

MASTER SERVICES AGREEMENT
MSA- 0838904

This master services agreement ("**Agreement**") between **AETNA LIFE INSURANCE COMPANY**, a Connecticut corporation, located at 151 Farmington Avenue, Hartford, Connecticut ("**Aetna**"), and **Brazoria County**, Texas, a political subdivision of the State of Texas, with headquarters located at 237 E Locust, Suite 203, Angleton, Texas ("**Customer**") is effective as of October 1, 2026 ("**Effective Date**").

This Agreement replaces and supersedes Services Agreement number MSA-838904, effective October 14, 2014.

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 three (3) one year terms beginning on the Effective Date, with the second and third one (1) year terms automatically renewing. 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 60 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 cleared basis, Aetna is not required to act on outstanding benefit checks (checks which have not been presented for payment) unless directed to do so by the Customer. The Customer may elect full escheat or stop pay services under a separate contract, to which additional fees may apply. In the absence of an escheat or stop pay contract, checks will be voided when they age five years, which does not eliminate the Customer's potential escheat liability.

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

- (i) One year has elapsed since Aetna completed its runoff obligations; or
- (ii) Aetna has exercised its right to suspend claim payments or terminate this Agreement as stated in section 17(B) (Termination).

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

6. FIDUCIARY DUTY

It is understood and agreed that the Customer, as plan administrator, retains complete authority and responsibility for the Plan, its operation, and the benefits provided 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 90 days’ prior written notice of when such termination will become effective.
- (B) Termination by Aetna and Suspension of Claim Payments** –
 - (1) Aetna may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving the Customer at least 90 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 pending 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.
- (O) **Subcontractors** - The work to be performed by Aetna under the Agreement may, at its discretion, be performed directly by it or wholly or in any part through a subsidiary, an affiliate, or under a contract with an organization of its choosing. Aetna will remain liable for Services under the Agreement. Upon request, Aetna shall provide a written list of Tier 1 subcontractors to the Customer. Tier 1 subcontractors are defined as a subset of Aetna suppliers for whom a portion of the Services provided may include direct Plan Participant contact or significant access to Plan Participant-identifiable data. Not all Aetna suppliers on the list provided are utilized in providing services to all customers or plan participants. Aetna shall make an updated Tier 1 subcontractor list available to the Customer for informational purposes, as requested by the Customer, but no more frequently than once annually, during the term of the Agreement. For the avoidance of doubt, neither Aetna's obligation to provide, nor the Customer's right to receive a Tier 1 subcontractor list under this paragraph, shall constitute a right of the Customer to pre-approve any Aetna subcontractor or a right to require Aetna to terminate any agreements (or services under any agreements) with any Aetna supplier. Aetna or its subcontractors will access the Customer or Plan Participant data from locations outside of the jurisdiction of the United States; provided that such access (i) is limited to screen viewing of the data, which shall, at all times, remain physically stored in the United States, and (ii) is subject to security controls, including limiting such access to devices with no download, print or storage capability.

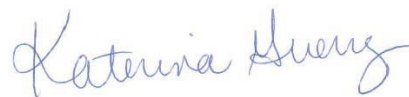
The parties are signing this agreement as of the date stated in the introductory clause.

Brazoria County

Aetna Life Insurance Company

By:

By:



Name:

Name: Katerina Guerraz

Title:

Title: Executive Vice President, Chief Operating Officer of Aetna Life Insurance Company

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**GENERAL ADMINISTRATION SCHEDULE
TO THE MASTER SERVICES AGREEMENT- 0838904
EFFECTIVE October 1, 2026**

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 MSA-0838904
EFFECTIVE October 1, 2026**

The Service Fees and Services effective for the period beginning October 1, 2026 and ending September 30, 2029 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’.

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Option 3: Medical with NACO Only

		Current	Year 1	Year 2	Year 3	
Guarantee Period Effective Date		October 01, 2025	October 1, 2026	October 01, 2027	October 01, 2028	
Guaranteed Medical Administrative Fee (PEPM)*	Estimated Enrollment	Current (No NACO included)	October 1, 2026	October 1, 2027	October 1, 2028	% Change
OA Aetna Select	586	\$40.22	\$43.02	\$43.88	\$44.76	2.0%
AHF-OA Aetna Select	902	\$43.46	\$46.33	\$47.26	\$48.21	2.0%
Plan Year Service Fees	1,488	\$753,238	\$803,993	\$820,106	\$836,577	

Additional Administrative Fee Guarantee*	OA AS	AHF- OA AS	% Change
Year 4 of 5 (October 01, 2029)	\$46.10	\$49.66	3.0%
Year 5 of 5 (October 01, 2030)	\$47.48	\$51.15	3.0%
Year 6 of 6 (October 01, 2031)	\$48.90	\$52.69	3.0%

Option 3: Medical with NACO Only***Clarifications**

- PEPM is defined as Per Employee, Per Month for subscribers covered under your Aetna medical plan.
- Please see Programs and Services for additional information. Some services may come at additional cost to the fees shown above.
- Broker Compensation, if applicable, is subject to customer approval.
- Any Plan Year costs are based on the Estimated Enrollment and subject to change based on actual enrollment.

Administrative Fee Guarantee

Our offer includes an administrative fee guarantee for the Guarantee Period October 1, 2026 to September 30, 2032. The guaranteed administrative fees excludes broker compensation, fee adjustments and other charges listed above. The guarantee is subject to the terms and conditions as stated in the caveats and is contingent upon the customer maintaining all lines of business with Aetna. Programs and Services billed via the Claim Wire and Additional Buy-up services outlined on the Programs and Services exhibit may be subject to annual increases provided at time of renewal.

Prescription Drug Benefits

Includes NACO

Our quotation assumes that prescription drug benefits are included and will be provided by Aetna. Additional pharmacy administrative fees may apply. Refer to our Pharmacy Service and Fee Schedule and Program Summary for additional information.

If you terminate your prescription drug benefits with us, we will increase the ASC Service Fees and the medical trend assumption used for any applicable claim projections or guarantees. You may also be subject to additional charges to integrate data with external Pharmacy vendors. Refer to the reporting charges outlined in the Programs and Services exhibit for more information.

