assigned an alternate National Drug Code (NDC) number.

“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 Group" means an active plan sponsor client of Coalition which elects for prescription drug benefits through Coalition, provided, however, that "Participating Group" shall in no event mean any group which enters into an independent contract with Aetna for the provision of prescription benefit management services to members of that group outside of the Coalition arrangement. If a Participating Group ceases to be an active member of Coalition, it will no longer be eligible to participate in the Coalition arrangement or receive the benefit of Coalition pricing. Coalition will notify Aetna when a Participating Group ceases to be an active member of Coalition.

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

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

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

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

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

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

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

(A) **"Rebates"** means the formulary rebates received by Aetna from various pharmaceutical companies, whether directly or indirectly, including in Aetna's capacity as a group purchasing organization for the Plan, that are attributable to the utilization of Covered Products by Members, including price/inflation protection and Manufacturer Administrative Fees.

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

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

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

"Specialty Products" means certain pharmaceuticals, biotech or biological drugs, that are used in the management of chronic or genetic disease, including but not limited to, injectable, infused, or oral medications, or products that otherwise require special handling, including without limitation those listed in Specialty Addendum (which Aetna may amend from time to time). For sake of clarify, Specialty Connect claims will be reconciled financially as Claims filled at a CVS Specialty Pharmacy with the Plan's applicable financial guarantees for Claims filled at a CVS Specialty Pharmacy.

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

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

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

"Usual and Customary Retail Price" or **"U&C Price"** means the lowest price a Participating Pharmacy would charge to a particular member if such member were paying cash for filling an identical Prescription Drug on that particular day at that particular location, as submitted by Participating Pharmacy. This price must include any applicable Dispensing Fee and/or level of effort, and must include any applicable discounts offered to attract members.

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

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

V. ADMINISTRATIVE SERVICES

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

1. General Responsibilities and Obligations

a. Exclusivity

During the term of this Schedule, the Coalition and Participating Group shall use Aetna as the exclusive provider of the Benefit Plan Design for Plan Participants covered thereby, including without limitation, for pharmacy claims processing, pharmacy network management, clinical programs, formulary management and rebate management. All terms under this Schedule and on the attached Pharmacy Service and Fee Schedule are conditioned on Aetna's status as the exclusive provider of the Benefit Plan Design. Any failure by the Coalition and Participating Group 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 Coalition and Participating Group fails to comply with this section, Aetna shall have the right to modify the terms and conditions of this Schedule, including without limitation, the financial terms set forth in the Pharmacy Service and Fee Schedule and any Performance Guarantees attached hereto.

b. Pricing Assumptions

In addition to any pricing assumptions set forth in the Pharmacy Service and Fee Schedule and any pricing implementation or similar document that is executed by Coalition and/or Participating Group:

(a) Upon thirty (30) days prior written notice to Coalition, Aetna may modify or amend the financial provisions in this Agreement in a manner designed to account for the impact of the events identified below. Such notice will include Aetna's explanation of the manner in which the modification accounts for the impact of the event:

1. After 4 quarters of claims experience (i.e. after 1/1/26), greater than fifteen percent (15%) change in total membership or claims volume based on the Coalition membership and claims volume at that point in time (i.e., this assumption goes into effect on 1/1/26, after 4 quarters of claims experience from the Effective Date, and the reference threshold for lives in claims shall be the lives and claims for Participating Groups on 1/1/26. For sake of clarity, if Coalition has 50,000 members on 1/1/26, the membership threshold / anchor will be set at 50,000).
2. For the first 4 quarters (i.e., until 1/1/26), and for groups without group-specific rebates, 100% Rebate value is greater than 7% below the Coalition Rebate guarantee, in aggregate (Rebate guarantees outlined in the Service and Fee Schedule);
3. Coalition and/or Participating Group initiated change to pharmacy benefit program, Plan design or Formulary alignment. Adding, deleting, or modifying Member choice or incentives to enroll in pharmacy benefit options (e.g. Exchanges, Medicare Part D plans);
4. Product offering decisions by drug manufacturers that result in a reduction of Rebates, including the introduction of a lower cost alternative product which may replace an existing rebateable brand product; an unexpected launch of an interchangeable version of a brand product; a branded product converted to OTC status, recalled or withdrawn from the market; or a material reduction in Wholesale Acquisition Cost (WAC); or
5. Any government imposed or industry-wide change, including any prohibition or restriction on Aetna's ability to receive rebates or discounts from pharmaceutical manufacturers; changes to methodology, availability, or publication of AWP; changes to tax laws; or changes in CMS guidelines for government regulated programs, if applicable.

