Pharmacy
Service and Fee Schedule
to the Master Services Agreement

Effective October 01, 2025
Brazoria County

aetna®

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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	Traditional
Network	Aetna National Network
Employees	1,463

RETAIL		
	10/01/2025	**10/01/2026**
Brand Discount	AWP - 20.10%	AWP - 20.20%
Generic Discount	AWP - 86.00%	AWP - 86.20%
Dispensing Fee	$0.60 per Script	$0.60 per Script

MAIL ORDER PHARMACY/MAINTENANCE CHOICE		
Mail Benefit Type	Mandatory Maintenance Choice with Opt Out	
	10/01/2025	**10/01/2026**
Brand Discount	AWP - 20.10%	AWP - 20.20%
Generic Discount	AWP - 91.70%	AWP - 91.90%
Dispensing Fee	$0.00 per Script	$0.00 per Script

SPECIALTY PHARMACY		
Network	Specialty Performance Network	
Product List	Specialty Fee Schedule	
	10/01/2025	**10/01/2026**
Discount	AWP - 22.25%	AWP - 22.35%

GENERIC DISPENSING RATE (GDR) GUARANTEE		
	10/01/2025	**10/01/2026**
Retail GDR	82.25%	82.30%
Mail GDR	77.00%	77.25%
Annual Maximum	$100,000	$100,000

Rebates

REBATES		
Formulary	Advanced Control Formulary	
Plan Design	3 Tier Qualifying	
Rebate Terms	Customer will receive the following guaranteed rebates:	
	10/01/2025	**10/01/2026**
Retail	$451.98 Per Brand Script	$482.91 Per Brand Script
Mail Order/Maintenance Choice	$1144.76 Per Brand Script	$1206.64 Per Brand Script
Specialty	$4,357.18 Per Brand Script	$5,026.98 Per Brand Script

REBATES		
Formulary	Advanced Control Formulary	
Plan Design	2 Tier	
Rebate Terms	Customer will receive the following guaranteed rebates:	
	10/01/2025	**10/01/2026**
Retail	$191.66 Per Brand Script	$207.19 Per Brand Script
Mail Order/Maintenance Choice	$568.05 Per Brand Script	$584.04 Per Brand Script
Specialty	$4,357.18 Per Brand Script	$5,026.98 Per Brand Script

Capitalized terms in the pricing charts above are not intended to reflect defined terms except where specifically noted in the Prescription Drug Services Schedule.

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

In the event of any inconsistencies between the terms and conditions set forth in this Pharmacy Service and Fee Schedule and the terms and conditions set forth in the Prescription Drug Services Schedule, the term and conditions of this Pharmacy Service and Fee Schedule shall prevail.

Terms & Conditions

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

- To the extent the pricing and services outlined in this document are part of a renewal to the Customer, the pricing set forth herein is valid for 90 days from the date of such offer.
- This pricing has an effective date of October 1, 2025. In order for Aetna to implement the pricing as set forth above by the effective date, a notification of award must be given 90 days prior to effective date.
- Our renewal assumes that Aetna administers both the medical and pharmacy benefits for Customer on an integrated basis. If Customer elects to use a different vendor to provide medical benefits, then Aetna reserves the right to adjust the pricing contained in this proposal.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Participating Pharmacy shall give the Plan Participant the benefit of the lesser of (i) the Participating Pharmacy's Usual and Customary Charge, (ii) MAC (where applicable) or (iii) discounted AWP cost. Participating Pharmacy shall collect and retain from the Plan Participant at the time of dispensing the lesser of (i) the Cost Share; (ii) the Participating Pharmacy's Usual and Customary Charge, (iii) MAC (where applicable) or (iv) discounted AWP cost.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
    - Discount and Dispensing Fee guarantees are measured individually and reconciled in the aggregate; surpluses in one or more component guarantees may be used to offset shortages in other component guarantees.
    - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within one hundred eighty (180) days following the guarantee period.
    - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant Cost Share and include zero balance due claims.
    - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein:
        - Compound Prescription claims
        - Direct Plan Participant reimbursement / out-of-network claims
        - Coordination of Benefits (COB) or secondary payor claims
        - In-house pharmacy claims
        - Vaccines (including for COVID) and other COVID testing-related claims
        - 340B claims
    - Retail pricing guarantees include claims that reflect the Usual & Customary Retail Price.
    - Single Source Generic Drugs are included in the Generic Discount guarantees.