Medical Pharmacy Rebate Retention Credit

This credit assumes Aetna retains 100% of the rebates for pharmacy products administered and paid through the medical benefit. Refer to the Caveats for more details.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

The information contained in this proposal is confidential and should not be shared with anyone other than your broker or benefit plan consultant.



Programs and Services – Self-Funded	Effective Date: October 01, 2026
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Program Summary	OA Aetna Select	AHF-OA Aetna Select	
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Programs & Services Included in the Service Fee

General Administration	
Experienced Account Management Team	Included
Designated billing, eligibility, plan set up, underwriting	Included
Onsite Open Enrollment Meeting Preparation	Included
Open Enrollment Marketing Material (non-customized)	Included
ID Cards*	Included
Review or draft plan documents	Included
Summary of Benefits and Coverage (SBC)	Included
Claim Fiduciary Option 4	Included
External Review	Included
Claim Administration	Included
Plan Sponsor Liaison	Included
Special Investigations / Zero Tolerance Fraud Unit	Included
Network Services	
Full National Reciprocity*	Included
Institutes of Excellence™ *	Included
Institutes of Quality® (IOQ) Network	Included
Gene-Based, Cellular and other Innovative Therapies (GCIT®) network	Included
National Medical Excellence Program®	Included
Network access	Included
Care Management	
Aetna Compassionate Care™	Included
Aetna One® Choice	Included
Aetna Advice	Included
Preventive Care Considerations (Electronic)	Included
Utilization Management (Inpatient Precertification, Concurrent Review, Discharge Planning, Retrospective Review)	Included
Member Resources	
Designated Service Center	Included
Provider search (online provider directory)	Included
Member Website and Mobile Experience	Included
Online Programs	Included
Wellness	
24-Hour Nurse Line: 1-800# Only	Included
Aetna Health Your Way™ Health Assessment and Digital Support	Included
Aetna Health Your Way™ Plus (includes MedQuery and Personal Health Record)	Included

Program Summary	OA Aetna Select	AHF-OA Aetna Select	
Allowances			
Health Plan Allowance		Included	
Reporting and Integration			
Analytic Consultation from Plan Sponsor Insights (50 Hours)		Included	
Clinical Consultation from Plan Sponsor Insights (50 Hours)		Included	
ART Reports - New analytic reporting platform		Included	
Aetna Health Information Advantage™ (AHIA)		Included	
Monthly Financial Claim Detail Reports		Included	
Monthly Banking Reports		Included	
Monthly Universal File Feed Outbound Medical (12 total reports)		Included	
Monthly 3rd Party Stop Loss Vendor Reports (12 total reports)		Included	
Behavioral Health			
Managed Behavioral Health		Included	
Behavioral Health Condition Management Program - Standard		Included	
Applied Behavior Analysis (ABA)		Included	
Aetna Discount Program			
at home products, fitness, hearing, LifeMart® shopping website, natural products and services, oral health care, vision, weight management		Included	

Program Summary	OA Aetna Select	AHF-OA Aetna Select	
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Programs & Services Included in the Claim Wire*

No Surprises Act - Fees*	
No Surprises Act (NSA) claim administration fee (per NSA eligible claim)	\$94
No Surprises Act (NSA) Independent Dispute Resolution (IDR) initial fee (per arbitration case)	Applicable fees are as set by law and passed through to the plan
No Surprises Act (NSA) Independent Dispute Resolution (IDR) arbitration expenses (per arbitration case)	Applicable fees are as set by law and passed through to the plan
Network Services	
Subrogation*	37.5% of savings
Contracted Services* (Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, Workers Compensation, DRG and Implant Audits)	37.5% of savings
Claim and Code Review Program*	30.0% of savings
National Advantage™ Program (NAP)*	We will retain 40% of savings (includes FCR, IBR)
Wellness	
Aetna Back and Joint Care™ (per engaged member, per year)*	Not to exceed an average of \$995

Program Summary	OA Aetna Select	AHF-OA Aetna Select	
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Additional Available Programs & Services (per employee, per month unless otherwise noted)

Network Services	
CVS Health Virtual Care™*	\$0.40 PEPM

Additional Available Programs & Services Billed through the Claim Wire*

Care Management	
Transform Diabetes Care® 2.0 (per diabetic, per month)*	\$14.15
Transform Oncology (per engaged member, per month)*	\$79
CVS Weight Management™ (per engaged member, per month)*	\$148

Wellness	
LCC Condition Coaching (per engaged member, per month)*	\$275

***Additional Program Details**

Claim Wire Billing, ID Cards, Subrogation, Contracted Services, Claim and Code Review

Details can be found in our UW Disclosure document located at the following URL:

<https://www.aetna.com/content/dam/aetna/pdfs/aetna.com/legal-notices/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-06-27-2025.pdf>

Claim and Code Review Program

This financial proposal includes enhancements that have been made to our claim and code review programs. Some of these capabilities were previously a component of our base fees, but this proposal assumes they will now instead be part of our standard shared savings arrangement.

No Surprises Act - Fees

The NSA claim administration fee will increase at each annual renewal and apply to NSA eligible claims paid on or after that renewal date. Refer to the NSA Payment Practices in our Caveats for information on our payment practices for NSA eligible claims.

No Surprises Act - IDR Fees

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



Aetna Back and Joint Care™

This program combines Hinge Health's MSK digital exercise therapy and prevention programs with Aetna's Care Management resources and claims predictive analytics to create a multi-faceted program to address musculoskeletal (MSK) related needs. It is available for medically covered members 18 years and older.

Prevention:

- There is no fee for members enrolled in the prevention program.

Acute and Chronic Care:

- You will be charged \$250 for each engaged member's first session and \$50 for each subsequent session.
- The maximum amount billed per individual engaged member will be capped at \$1,750 per 365-day period, regardless of the number of programs or sessions utilized.
- The maximum average cost per member for your engaged members will be capped at \$995. Calculation of this maximum average will occur after the end of the program year.
 - If your maximum average member program cost exceeds \$995, a reconciliation credit will be allocated and provided by Hinge Health.

CVS Health Virtual Care™

In addition to the administrative fees as outlined above, there is a per consultation charge which will be shared by the member and plan sponsor based on type of service provided and member's benefit plan. Specific charges are available upon request.