2. Pharmacy Benefit Management Services

a. Pharmacy Claims Processing

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

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

b. Pharmacy Network Management

(i) Participating Retail Pharmacies. Any additions or deletions to the network of Participating Retail Pharmacies shall be made in Aetna's sole discretion. Aetna shall provide notice to the Participating Group 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 Participating Group, any Plan Participant or any other person or entity for any act or omission of a Participating Retail Pharmacy or its agents, employees or representatives.

- Aetna shall adjudicate each On-Line Claim for services rendered by a Participating Retail Pharmacy at the applicable Discount and Dispensing Fee negotiated between Aetna and the Participating Group. For the avoidance of doubt, the Benefit Cost paid by the Participating Group 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.

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

- For Participating Groups contracted or headquartered in Tennessee, the Customer acknowledges that the Discounts and Dispensing Fees contained in this Agreement reflect a "transparent" or "pass-through pricing" arrangement with Tennessee Non-Low Volume Pharmacies at retail and Tennessee Low Volume Pharmacies at both retail and specialty. Transparent or pass-through pricing means the amount charged to Participating Group and Plan Participants for network claims shall equal the amount paid to the Participating Pharmacy. Such amounts will include NADAC pricing where available in the Low Volume Network at both retail and specialty. The amount billed to the Participating Group will be equal to the amount paid to the Participating Pharmacies. Maintenance Choice Claims dispensed at CVS/pharmacy, if applicable, are exempt from the transparent pricing requirements under this Agreement.

- For Participating Groups contracted or headquartered in West Virginia, Aetna shall adjudicate each On-Line Claim filled in West Virginia for services rendered by a Participating Retail Pharmacy at the applicable NADAC or WAC (in the event NADAC is not available) or at the prices paid to the Participating Retail Pharmacy (in the event WAC is not available). For the avoidance of doubt, the Benefit Cost paid by the Participating Group in connection with On-Line Claims for services rendered by the Participating Retail Pharmacies located in West Virginia will be equal to the Discount and

Dispensing Fees paid to such pharmacy. This is considered "transparent" or "pass through" pricing. Maintenance Choice Claims dispensed at CVS/pharmacy, if applicable, are exempt from the transparent pricing requirements under this Agreement. For further clarification for Claims filled in West Virginia, pursuant to state regulations (subject to change as future regulations are introduced), the ingredient cost component will be calculated as follows: (NADAC price on the date dispensed) * the number of units dispensed. If no NADAC price is available, the calculation will be: (WAC price on the date dispensed) * the number of units dispensed. If no WAC price is available, the calculation will default to AWP minus a given percentage as negotiated with the pharmacy. Further, the Dispensing Fee component will be as outlined in state regulation.

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

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

c. Clinical Programs

(i) Formulary Management. Aetna offers several versions of formulary options ("Formulary") for Participating Group to consider and adopt as its Formulary. The Formulary options made available to Participating Group will be determined and communicated by Aetna prior to the implementation date. Participating Group agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted Participating Group the right to use one of its Formulary options during the term of the Agreement solely in connection with the plan, and to distribute or make the Formulary available to members. As such, Participating Group 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. Participating Group 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. Participating Group agrees that any proposed additions and/or deletions to the Formulary will be adopted by the plan sponsor as a matter of the plan sponsor's plan design, and that Participating Group has the right to elect to not implement any such addition or deletion, which such election shall be considered a Customer change to the Formulary subject to Aetna's ability to operationally administer such election and, if so, Aetna's reservation of right to make appropriate and equitable financial changes resulting therefrom. Participating Group also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

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

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

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

program results may be communicated to Plan Participants, providers and plan sponsors. Aetna's Retrospective DUR programs are administered using information submitted to and available in Aetna's On-Line Claims system, as well as On-Line Claims information submitted by the Participating Pharmacy.