  - Only Specialty Products dispensed by a Specialty Pharmacy are included in the Specialty Pharmacy Discount guarantee listed above. Specialty Products dispensed by Participating Retail Pharmacies are not included in any Discount guarantee listed above.
  - Aetna has assumed 0.00% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.
- Pricing and terms in this proposal assume the Customer has elected the Advanced Control formulary and the Choose Generics program.
- The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members
- Specialty Performance Network means that Plan Participants are required to use CVS Specialty Pharmacies (no fills at retail allowed), with the exception of the HIV class which is not required to be dispensed at CVS Specialty Pharmacies.
- Non-Specialty Claims dispensed by a CVS Specialty Pharmacy will adjudicate as a Retail Non-Specialty Claim.
- The Overall Effective Discount (OED) offer is conditioned on Plan Participants using the Aetna Specialty Performance Network with Aetna being the exclusive provider of Specialty Services with the exception of the HIV class and Client implementing and maintaining a generics first plan design for specialty. The Aetna Specialty Performance Network option may not be available to Plan Participants in certain states. If Aetna Specialty Performance Network is no longer available in certain states, then Client must select an alternate Specialty Pharmacy network option made available by Aetna. Aetna may equitably adjust the financial terms in this Agreement to account for the impact of any such network change. The rates quoted herein apply to specialty products dispensed from CVS Specialty mail pharmacies, including through the Specialty Connect process. 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 by CVS Specialty pharmacy, including through the Specialty Connect process, 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.

  In the event retail leakage increases by a percentage change of 10%, or more, from the effective date of the agreement, Aetna reserves the right to amend pricing.
- Our financial offer does not assume any adoption of the Transform Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.
- Rebate guarantees may be subject to:
  - The adoption of Specialty Guideline Management (SGM) program
  - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.

- The above rebate guarantees exclude:
    - Over the Counter (OTC) Claims
    - Limited distribution drug (LDD) Claims
    - Any other Claim identified as having received 340B program wholesale pricing
    - Compound Drug Claims
    - Paper or Member Submitted Claims
    - Coordination of Benefits (COB) or secondary payor Claims
    - Vaccine and vaccine administration Claims
    - COVID treatment Claims
    - Claims approved by Formulary Exception
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty rebate guarantees apply to Specialty Product claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:
    - Two-tier qualifying plan designs - will consist of an open plan design, with the first tier comprised of Generic Drugs and the second tier comprised of Brand Drugs. There are no requirements for a minimum Cost Share differential between these tiers. The plan design may need to implement formulary interventions recommended by Aetna.
    - Three-tier non-qualifying plan designs – maintain a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs.
    - Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a $15.00 co-payment differential between preferred and non-preferred Brand Drugs, at least a $15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).
- The GDR guarantees are based upon plan design, membership, and demographics as represented by Customer, and changes to these aspects may materially affect Aetna's ability to meet the GDR guarantees. In the event of a change to the Plan design, or the Plan's demographics, both parties agree to work in good faith to determine if the GDR guarantees should be adjusted to account for such change, whether higher or lower, depending on the actual impact of such change. An example of this would be situations where generically available medications are excluded from the benefit, such as OTC equivalent strengths. If a brand does not lose patent protection when expected due to unforeseen circumstances,

including but not limited to litigation, the parties acknowledge and agree an adjustment may need to be made to the GDR guarantees. The GDR guarantees will be measured and reconciled in the aggregate. The following are excluded from the GDR guarantees calculation: Specialty Drugs, Compound claims, Direct Plan Participant reimbursement / out-of-network claims, COB claims, DAW 1, 2, and 7, and Vaccines. Any potential amount owed will be determined based on the following formula: (Average Amount Paid per Brand claim - Average Amount Paid per Generic claim) multiplied by (GDR guarantee - GDR measured) multiplied by total claims. Penalties for a shortfall on the GDR guarantees will be paid on a dollar-for-dollar basis, with a maximum annual payment cap of $100,000.00.