CVS Weight Management™

CVS Weight Management™ requires pharmacy coverage is provided by Aetna, includes the Weight Management UM Bundle and your pharmacy plan provides coverage for Weight Management drugs. Member engagement is defined as any calendar month in which a two-way interaction (i.e., telephonic, virtual visit, secured messaging, etc.) between the enrolled member and a Registered Dietician takes place. The minimum duration for engagement-based billing is 3 months. CVS Weight Management™ may impact your pharmacy rebates. If implemented, you may receive an updated Pharmacy Service and Fee Schedule (SFS).

Institutes of Excellence™ (IOE)

This program includes a steerage component by educating members on the benefits of using an IOE designated facility. However, benefit differential steerage is not supported for IOE Infertility network.

National Advantage™ Program (including the Contracted Rates, Facility Charge Review and Itemized Bill Review Components)

NAP includes a Contracted Rates component and two optional components: Facility Charge Review (FCR) and Itemized Bill Review (IBR). In addition, some plans also elect Professional Claims Repricing Service (PCRS) as their out-of-network plan rate for professional services. NAP's Contracted Rates component offers access to contracted rates for many medical claims from non-network providers (including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers) and ad hoc negotiations (when a contracted rate is not available). We retain a percentage of savings achieved through NAP, including savings achieved through FCR, IBR, and PCRS, if elected. This NAP Fee is in addition to the per employee, per month administrative service fees.

Transform Diabetes Care® 2.0

Members are identified for the program based on diabetes diagnosis codes and at least one other identifier which corroborates diabetes. Additional identifiers may include but are not limited to pharmacy claims for antidiabetic medication, and/or laboratory test results.

Transform Oncology

Engagement begins upon the second two-way call with a Personal Navigator, regardless of timeframe. After one month without a two-way call with a Personal Navigator a member is no longer considered engaged. Reengagement occurs after the first two-way call with a Personal Navigator for a member that was previously engaged. The minimum duration for engagement-based billing is 2 months.



National Advantage™ Program (NAP)**Effective Date: October 01, 2026**

Program Type	NAP
Facility Charge Review (FCR) Charged through the claim wire. Not included in billed Administrative Fees.	Standard
Itemized Bill Review (IBR) Charged through the claim wire. Not included in billed Administrative Fee.	Included
Professional Claims Repricing Service (PCRS) Charged through the claim wire. Not included in billed Administrative Fee. (Not available for in-network only plans)	Not Included
Maximum PEPM NAP fee	\$3.75
Out of Network Plan Rate for Facility Services For plans that cover voluntary out-of-network services	Facility Charge Review
Out of Network Plan Rate for Professional Services For plans that cover voluntary out-of-network services	80th percentile of FAIR Health

National Advantage™ Program (including the Contracted Rates, Facility Charge Review and Itemized Bill Review Components)
NAP includes a Contracted Rates component and two optional components: Facility Charge Review (FCR) and Itemized Bill Review (IBR). In addition, some plans also elect Professional Claims Repricing Service (PCRS) as their out-of-network plan rate for professional services. NAP's Contracted Rates component offers access to contracted rates for many medical claims from non-network providers (including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers) and ad hoc negotiations (when a contracted rate is not available).

We retain a percentage of savings achieved through NAP, including savings achieved through FCR, IBR, and PCRS, if elected. This NAP Fee is in addition to the per employee, per month administrative service fees.

Allowances - Self-Funded**Effective Date: October 01, 2026**

We are including allowance(s) for your Aetna plans applicable to each year of the Guarantee Period as outlined in the chart below. Allowance dollars must be used for your commercial Aetna medical plans and Aetna medical members.

Annual Allowance Type	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
Plan Year Effective Date	10/01/2026	10/01/2027	10/01/2028	10/01/2029	10/01/2030	10/1/2031
Health Plan	\$185,000	\$185,000	\$185,000	\$185,000	\$185,000	\$185,000
Total	\$185,000	\$185,000	\$185,000	\$185,000	\$185,000	\$185,000

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

Health Plan Allowance

- The **Health Plan allowance** can be used to offset reasonable documented expenses applicable to the Guarantee Period(s) for which it is offered. Your allowance can be used for implementation, communication, reporting, and audit associated with your Aetna Medical plan. Examples of reimbursable expenses include:
 - implementing your contract with us
 - promoting our products, programs or services, such as, educational content and materials for enrollees or prospective enrollees
 - Aetna required technology platforms or our system front-end charges to support our plans
 - communicating with our members
 - auditing our readiness
 - recurring or ad hoc reporting with us
 - reporting costs to integrate our data with third-party vendors.
- Your allowance can also be used to offset reasonable documented wellness-related programs or activities incurred during the Guarantee Period for which the allowance is offered. Wellness allowance expenses must be for wellness-related programs or activities that are reasonably designed to promote the health and well-being of Aetna members, or to educate Aetna members about healthy lifestyles and/or prevent disease. This means that there must be a connection to the health and well-being of the members, with a focus on preventative measures or healthy living (i.e., diet, exercise), not on acute care. Wellness programs and activities funded by allowance funds are not covered benefits under your Aetna plan.
- Claims audit expenses must be incurred during the Guarantee Period for which the allowance is offered.
- Should you terminate your contract with us, the allowance cannot be used to fund implementation/communication expenses related to the new carrier's contract.
- Any expenses associated with the implementation, administration or communication of another carrier's plans, programs or services are also ineligible.

The above referenced fund(s) will be available after the effective date of each plan year. Only those expenses performed and billed by a third party are payable. Reimbursement for time and materials incurred directly by the plan sponsor (e.g., hours worked by the plan sponsor's own employees) are not eligible. Your normal business operation expenses, including employee salaries and overtime, are not eligible under the allowance. Our preferred method of payment is directly to the third-party vendor. We require submission of appropriate documentation detailing charges for the services provided by the vendor. Acceptable documentation includes, but is not limited to, detailed vendor invoices itemizing services provided, specific cost-elements and associated line-item charges.

On an exception basis, we can reimburse you directly provided you submit both the detailed invoice and receipt showing payment to the third-party vendor.

You should submit documentation within 60 days of the invoice date. We must receive all documentation no later than 60 days following the close of the plan year to be considered for reimbursement.