(v) Drug Savings Review If purchased by Participating Group as indicated on the Pharmacy Service and Fee Schedule, Aetna shall administer the Drug Savings Review program. Drug Savings Review uses Retrospective DUR approach. Claims are systematically analyzed within 72 hours of adjudication, for possible physician outreach based on program algorithms. The specific outreach programs are designed to promote quality, cost-effective care in accordance with accepted clinical guidelines through mailings or telephone calls to physicians.

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

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

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

(vii) Aetna Healthy Actions[SM] Rx Savings. If purchased by Participating Group as indicated on the Pharmacy 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.

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

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

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

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

d. Plan Participant Services and Programs

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

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

RxSavings Plus Program (Core)

The RxSavings Plus Program (Core) allows Discount Program Participants to fill certain Prescription Drugs at discounted prices through Program Pharmacies. Discount Program Participants include former Plan Participants as well as non Plan Participants (i.e., part-time employees and new employees prior to benefit eligibility under this Agreement). Program Pharmacies are certain retail pharmacies participating in a discount network. All communication regarding the Rx Savings Plus Program (Core) will be provided by Participating Group.

RxSavings Plus Program (Optional)

If elected by Participating Group as indicated on the Pharmacy Service and Fee Schedule, the RxSavings Plus Program (Optional) will allow Plan Participants to fill Prescription Drugs not covered under the Benefit Plan Design through Program Pharmacies. All communication regarding the RxSavings Plus Program (Optional) will be provided by Participating Group.

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

(ii) If Participating Group is eligible to receive Rebates under this Schedule, Participating Group 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 Participating Group in accordance with this Schedule. Aetna may delay payment of Rebates to Participating Group to allow for final adjustments or reconciliation of Service Fees or other amounts owed by Participating Group upon termination of this Schedule.

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

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

Coalition and Participating Group 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 Coalition, Participating Group, 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 Coalition or Participating Group 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, Participating Group as necessary to prevent duplicative Rebates on such drugs.

VI. IMPORTANT INFORMATION ABOUT THE PHARMACY BENEFIT MANAGEMENT SERVICES

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

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

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

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

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

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

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

3. Coalition and Participating Group acknowledges that in evaluating clinically and therapeutically similar Prescription Drugs for selection for the Formulary, Aetna reviews the costs of Prescription Drugs and takes into account Rebates negotiated between CVS Caremark and Prescription Drug manufacturers. Consequently, a Prescription Drug may be included on the Formulary that is more expensive than a non-Formulary alternative before any Rebates Aetna may receive from CVS Caremark are taken into account. In addition, certain

Prescription Drugs may be chosen for Formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-Formulary alternatives. The net cost to Participating Group for Covered Services will vary based on: (i) the terms of CVS Caremark's arrangements with Participating Pharmacies; (ii) the amount of the Cost Share obligation under the terms of the Plan; and (iii) the amount, if any, of Rebates to which Participating Group is entitled under this Schedule and Pharmacy Service and Fee Schedule. As a result, Participating Group's actual claim expense per prescription for a particular Formulary Prescription Drug may in some circumstances be higher than for a non-Formulary alternative.