Additional Disclosures

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

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

1. Greater than 15% change in total membership or Claims volume as compared to the baseline
2. Customer-initiated change to the Benefit Plan Design, or Formulary alignment. To the extent applicable, Aetna will notify Customer in advance of any proposed Equitable Adjustment
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 rebateable 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 the Wholesale Acquisition Cost (WAC); or
4. Other events triggering an Equitable Adjustment as detailed below:
    - Legal and/or regulatory changes specific to customers which negatively affects the economic value of the Agreement to a party or the parties under the Agreement, for example restrictions on preferred or limited network arrangements; policy changes impacting drug manufacturers which negatively affect the economic value of the Agreement including the ability to provide or maintain discounts or Rebates; and/or
    - An inability to access, or changes to, industry pricing information (e.g. AWP) required to support the current economic structure of the Agreement.

If one or more of such triggering events occurs, Aetna may initiate a review to determine if an Equitable Adjustment to any of the financial provisions is warranted as a direct result of the triggering event(s). Aetna will conduct an analysis based upon Customer-specific Claims, utilization, and membership data demonstrating how the triggering event(s) result in the proposed Equitable Adjustment. Any such Equitable Adjustment based upon events #1 or #2 described above shall be effective on the first day that the triggering event occurred. Any such Equitable Adjustment based upon events #3 or #4 described above shall be effective 30 days after notification to Customer. Aetna will provide documentation of the reason for the proposed Equitable Adjustment in addition to a summary analysis demonstrating that the Equitable Adjustment is solely related to the impact of the specific triggering event. Aetna will disclose necessary facts and data to an independent auditor for validation.

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

Rebate Payment Terms

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

Guaranteed earned Rebates are paid quarterly one hundred and eighty (180) days after the quarter ends. Rebates are calculated and paid in accordance with the terms and conditions of this Agreement.

Earned Rebates are distributed in March, June, September and December each contract year.

Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

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

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 processed, 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 Low Cost Brands, 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 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.

Formulary Management

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

Other Payments

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

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and

members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with Customers.

Aetna may also receive network transmission fees from our network pharmacies for services we provide for them. These amounts are not considered Rebates and are not shared with Customers. These amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees, if applicable.

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

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

Early Termination

In the event Customer terminates Aetna's arrangement of prescription drug benefit services as described in the Prescription Drug Services Schedule and Pharmacy Service and Fee Schedule to the Agreement prior to September 30, 2027 (an "Early Termination") Aetna shall retain any earned but unpaid rebates as of the Early Termination date subject to any exception thereto provided herein.

In the event of an Early Termination, the pharmacy guarantees described hereunder, if any, shall be considered null and void for the Plan year and, therefore, not subject to reconciliation.

Aetna's remedies as described immediately above are liquidated damages and shall not be characterized as a penalty (collectively, the "Early Termination Fee"). Unless otherwise agreed in writing by the parties, such Early Termination Fee will be due and paid in full within sixty (60) days after the termination effective date.

Late Payment Charges

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

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

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

Pharmacy Audit Rights and Limitations

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the Prescription Drug Services Schedule.

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

Aetna Pharmacy Program summary – Core Services

Unless otherwise specified, the services outlined below are available at no additional cost for our Customers and Members.