The allowance amounts indicated above for the following Allowance Type(s) are available for the years indicated in the chart. These allowances are forfeited at the end of each plan year if not fully utilized. There is no roll over of unused funds to the next policy year. Any unredeemed wellness incentives that may be offered through a "reward program" are forfeited at the end of each plan year.

- Health Plan

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

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



For the purposes of this document, Aetna may be referred to using "we", "our" or "us" and Brazoria County may be referred to using "you" or "your".

If fees are adjusted, the caveats below will apply and be based on the new assumptions.

Underwriting Caveats

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

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

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

Enrollment

There is a 15 percent change in total or by product from the assumed enrollment shown on the Fee exhibit. Our renewal assumes coverage will not be extended to additional employee groups without review of supplemental census information and other underwriting information for appropriate financial review.

Member-to-Employee Ratio

The member-to-employee ratio changes by more than 15 percent from the 1.79 ratio assumed in this quote.

Quoted Benefits and Administration

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

National Advantage™ Program

You change or terminate the National Advantage™ Program (NAP), Facility Charge Review (FCR), Itemized Bill Review (IBR), or Professional Claims Repricing Service (PCRS) programs.

Multi-Year Provision

You place the products, programs and services included in this multi-year fee guarantee out to bid with an effective date prior to September 30, 2032, then this guarantee is no longer valid.

Total Replacement

Any of the quoted lines of coverage are offered with an additional carrier.

Performance Guarantees

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

Multiple Employer Welfare Arrangements (MEWAs) and Employer Association Health Plans (AHPs)

This quote was prepared based on the demographic information for eligible enrollees, including their home zip codes, in accordance with all applicable mandates. We must be notified immediately of any changes that affect plan locations due to new or changing enrollment statuses. We will evaluate regulatory requirements and may not be able to extend coverage in states which prohibit large group coverage through MEWAs and AHPs.

Assumptions
Underwriting

Agreement Provisions

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

Participation

A minimum of 150 enrolled employees is required to administer the proposed products on a self-funded basis.

Plan Design

This renewal is based on the current benefit plan designs, plus any noted deviations, subject to the terms of our Benefit Review document.

Claim Fiduciary - Option 4

Our renewal assumes we'll provide mandatory Level I (benefit review and determination of claims) and Level II (deciding appeals and final claims determination) appeals. We'll also write the letter to the member to communicate the appeal decision. We'll defend any lawsuit originating during or after completion of the first two levels of appeals. You'll act as claim fiduciary for all voluntary appeals after Level I and Level II appeals are exhausted.

External Review

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

Member Communications

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

Wellness Incentives and Rewards

We offer several different wellness incentives and rewards programs that you may choose from to offer to your members. We, or our third-party vendors, will administer and distribute to your members any wellness incentives or rewards earned based on the programs selected under the direction and control of your plan. The wellness incentives and rewards earned through these programs may be taxable for your members. We will provide you with reporting which will identify members who have earned such wellness incentives or rewards. These reports will provide the data needed for any tax information reporting requirements that you determine are necessary.

With regard to these wellness incentives and rewards, you, as the Plan Sponsor have the following responsibilities:

- Ensure any incentives or rewards offered to your members comply with applicable law and any limitations imposed thereunder. This includes but is not limited to, the Health Insurance Portability Act (HIPAA), the Americans With Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA).
- Distribute notices and/or obtain any authorizations required by law.
- Comply with all tax information reporting requirements regarding any wellness incentives or rewards earned through these programs (cash, cash equivalent, or other tangible property) and provided by us or our third-party vendor to your members.
- Assume any and all liability for your noncompliance with any tax withholding or information reporting requirements.

You may wish to consult with your legal counsel or other advisors as to the proper tax treatment of such wellness incentives or rewards and to ensure that the incentives or rewards offered under your program comply with applicable law.

Mental Health/Substance Abuse Benefits

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

Prescription Drug Benefits

Our quotation assumes that prescription drug benefits are included and will be provided by Aetna.

Additional pharmacy administrative fees may apply. Refer to our Pharmacy Service and Fee Schedule and Program Summary for additional information.

If you terminate your prescription drug benefits with us, we will increase your ASC medical fees and the medical trend assumption used for any applicable claim projections or guarantees. You may also be subject to additional charges to integrate data with external Pharmacy vendors. Refer to the reporting charges outlined in the Programs and Services exhibit for more information.

Pharmacy Rebate Prefund Program

We have offered an alternative to our traditional pharmacy rebate sharing agreement, referred to as Pharmacy Rebate Prefund Program. We have estimated your pharmacy rebates for the 2026 Guarantee Period. With this estimate, we are reducing your monthly medical administrative service fees as outlined in the ASC Fees exhibit. When each quarterly rebate review is performed, any amounts collected which exceed the cumulative Pharmacy Rebate Prefund Program amount will be credited to you through the claim wire.

After the annual reconciliation, if the actual pharmacy rebates earned during the Guarantee Period are less than the Pharmacy Rebate Prefund Program amount, you agree to remit to us the difference within 30 days of the request.

We will re-evaluate our rebate estimates at each renewal during your multi-year Guarantee Period. We will use the updated estimate for each renewal to provide a Pharmacy Rebate Prefund Program amount reduction to your administrative fees for that Guarantee Period.

Stop Loss Reporting

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

Aetna HealthFund® (AHF)

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

Medical Pharmacy Rebates

Rebates for pharmacy products administered and paid through the medical benefit rather than the pharmacy benefit will be retained by Aetna as compensation for our efforts in administering this program.

Additional Products, Programs and Services

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

Billing Information**Advanced Notification of Fee Change**

We'll notify you of any off-anniversary fee change within 31 days of the fee change.

Late Payment

We reserve the right to assess a late payment charge at a 12 percent annual interest rate as follows:

- if you fail to pay plan benefit payments in accordance with the terms as outlined in your Master Service Agreement.
- if you fail to pay administrative service fees within 31 days of the due date.

We'll 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.

Incurred late wire interest charges will be added to a future wire request and collected through your claim wire billing account.

Incurred late fee payment interest charges will be added to a future service fee bill.

Producer Compensation

The quoted fees don't include producer compensation.