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

4. Coalition and Participating Group acknowledges that Aetna contracts with Participating Pharmacies through CVS Caremark to provide Participating Group and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by Participating Pharmacies can vary from one pharmacy product, plan or network to another. Under this Schedule and Pharmacy Service and Fee Schedule, Participating Group and Aetna have negotiated and agreed upon a uniform or "lock-in" price to be paid by the Participating Group for all claims for Covered Services dispensed by Participating Pharmacies. This uniform price may exceed or be less than the actual price negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by the Participating Pharmacy. Where the uniform price exceeds the actual price negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by the Participating Pharmacy, Aetna realizes a positive margin. In cases where the uniform price is lower than the actual price negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by the Participating Pharmacy, Aetna realizes a negative margin. Overall, lock-in pricing arrangements result in a positive margin for Aetna. Such margin is retained by Aetna in addition to any other fees, charges or other amounts agreed upon by Aetna and Participating Group, as compensation for the pharmacy benefit management services Aetna provides to Participating Group. Also, when Aetna receives payment from Participating Group before payment to CVS Caremark, Aetna retains the benefit of the use of the funds between these payments**.[Applicable if Participating Group elects Traditional Pricing]**

   Coalition and Participating Group acknowledges that Aetna contracts with Participating Pharmacies through CVS Caremark to provide Participating Group and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by Participating Pharmacies can vary from one pharmacy product, plan or network to another. Under this Schedule and Pharmacy Service and Fee Schedule, Participating Group and Aetna have negotiated and agreed the amount billed to Participating Group will be equal to the amount paid to the Participating Pharmacies. The retail networks proposed are based on the number of Pharmacies at the time of the proposal and may vary from time to time**.[Applicable if Participating Group elects Transparent Pricing]**

5. Participating Group acknowledges that Aetna generally pays CVS Caremark for Brand Drugs dispensed by Participating Pharmacies whose patents have expired and their Generic Drug equivalents at a single, fixed price established by Aetna (Maximum Allowable Cost or MAC). MAC pricing is designed to help promote appropriate, cost-effective dispensing by encouraging Participating Pharmacies to dispense equivalent Generic Drugs where

clinically appropriate. When a Brand Drug patent expires and one or more generic alternatives first become available, the price for the Generic Drug(s) may not be significantly less than the price for the Brand Drug. Aetna reviews the drugs to determine whether to pay CVS Caremark based on MAC or on a discounted fee-for-service basis, typically a percentage discount off of the listed Average Wholesale Price of the drug (AWP Discount). This determination is based in part on a comparison under both the MAC and AWP Discount methodologies of the relative pricing of the Brand and Generic Drugs, taking into account any Rebates Aetna may receive from CVS Caremark in connection with the Brand Drug. If Aetna determines that under AWP Discount pricing the Brand Drug is less expensive (after taking into account manufacturer Rebates Aetna receives) than the generic alternative(s), Aetna may elect not to establish a MAC price for such Prescription Drugs and continue to pay CVS Caremark according to an AWP Discount.

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

VII. AUDIT RIGHTS

1. General Pharmacy Audit Terms and Conditions The parties agree that individual Participating Groups will have the following Claims and Pricing audit rights as clearly defined below. The Coalition and only those Participating Groups with individual rebate guarantees will have the Rebate Audit rights as clearly defined below:

A. Claims (Plan Design) Audits. Individual Participating Groups, or a mutually acceptable independent third party retained by the individual Participating Group, may conduct an annual audit of plan design, for the prior Contract Year. Answers to Claim level questions are normally provided within 30 business days for a maximum of (i) 300 Claims sample for Plans with a minimum of 20,000 Plan Participants and (ii) 250 Claims for Plans under 20,000 Plan Participants. The same data and same time period may only be audited once.

Any mutually agreed upon third party auditor engaged by Individual Participating Group shall execute Aetna's form confidentiality agreement prior to conducting a Claims audit ensuring that all information reviewed during such audit and all details will be treated as confidential and will not be revealed in any manner or form by or to any third party. The scope and procedures of the Claims audit shall be in accordance with the procedures set forth in this section VII. Participating Group acknowledge that each shall not be entitled to audit agreements with vendors, pharmaceutical companies, Participating Pharmacies or other providers of products or services to Aetna as part of any Claims audit. The same time period and data may only be audited once. Claims audit may include review of, but is not limited to: Channel steerage, AWP, Invalid NDC, Clinical edits, Compound edits, Day Supply limits, Dispense as written penalties, Duplicate claims, "Lesser of" language application, Member cost share amounts, Member eligibility, Refill too soon thresholds, Service performance guarantee reporting and calculation. For purposes of clarification, only a single Participating Group may conduct a Claims audit at any time.