PBM Services	
Included in Core Services	
PBM Benefit Administration	**Member Services**
• Maintenance Choice	• Member Services Call Center – Available 24/7
• Aetna Standard Preventive Drug List (HDHP)	• Real-Time Benefits
• Aetna Standard Preventive Drug List (ACA)	• Aetna Health Mobile App and Internet Tools
• Integrated retail, mail and specialty claims with medical benefit claims in real-time • Benefit Automation • Loading Client Benefit Plan • RxSavingsPlus Savings Program • Generic Substitution/DAW Penalties	• Price-A-Drug Tool available at **aetna.com** or through our mobile app, Aetna Health
Member Communication Materials	**Customer Services**
• Initial Implementation benefits communication materials, printed and online support	• Claim funding and banking arrangements integrated with your Aetna medical plan
• Member specific e-mail communications	• Consultative services
• Aetna Integrated Pre- and Post-enrollment materials	• Education materials on key healthcare topics
• Clinical program member letters, including transition letters for formulary changes/updates	• Implementation support including eligibility loading and ongoing additions/deletions
• Informational brochures for using the CVS Caremark Mail Service Pharmacy, including order forms	• Regulatory and compliance support by specific line of business
• Member-specific formulary and plan design	• Meetings to discuss program performance
• Aetna Health website and app brochures	• Account Management • Client Authorized Override • Member Satisfaction Surveys • Post Rejection Communications (PRC) • Proactive Retail Refill Notice
Claims Processing Services	**Mail Service Pharmacy**
• Online, Point-of-Service (POS) claims adjudication with real-time integration with medical claims	• Use of CVS Caremark Mail Service Pharmacies • Information System Infrastructure & Maintenance • Profile/order form and return envelope • Member counseling labels – drug specific • First time fill prescription processing
Online Customer Access	
• Online Services (on-site eligibility maintenance and prior authorization overrides-viewing member claims history	

• Website Access allowing customized dashboard creating for members--keep

AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Analytics and Reporting	
Included in Core Services	
Analytic Support	**Analytic Support cont.**
• Aetna Report Rx self-service reporting tool suite for up to 10 Customer users • RxNavigator Self-Service Reporting Tool Suite • E Tool Access (Self Service for Rx Insight Reports)	• Claim detail reporting combined with medical reporting through the new reporting tool, ART
• Account Team Supported Reporting • Clinical Program Opportunity Analysis	• Quarterly clinical and financial reports based on aggregate customer utilization

Formulary	
Included in Core Services	
Standard Formulary Administration	**Standard Formulary Administration cont.**
• Formulary maintenance	• Rebate administration
• Formulary exclusions lists	• Point of Sale (POS) Rebates Type 3
• Hyperinflation management	• Compound Management

Clinical Programs and Utilization Management Edits	
Included in Core Services	
Clinical Solutions	**Clinical Solutions cont.**
• Diabetic Meter Program • Standard Utilization Management edits, including quantity limits and step therapy • Pharmacy Advisor Support – Automatic refill and renewal programs	• Dose Optimization • Core Medication Management: Closing Gaps in Medication Therapy • Retrospective Safety Review • Point of Sale (POS) Drug Safety Alerts
• Pharmacy Advisor Support – Adherence to Drug Therapy	• Member and Physician clinical education
• Smart Edit overrides	• Global safety edits
• Opioid safety edits	• Compound drugs management
• Maximum pay edits • Mail Order DAW Solution	• Select OTC Coverage

AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Specialty	
Included in Core Services	
Specialty Clinical Solutions	**Specialty Support cont.**
• Specialty Starter Fill AccordantCare Specialty • Proactively supports and empowers Members with rare conditions to manage their whole condition, not just adherence to their medication (beyond traditional specialty pharmacy care). Members identified by Aetna Specialty dispense for nine (9) specialty conditions. Available to Customers who use the Aetna Specialty Performance Network.	• Specialty Expedite • Specialty Connect • Digital - Secure Messaging • First time fill prescription processing • Specialty CareTeam • Patient Assistance Program
Specialty Benefit Administration	**Specialty Pharmacy**
• Specialty Guideline Management (SGM) – criteria development and maintenance	• Use of the CVS Specialty Pharmacy network with full integration of retail, mail and specialty claims • Information System Infrastructure & Maintenance
• Specialty Copay Card Plan Designs • Standard Specialty Product List	• Member Onboarding • Member counseling label – drug specific
• Exclusive Specialty Grace Fill Member Letter (Under Member Communication Materials)	• Supply Management Optimization (SMO (Exclusive and Preferred Specialty Customers) • Specialty Connect • Digital Secure Messaging • Specialty Expedite • Specialty CareTeam