Claim and Member Services**Runoff Claims Processing**

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

Medical Explanation of Benefits (EOB)

Unless required by state law, we standardly don't produce paper EOBs for members registered through our member website. In addition, we don't produce EOBs for claims when there is no member liability. However, you have requested to continue to produce paper EOBs. An additional charge has been included in your administrative fees. EOBs are always available electronically through our member website. Members can visit www.aetna.com to register and sign in to their account.

Onshore Services

At your request, we have included the cost to handle the following services within the United States. If you'd like to make changes to these services, please contact your Account Manager.

- Member Calls and Correspondence

Certain ancillary services such as imaging, error correction, intake and triage for complaints, grievances and appeals, and internal application

Summary Plan Description (SPD) Modification

We've assumed that the standard SPD language will be used and any customization may require an additional cost.

Reporting and Data Transfer

Aetna Intellectual Property

Under the Agreement, you may have access to certain of Aetna's Plan Sponsor reporting systems. Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under the Agreement ("Aetna IP"). Aetna will grant you, as the Plan Sponsor, a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in the Agreement. You agree not to modify, create derivative product from, copy, duplicate, decompile, 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 the Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent, or otherwise transfer or convey, the Aetna IP to you.

Data Integration (Historical)

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

Data Integration (Ongoing)

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

Data Transfer at Termination

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

Banking

We've assumed that you provide funds through a bank initiated Fedwire wire transfer for drafts issued under the self-funded arrangement assumed in this renewal.

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

The proposed banking arrangement is subject to change based on results of a credit risk evaluation. We may complete an evaluation upon notification of sale.

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

Additional

Please review the additional important information found at the following URL. This information is incorporated by reference into this package and considered part of your Agreement. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriting Disclosure Document, the information in your package prevails.

<https://www.aetna.com/content/dam/aetna/pdfs/aetna.com/legal-notice/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-06-27-2025.pdf>

Legislative and Regulatory Requirements

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

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

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

NSA Payment Practices

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

Recovery of Overpayments

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

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

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.

**DENTAL
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT- MSA- 838904
EFFECTIVE October 1, 2026**

The Service Fees and Services effective for the period beginning October 1, 2026 and ending September 30, 2027 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to “Member” shall mean a Plan Participant as defined in the Agreement.

Administrative Service Fees

Effective Date: October 1, 2026

End Date: September 30, 2027

Your fees include a savings for Medical.

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

		Current	Proposed	% Change
Guarantee Period Effective Date			10/1/2026	
Fee Basis		Mature	Mature	
Dental Fees as Billed (PEPM)	Estimated Enrollment	Current	Proposed	% Change
PPO Dental	1,803	\$2.66	\$2.66	0.00%
Plan Year Service Fees		\$57,552	\$57,552	0.00%
Service Fee Summary (Plan Year)		Current	Proposed	% Change
Administrative Service Fees		\$57,552	\$57,552	
Total Fees (incl Discounts, Credits, Broker Comp, Other Charges)		\$57,552	\$57,552	0.00%

Additional Service Fee Guarantee* (Excluding Other Charges)	% Change
Year 2 of 6 (10/1/2027) Mature	0.00%
Year 3 of 6 (10/1/2028) Mature	2.00%
Year 4 of 6 (10/1/2029) Mature	3.00%
Year 5 of 6 (10/1/2030) Mature	3.00%
Year 6 of 6 (10/1/2031) Mature	3.00%

Clarifications

- PEPM is defined as Per Employee Per Month.
- Please see Programs & Services for additional information. Some services may come at an additional cost to the fees shown above.
- Broker Compensation, if applicable, is subject to customer approval.
- Any Plan Year costs are based on the Estimated Enrollment and subject to change based on actual enrollment.
- Aetna retains 40 percent of the negotiated PPOII savings as a network access charge for this subset of the network

***Service Fee Guarantee**

Our offer includes a service fee guarantee for the guarantee period October 1, 2026 to September 30, 2032. The guaranteed service fees excluding broker compensation are listed above. The service fee guarantee is subject to the terms and conditions as stated in the caveats and is contingent upon the customer maintaining all lines of business with Aetna.

Program Summary	PPO Dental
General Admin	
Claim Fiduciary-Option 4 - Aetna 90% of Fiduciary Role & External Review	Yes
Communication Materials	Yes
Customer Team Services	Yes
Designated billing, eligibility, plan set up, underwriting and drafting services	Yes
Eligibility (Standard)	Yes
Experienced Account Management Team	Yes
Review or draft plan documents	Yes
Banking	
Alternate Stockpiling	Yes
Banking Method-Bank Initiated ACH	Yes
Funding Basis-Cleared	Yes
Claim and Member Services	
Aetna Dental/Medical Integration SM (DMI)	Yes
Aetna Voice Advantage [®] Level 2	Yes
Claim Administration	Yes
Digital ID Cards	Yes
Member Services	Yes
Special Investigations/Zero Tolerance Fraud Unit	Yes
Network Information	
Network Access	Yes
Provider Relations	Yes
Web Tools	
Claim Research/forms/Contact us (English & Spanish Version)	Yes
Member Website and Mobile Experience	Yes
Aetna Discount Program	
Aetna Discount Program - at home products, fitness, hearing, LifeMart [®] shopping website, natural products and services, oral health care, vision, weight management	Yes
Reporting	
Analytic Consultation from Plan Sponsor Insights (5 hours)	Yes

For the purposes of this document, Aetna may be referred to using "we", "our" or "us" and Brazoria County may be referred to using "you" or "your".

Our renewal is illustrative and subject to change based upon underwriting review of the information listed and requested below. Any of the information listed below, which has not been provided, may be required prior to final approval of a sale.

Underwriting Caveats

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

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

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

Enrollment

There is a 10 percent change in the number of enrolled employees from our enrollment assumptions or from any subsequently reset enrollment assumptions. Our renewal assumes coverage will not be extended to additional employee groups without review of supplemental census information and other underwriting information for appropriate financial review.

Member-to-Employee Ratio

The member-to-employee ratio changes by more than 10 percent from the 1.75 ratio assumed in this quote.