B. Pricing Audits.
Individual Participating Groups, or a mutually acceptable independent third party retained by the individual Participating Group, may conduct an annual pricing reconciliation audit for the prior two contract years. The same data and time period may only be audited once. This includes, but is not limited to the performance of

contracted discount guarantees, dispensing fee guarantees, and administrative fees. The same data and time period may only be audited once. The Pricing Audit for any Participating Group would need to be conducted with a Plan Design Audit if both are being audited in the same year, done at the same time and by the same auditor. Otherwise, any separate request in the same year would warrant a fee by Aetna. For purposes of clarification, only a single Participating Group may conduct a Pricing audit at any time.

C. Rebate Audits.

Coalition, through a mutually agreeable independent third party retained by Coalition, may conduct an annual Rebate audit for the prior Contract Year for those Participating Groups that do not have their own Minimum Rebate Guarantee Reconciliation. This audit shall also include the Minimum Rebate Guarantee Reconciliation for the Participating Groups that do not have their own Minimum Rebate Guarantee. Such audit shall be limited to a review of up to ten (10) pharmaceutical company contracts directly related to Participating Groups' Rebates as selected by Coalition. Such review of pharmaceutical company contracts may include formulary and Rebate provisions to the extent permitted by such contracts and shall be limited to information necessary for validating the accuracy of the Rebate amounts remitted to Participating Group by Aetna. The scope and procedures of the Rebate audit shall be in accordance with the procedures set forth in this section VII. The same time period and data may only be audited once.

Individual Participating Groups that have their own Minimum Rebate Guarantee Reconciliation, through a mutually agreeable independent third party retained by Participating Group, may conduct an annual Rebate audit for the prior Contract Year. This audit shall also include the Minimum Rebate Guarantee Reconciliation. Such audit shall be limited to a review of (i) up to five (5) pharmaceutical company contracts directly related to Participating Groups' Rebates as selected by the Participating Group for Plans with a minimum of 20,000 but less than 50,000 Plan Participants and (ii) up to ten (10) pharmaceutical company contracts directly related to Participating Groups' Rebates as selected by the Participating Group for Plans greater than 50,000 Plan Participants. Such review of pharmaceutical company contracts may include formulary and Rebate provisions to the extent permitted by such contracts and shall be limited to information necessary for validating the accuracy of the Rebate amounts remitted to Participating Group by Aetna. The scope and procedures of the Rebate audit shall be in accordance with the procedures set forth in this section VII. The same time period and data may only be audited once.

D. Confidentiality Agreement. Any mutually agreed upon third party auditor engaged by the Coalition or the Participating Group shall execute Aetna's form confidentiality agreement prior to conducting a Rebate audit ensuring that all information reviewed during such audit and all details and terms of any pharmaceutical company contract reviewed will be treated as confidential and will not be revealed in any manner or form by or to any third party, including Participating Groups.

2. Additional Claim and Rebate Audit Terms and Conditions

Aetna and Participating Group agree the following guidelines shall apply to any audit described by this Agreement.

1. Audit Notification Letter

A Participating Group request for an audit of Aetna will be directed to the Participating Group's account manager either in writing on Participating Group's letterhead or by e-mail. Audits require thirty (30) days prior written notice, including receipt of fully executed confidentiality agreement by the Participating

Group's auditor and Aetna, detailed audit scope document, and a complete Claims sample, if applicable. A new audit may not be started until the prior audit, if any, is closed.

2. Use of Third-Party Auditor

In the event a third-party auditor is used, the auditor shall be a mutually acceptable independent third party retained by Participating Group. The third-party auditor shall execute a confidentiality agreement with Aetna in a form and substance reasonably acceptable to Aetna prior to conducting an audit.