Digital	
Included in Core Services	
Standard Digital Services	**Standard Digital Services cont.**
• Open enrollment links	• Single Sign on (SSO)
• Aetna.com configurations	• Integrated medical and pharmacy websites

AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Mandatory Fees

The services outlined below are associated with meeting federal, state, and local regulatory compliance requirements

Regulatory Programs	Member Threshold, if any	Fee	Basis
State Regulatory Impact Assessment[1]		$0.30	Per Retail Claim Only
Traditional Pricing Auxiliary Fee[2]		$1.50	Per Retail Claim Only
Retail Network Pharmacy Third Party Appeal		Pass through Fees Per Review	

[1]Applies to claims in select states with relevant regulatory requirements. The current list of states includes AL, AR, AZ, CO, DE, FL, GA, IA, LA, MD, MI, ND, NM, OK, SD, MS, NJ, TN, VA, TX, WA, WV, WY and is subject to change

[2]Applicable to clients under Traditional pricing arrangements only. Applies to claims in states with extraterritorial regulations requiring transparent pricing. The current list of states includes AR, FL, OK, TN, WV and is subject to change.

AETNA PHARMACY PROGRAM SUMMARY – ADDITIONAL SERVICES

Custom Formulary	Fee	
Custom Formulary and Maintenance, including services such as: • Custom UM Criteria • Custom Exclusion Lists • Custom Preventive Lists • Hyperinflation Management • Compound Management • Net Cost Analysis and Consultation	$100,000	
Enhanced Safety, Adherence and Gaps in Care Programs	**Fee**	**Basis***
Pharmacy Advisor Counseling at CVS Pharmacy [1]	$0.25**	PMPM
Pharmacy Advisor Counseling All Channels[1]	$0.60**	PMPM
Pharmacy Advisor Counseling Retail All Channels[1]	$0.60**	PMPM
Integrated Fraud and Safety Solutions	$0.06	PMPM
Drug Savings Review (DSR) (2:1 ROI over 1 year)[2]	$0.30	PMPM
Precertification	**Fee**	**Basis**
Clinical and Non-Clinical Review		
• Precertification	$45.00	Per review
• Formulary Exceptions	$45.00	Per review
• Wegovy Cardiovascular	$45.00	Per review
Specialty Precertification	**Fee**	**Basis**
Specialty Guideline Management (SGM) Precertification	$45.00	Per review
Initial Reviews & Appeals	**Fee**	**Basis**

Initial Clinical and Non-Clinical Reviews, including Prior Authorization and Exceptions[4]	$45.00	Per review
Appeals		
• First Level Appeals	$100.00	Per review
• Second Level Appeals	$500.00	Per review
• Urgent Appeals (Combination of 1st & 2nd Level Appeals)	$600.00	Per review
• External Review	$500.00	Per review
Vendor Transition Files	**Fee**	**Basis**
Termination files for all open mail service and specialty pharmacy refill files (one test and two production files)	$5,200	As listed
Specialty User Report (SUR) – specialty pharmacy file	$1,500	Per file
Refill Transfers upon termination	$4,500	Per file
Precertification history	$3,500	Per file
Accumulator files	$1,000	Per file
Historical claims data	$1,000	Per file
Additional Services	**Fee**	**Basis**
Custom programming (includes customer-specific data file formats, reporting, or IT systems work)	$150	Per Hour
Standard on-going claim files to third-parties (includes Universal Pharmacy Claim File)	$500	$500 for initial set up and $500 per file for ongoing frequencies.
Optional pre-transition Open Refill Transfer	$1,500	Per file
Audit Claim Files for data over 24 months old	$5,000	Per file
Open enrollment site: applicable link changes not included	$150	Per hour