Projected Processed Claim Transactions (PCT) Per Employee

The actual PCT ratio changes by more than 10 percent from the 3.34 ratio assumed in this quote.

Quoted Benefits and Administration

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

Multi-Year Provision

You place the products, programs and services included in this multi-year fee guarantee out to bid with an effective date prior to September 30, 2027, then this guarantee is no longer valid.

Performance Guarantees

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

Non-Compliance Notice

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

Multiple Employer Welfare Arrangements (MEWAs) and Employer Association Health Plans (AHPs)

This quote was prepared based on the demographic information for eligible enrollees, including their home zip codes, in accordance with all applicable mandates. We must be notified immediately of any changes that affect plan locations due to new or changing enrollment statuses. We will evaluate regulatory requirements and may not be able to extend coverage in states which prohibit large group coverage through MEWAs and AHPs.

Assumptions**Underwriting****Agreement Provisions**

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

Aetna Medical/Dental Coverage

The proposed medical and dental fees are contingent upon you purchasing both medical and dental lines of coverage.

Plan Design

This renewal is based on the current benefit plan designs, plus any noted deviations.

Claim Fiduciary

Our renewal assumes we'll provide mandatory Level I (benefit review and determination of claims) and Level II (deciding appeals and final claims determination) appeals. We'll also write the letter to the member to communicate the appeal decision. We'll defend any lawsuit originating during or after completion of the first two levels of appeal. You'll act as claim fiduciary for all voluntary appeals after Level I and Level II appeals are exhausted.

Waiting Period

New employees must complete the waiting period designated by their employer prior to enrolling in one of our plans. The waiting period must be consistently applied within a class of employees.

Additional Products and Services

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

Billing Information**Advanced Notification of Fee Change**

We'll notify you of any fee change at least 31 days prior to the effective date of fee change.

Late Payment

We reserve the right to assess a late payment charge at a 12 percent annual interest rates as follows:

- if you fail to pay plan benefit payments in accordance with the terms as outlined in your Master Service Agreement.
- if you fail to pay administrative service fees within 31 days of the due date.

We'll 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.

Incurred late wire interest charges will be added to a future wire request and collected through your claim wire billing account. Incurred late fee payment interest charges will be added to a future service fee bill.

Producer Compensation

The quoted fees don't include producer compensation.

Claim and Member Services**Runoff Claim Processing**

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

Dental Service Center

Claim administration and member services for the quoted plans will be centrally managed. Members will be able to reach the Member Service representatives Monday through Friday, from 8 a.m. to 6 p.m., local time (based on where the member resides).

Reporting and Data Transfer**Aetna Intellectual Property**

Under the Agreement, you may have access to certain of Aetna's Plan Sponsor reporting systems. Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under the Agreement ("Aetna IP"). Aetna will grant you, as the Plan Sponsor, a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in the Agreement. You agree not to modify, create derivative product from, copy, duplicate, decompile, 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 the Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent, or otherwise transfer or convey, the Aetna IP to you.

Data Transfer at Termination

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

Banking

We've assumed that you provide funds through a bank initiated ACH wire transfer for drafts clearing the bank under the self-funded arrangement assumed in this renewal.

Our standard banking arrangement is to request funds when claims have accumulated to more than \$20,000. In this arrangement, a wire request is sent to you and/or your bank requesting funds for the total claims from the previous day(s). In place of this arrangement, we'll request funds for claims. In addition, there will be a month end close out request on the first banking day of each subsequent month. We've included the cost for this service in your Guaranteed Fees.

The proposed banking arrangement is subject to change based on results of a credit risk evaluation. We will complete an evaluation upon notification of sale.

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

Additional

Please review the additional important information found at the following URL. This information is incorporated by reference into this package and considered part of your Agreement. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriting Disclosure Document, the information in your Renewal Package prevails.

<https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/legal-notice/documents/large-group-dental-underwriting-self-funded-disclosure-as-of-01-01-2025.pdf>

Legislative and Regulatory Requirements

Fees and Assessments

This proposal is intended to be compliant with health care reform. Aetna reserves the right to modify its products, services, rates, and fees, in response to legislation, regulation or requests of government authorities resulting in changes to plan benefits and to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

Recovery of Overpayments

Our process of recovering overpayments attempts to recoup money in the most accurate, effective, and cost-efficient manner. We have provided more detail below on how we recover overpayments.

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

**COALITION PHARMACY SERVICE AND FEE SCHEDULE
MASTER SERVICES AGREEMENT MSA- 0838904
EFFECTIVE October 1, 2026 (“Schedule Effective Date”)**

DRAFT

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	Pass Through at Retail
Network	Aetna National Network
Employees	1,492

RETAIL			
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
Brand Discount	AWP - 20.50%	AWP - 20.50%	AWP - 20.50%
Generic Discount	AWP - 87.10%	AWP - 87.20%	AWP - 87.20%
Dispensing Fee	\$0.20 per Script	\$0.20 per Script	\$0.20 per Script

MAIL ORDER PHARMACY/MAINTENANCE CHOICE			
Mail Benefit Type	Mandatory Maintenance Choice with Opt Out		
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
Brand Discount	AWP - 20.50%	AWP - 20.50%	AWP - 20.50%
Generic Discount	AWP - 92.10% (MAC & NON-MAC Combined)	AWP - 92.20% (MAC & NON-MAC Combined)	AWP - 92.20% (MAC & NON-MAC Combined)
Non-MAC Generics	AWP - 25.00%	AWP - 25.00%	AWP - 25.00%
Dispensing Fee	\$0.00 per Script	\$0.00 per Script	\$0.00 per Script

SPECIALTY IN RETAIL			
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
Brand Discount	AWP - 18.00%	AWP - 18.00%	AWP - 18.00%
Generic Discount	AWP - 50.00%	AWP - 50.00%	AWP - 50.00%
Limited Distribution Drugs (With & Without Access)	AWP - 17.00%	AWP - 17.00%	AWP - 17.00%
Dispensing Fee	\$0.20 per script	\$0.20 per script	per script

SPECIALTY PHARMACY			
Network	Specialty Performance Network		
Product List	Aetna Specialty Product List		
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
Discount	AWP - 23.50%	AWP - 23.50%	AWP - 23.50%