3. Teleconference

Upon Aetna's receipt of a request for an audit, Aetna will organize and conduct an initial teleconference between Participating Group and Aetna. This teleconference will address the following:

- Individual audit participants
- Requirement and purpose of an approved confidentiality agreement (for use with outside audit firms or other Participating Group representatives, as applicable)
- Onsite requirements
- Mutually established timelines
- Claims tape needs and costs
- Prescription copies: timelines, availability and cost
- Guidelines for acceptable verification of audit questions
- Aetna's right to respond within a reasonable time after questions arise and before audit results are disseminated by the auditor to Participating Group
- Audit process confirmation letter
- Other appropriate issues.

4. Mutually Agreed Timelines

Participating Group and Aetna will mutually agree upon an audit timeline, taking into consideration individual circumstances and constraints.
An example of a standard timeline is as follows (from the time a signed confidentiality agreement is secured):

- Claim tape request – two (2) weeks for one (1) Participating Group
- Standard screen prints – fourteen (14) business days
- Mail service prescription copies – six (6) weeks (cost is typically $5.00 per script copy)
- Audit report reply – Participating Group or Participating Group's auditor may review the entire prior Contract Year's Claims data. Aetna will review a maximum of 300 Claims for Plans with a minimum of 20,000 Plan Participants and a maximum of 250 Claims for Plans with less than 20,000 Plan Participants from the Participating Group or Participating Group Auditor's fall out report related to such Claims and will respond within thirty (30) business days.

Due to the larger extent of Coalition audits, compared to Participating Group audits, Coalition audits will have a longer turnaround time that will be mutually agreed to by the Coalition and Aetna, dependent on the size and scope of the audit.

5. Response to Sampling Questions

The Participating Group can submit to Aetna questions related to provided Claim samples. Answers to generic questions are normally provided within fourteen (14) business days after the questions have been presented. Answers to Claim level questions are normally provided within thirty (30) business days for a maximum of 300 Claim (or 250 Claim if less than 20,000 Plan Participants) sample from the Participating Group or Participating Group Auditor's fall out report.

6. Claims Tape Requests

Claims tape specifications shall be clarified during the initial teleconference and processed following Aetna's receipt of a signed confidentiality agreement from any third party auditor. Delivery to the specified party normally takes place within two (2) weeks for the prior Contract Year of data and at Aetna's standard data fees (($125 per month of data). Audits requiring more than a prior Contract Year of data, and/or multiple Contract Years during a single audit, may be conducted at Aetna's standard audit cost plus additional data fees ($5,000 per year of data) and a mutually agreed upon timetable.

7. Audit Report

In the event of an audit by a third party, the third-party auditor and Participating Group shall provide Aetna with a copy of any proposed audit report, and Aetna will have a reasonable opportunity to comment on any such report before it is finalized.

8. Close of Audit

Upon finalization of audit results and agreement between Participating Group and Aetna on any identified financial discrepancies, the audit period under review will be closed. Any adjustments, payments and/or reimbursements determined to be necessary as a result of any examination or audit shall be paid by the appropriate party within thirty (30) days of execution of an appropriate release document covering the audit period. Participating Groups are responsible for requesting and performing a comprehensive audit regularly. To enable the parties to close their financial records in a timely manner, once a Contract Year has been audited, no further auditing activity for the Contract Year may be performed, notwithstanding that an issue arises in a future period that dates back to the previously audited period. In the event that no prior audits have occurred, any audit findings and adjustments will be limited to a maximum timeframe of three (3) Contract Years (i.e., the Contract Year being audited and up to the preceding two (2) Contracts Years).

9. Audit Costs

Participating Group shall be responsible for all their expenses of the audit. Audit requests beyond those defined within this section of the Agreement is subject to payment of an audit support charge.

The audit rights herein are valid during the term of the contract and through one (1) year of termination. Unless required by state law, any audit ask after one (1) year of termination will be at Aetna's standard audit fee.

TEMPORARY EXHIBIT 1 –HEALTH COVERAGE
PLAN OF BENEFITS
TO THE MASTER SERVICES AGREEMENT- xxxxxx
EFFECTIVE January 1, 2027

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.