Prior Authorization Microsite	$150	Per hour
Prescription Drug Data collection - annual reporting	$0.02	PMPY
Aetna Report Rx Self-Service Reporting Tool License over 10 Customer users	$1,500	Per License
Caremark Cost Saver™ 3	$0.00	Optional
Vaccine Program Management Fee	$0.05	PMPM
Manual Claim Administration Fee	$1.50	Per claim
Shipping and Handling of Temperature Sensitive Products	$22.00	Per Non-Specialty Mail Rx Temperature Sensitive

AETNA PHARMACY PROGRAM SUMMARY – ADDITIONAL SERVICES

Additional Specialty Programs	Fee	Basis
Custom Specialty Network - When Accreditation Support is Required	Quoted Upon Request	

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

Pricing noted above for programs not implemented within twelve (12) months from the time of pricing negotiations is subject to change.

NOTES:

[1] Pharmacy Advisor Counseling Additional Terms:

(a) Customer may terminate the Pharmacy Advisor Counseling program by providing Aetna at least 60-days prior written notice.

(b) The pricing described above for Pharmacy Advisor Counseling program is based on the following conditions:

(i) In the event Customer desires to include additional lines of business, implement a portion of the Plan Participants, or reduces the Plan Participants participating in the Pharmacy Advisor program, Aetna may revise pricing for the program.

(ii) Customer agrees to implement all the current conditions in Pharmacy Advisor Counseling: Asthma/COPD, Breast Cancer, Depression, Diabetes, Cardiovascular conditions, and Osteoporosis.

(iii) The above pricing reflects the current program and future program expansions may require an additional fee.

[2] Drug Savings Review Additional Terms:

Aetna guarantees that the gross Customer savings realized from DSR Program over the first Clinical Program Year shall be 200% of the DSR Program fees paid by Customer during the first Clinical Program Year. For the subsequent Clinical Program Years, Aetna guarantees that the gross Customer savings realized from DSR Program shall be 300% of the DSR Program fees paid by Customer during subsequent Clinical Program Years. "Clinical Program Year" means the twelve (12) month period commencing on the start date of the Drug Savings Review Program and each full consecutive twelve (12) month period thereafter that the Drug Savings Review program is provided. In the event Aetna fails to meet the targeted savings, Customer shall be credited for any guaranteed savings short-fall following the end of the applicable Clinical Program Year, up to the amount of fees paid by Customer for the Drug Savings Review Program during the Clinical Program Year. Reconciliation will occur during the quarter after the conclusion of Clinical Program Year.

Aetna may revise the performance guarantee at time of reconciliation in a manner designed to account for membership shifts of 20% or more during the Clinical Program Year. The performance guarantee offered for the Drug Savings Review Program is conditioned on (1) Customer maintaining a monthly average of at least 1,500 Members throughout the Clinical Program Year and (2) Customer participating in the Drug Savings Review Program for the entire Clinical Program Year.

[3] Caremark Cost Saver™ **:** The pricing in the Pharmacy Service and Fee Schedule 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 prescription through retail may be less than the same Drug, dosage form, and dose through mail on the same day of adjudication.

[4] Reviews through the Specialty Guideline Management and Specialty Preferred Drug Plan Design programs will be charged this per review fee.

***DEFINITIONS:**

PMPM = Per Member Per Month

PEPM = Per Employee Per Month

****i**f retiree membership is over 15%, referral needed to review for custom pricing.

AETNA PHARMACY PROGRAM SUMMARY – THIRD-PARTY SERVICES

The services outlined below are provided by third party providers.

Optional Third-Party Services	Fee
PrudentRx Copay Optimization • The PrudentRx offering minimizes the impact of manufacturer copay cards, targeting all Specialty Drugs, including highly utilized classes such as hepatitis C, autoimmune, oncology and multiple sclerosis, to drive maximum value for Customers while providing Members with $0 out-of-pocket costs. • Customers contract directly with PrudentRx for this service. • Program costs are a percentage of shared savings billed monthly by PrudentRx. Aetna does not charge any fees to Customer to support the PrudentRx Copay Optimization services.	Quoted by Prudent Rx upon request