ADMINISTRATIVE FEES/CLINICAL PROGRAM FEES			
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
Electronic Claim Administration Fee	\$1.80 per Claim	\$1.80 per Claim	\$1.80 per Claim
Manual Claim Administration Fee	\$1.50 per Claim	\$1.50 per Claim	\$1.50 per Claim
Third Party Payment	\$2.00 per Claim	\$2.00 per Claim	\$2.00 per Claim
Drug Savings Review	\$0.30 PMPM	\$0.30 PMPM	\$0.30 PMPM
Vaccine Program	\$0.05 PMPM	\$0.05 PMPM	\$0.05 PMPM

ALLOWANCES			
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
General Allowance	\$3.00 PMPY	\$3.00 PMPY	\$3.00 PMPY

SPECIALTY PHARMACY			
Network	Specialty Performance Network		
Product List	Aetna Specialty Product List		
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
Discount	AWP - 23.50%	AWP - 23.50%	AWP - 23.50%

ADMINISTRATIVE FEES/CLINICAL PROGRAM FEES			
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
Electronic Claim Administration Fee	\$1.80 per Claim	\$1.80 per Claim	\$1.80 per Claim
Manual Claim Administration Fee	\$1.50 per Claim	\$1.50 per Claim	\$1.50 per Claim
Third Party Payment	\$2.00 per Claim	\$2.00 per Claim	\$2.00 per Claim
Drug Savings Review	\$0.30 PMPM	\$0.30 PMPM	\$0.30 PMPM
Vaccine Program	\$0.05 PMPM	\$0.05 PMPM	\$0.05 PMPM

ALLOWANCES			
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
General Allowance	\$3.00 PMPY	\$3.00 PMPY	\$3.00 PMPY

Rebates

REBATES			
Formulary	Advanced Control Formulary		
Rebate Terms	Customer will receive the following guaranteed rebates:		
	10/01/2026 - 12/31/2027	01/01/2028 - 12/31/2028	01/01/2029 - 09/30/2029
Retail	\$557.43 Per Brand Script	\$587.00 Per Brand Script	\$587.00 Per Brand Script
Mail Order/Maintenance Choice	\$1,223.47 Per Brand Script	\$1,260.00 Per Brand Script	\$1,260.00 Per Brand Script
Specialty	\$6,500.00 Per Brand Script	\$6,900.00 Per Brand Script	\$6,900.00 Per Brand Script
Specialty at Retail	\$6,500.00 Per Brand Script	\$6,900.00 Per Brand Script	\$6,900.00 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.

Additional Disclosures

This pricing has an effective date of October 1, 2026 and is contingent upon signing a three-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 Customer 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.

Maintenance Choice

The voluntary Maintenance Choice Program is a standard program available to our eligible* Customers who elect Aetna as your prescription benefit manager. Our innovative voluntary Maintenance Choice® program combines Aetna mail and CVS Pharmacy retail capabilities to provide members improved choice in how they access and receive maintenance medications (e.g., 84-90 day supplies). The voluntary Maintenance Choice Program allows members to receive: (i) prescriptions from all participating retail pharmacies for 30-day maintenance medications; and (ii) 90-day prescriptions of Maintenance Choice prescriptions from CVS Pharmacy retail locations and Aetna mail service. All 30-day maintenance medications dispensed by participating retail pharmacies will be charged in accordance with the retail rates set forth in the Agreement.

Enrollment into the voluntary Maintenance Choice® program is automatic as part of our standard offering. If you do not wish to implement the voluntary Maintenance Choice® program, please notify your Implementation and/or Account Team of your intent to opt-out. Your Account Team would also be pleased to discuss other Maintenance Choice offerings that can further maximize the savings and convenience that our Maintenance Choice® program offers Customers and their members.

Maintenance Choice Prescriptions will be treated the same as prescriptions filled at our mail service pharmacies for purposes of any mail pricing guarantees and generic dispensing rate guarantees set forth in the Agreement. Maintenance Choice Prescriptions will be disregarded and therefore excluded for purposes of calculating all mail service pharmacy non-financial performance guarantees set forth in the Agreement. The participating pharmacy may collect from the member the lowest of the discounted cost, applicable cost share, or the participating pharmacy's usual and customary price.

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 Advanced Control 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: AWP -15.00%;
- New to Market Generic Drugs: AWP -15.00%;
- New to Market Limited and exclusive distribution drugs: AWP -10.00%.

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 \$3.00 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.

Third Party Payment

Aetna will bill the Participating Groups an administrative fee of \$2.00 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 90 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 the information from disclosure.

**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 - Aetna Standard Preventive Drug List (HDHP) - Aetna Standard Preventive Drug List (ACA) - 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	- Member Services Call Center – Available 24/7 - Real-Time Benefits - Aetna Health Mobile App and Internet Tools - 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 - Member specific e-mail communications - Aetna Integrated Pre- and Post-enrollment materials - Clinical program member letters, including transition letters for formulary changes/updates - Informational brochures for using the CVS Caremark Mail Service Pharmacy, including order forms - Member-specific formulary and plan design - Aetna Health website and app brochures	- Claim funding and banking arrangements integrated with your Aetna medical plan - Consultative services - Education materials on key healthcare topics - Implementation support including eligibility loading and ongoing additions/deletions - Regulatory and compliance support by specific line of business - Meetings to discuss program performance - 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 - 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) - Account Team Supported Reporting - Clinical Program Opportunity Analysis	Analytic Support cont. - Claim detail reporting combined with medical reporting through the new reporting tool, ART - Quarterly clinical and financial reports based on aggregate customer utilization

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

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



AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Specialty	
Included in Core Services	
Specialty Clinical Solutions - 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 Support cont. - Specialty Expedite - Specialty Connect - Digital - Secure Messaging - First time fill prescription processing - Specialty CareTeam - Patient Assistance Program
Specialty Benefit Administration - Specialty Guideline Management (SGM) – criteria development and maintenance - Specialty Copay Card Plan Designs - Standard Specialty Product List - Exclusive Specialty Grace Fill Member Letter (Under Member Communication Materials)	Specialty Pharmacy - Use of the CVS Specialty Pharmacy network with full integration of retail, mail and specialty claims - Information System Infrastructure & Maintenance - Member Onboarding - Member counseling label – drug specific - 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 - Open enrollment links - Aetna.com configurations	Standard Digital Services cont. - Single Sign on (SSO) - 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 Assessment¹		\$0.30	Per Retail Claim Only
Traditional Pricing Auxiliary Fee²		\$1.50	Per Retail Claim Only
Retail Network Pharmacy Third Party Appeal		Pass through Fees Per Review	

¹Applies 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

²Applicable 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

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. Aetna calculates the guaranteed savings short-fall and reimburses Customer a portion of the fees paid based on the difference between the actual savings generated and the guaranteed savings, divided by the ROI guarantee amount.



The amount of the fees credited to Customer reduces the DSR Program Fees paid by Customer to an amount that satisfies the savings guarantee based on actual savings. 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

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



PSUID

NACo Exclusive 01012026
Specialty Fee Schedule
85784653

Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Acromegaly	octreotide	49.50%
Acromegaly	SANDOSTATIN	17.25%
Acromegaly	SOMATULINE	17.50%
Acromegaly	SOMAVERT	16.25%
Allergic Asthma	CINQAIR	15.25%
Allergic Asthma	DUPIXENT_ASTHMA	17.50%
Allergic Asthma	FASENRA	16.50%
Allergic Asthma	NUCALA	16.75%
Allergic Asthma	TEZSPIRE	17.25%
Allergic Asthma	XOLAIR	16.00%
Alpha-1 Antitrypsin Deficiency	ARALAST NP	18.00%
Alpha-1 Antitrypsin Deficiency	GLASSIA	18.00%
Alpha-1 Antitrypsin Deficiency	ZEMAIRA	18.00%
Amyloidosis	AMVUTTRA	15.75%
Amyloidosis	ONPATRO	15.75%
Amyloidosis	VYNDAMAX	17.25%
Amyloidosis	VYNDAQEL	14.50%
Anemia	ARANESP	14.25%
Anemia	ENJAYMO	10.00%
Anemia	EPOGEN	8.00%
Anemia	PROCRIT	14.00%
Anemia	REBLOZYL	17.00%
Anemia	RETACRIT	6.00%
Atopic Dermatitis	ADBRY	18.50%
Atopic Dermatitis	CIBINQO	16.25%
Atopic Dermatitis	DUPIXENT_ATOPIC DERMATITIS	17.50%
Bone Disorders - Other	SOHONOS	10.00%
Bone Disorders - Other	VOXZOGO	15.75%
Cardiac Disorders	CAMZYOS	13.50%
Cardiac Disorders	dofetilide	MAC
Cardiac Disorders	TIKOSYN	13.75%
Coagulation Disorders	CEPROTIN	16.75%
Cryopyrin Associated Periodic Syndromes	ARCALYST	16.50%
Cryopyrin Associated Periodic Syndromes	ILARIS	17.75%
Cystic Fibrosis	BETHKIS	14.25%
Cystic Fibrosis	BRONCHITOL	15.00%
Cystic Fibrosis	CAYSTON	17.00%
Cystic Fibrosis	KITABIS PAK	17.50%
Cystic Fibrosis	PULMOZYME	16.50%
Cystic Fibrosis	TOBI	17.25%
Cystic Fibrosis	TOBI PODHALER	17.25%
Cystic Fibrosis	tobramycin	MAC
Dupuytren's Contracture	XIAFLEX	10.00%
Electrolyte Disorders	dichlorphenamide	38.00%
Electrolyte Disorders	SAMSCA	17.50%
Electrolyte Disorders	tolvaptan	MAC
Endocrine Disorders	CORTROPHIN	13.75%
Enzyme Deficiency Disorders - Other	betaine anhydrous	MAC
Enzyme Deficiency Disorders - Other	nitisinone	MAC
Enzyme Deficiency Disorders - Other	RYPLAZIM	10.00%
Gastrointestinal	GATTEX	16.25%
Gastrointestinal	OCALIVA	15.50%
Gastrointestinal	SOLESTA	14.25%
Gout	KRYSTEXXA	17.50%
Growth Hormone	EGRIFTA	17.00%
Growth Hormone	GENOTROPIN	16.50%
Growth Hormone	HUMATROPE	18.00%
Growth Hormone	INCRELEX	17.75%
Growth Hormone	NGENLA	10.00%
Growth Hormone	NORDITROPIN	21.00%
Growth Hormone	NUTROPIN	16.00%



PSUID

Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Growth Hormone	OMNITROPE	15.75%
Growth Hormone	SAIZEN	16.75%
Growth Hormone	SEROSTIM	17.00%
Growth Hormone	SKYTROFA	21.00%
Growth Hormone	SOGROYA	10.00%
Growth Hormone	ZOMACTON	13.50%
Growth Hormone	ZORBTIVE	18.00%
Hematopoietics	MOZOBIL	17.50%
Hematopoietics	plerixafor	15.00%
Hemophilia	ADVATE	38.00%
Hemophilia	ADYNOVATE	30.00%
Hemophilia	AFSTYLA	34.50%
Hemophilia	ALPHANATE	38.00%
Hemophilia	ALPHANINE SD	35.50%
Hemophilia	ALPROLIX	17.00%
Hemophilia	ALTUVIIIO	26.00%
Hemophilia	BENEFIX	15.00%
Hemophilia	COAGADEX	25.50%
Hemophilia	CORIFACT	26.00%
Hemophilia	ELOCTATE	22.00%
Hemophilia	ESPEROCT	25.00%
Hemophilia	FEIBA	24.50%
Hemophilia	FIBRYGA	14.25%
Hemophilia	HEMLIBRA	19.00%
Hemophilia	HEMOFIL M	37.50%
Hemophilia	HUMATE-P	30.00%
Hemophilia	IDELVION	18.00%
Hemophilia	IXINITY	26.00%
Hemophilia	JIVI	20.50%
Hemophilia	KOATE	40.50%
Hemophilia	KOGENATE	39.00%
Hemophilia	KOVALTRY	39.00%
Hemophilia	MONONINE	22.00%
Hemophilia	NOVOEIGHT	36.00%
Hemophilia	NOVOSEVEN RT	25.00%
Hemophilia	NUWIQ	32.00%
Hemophilia	OBIZUR	10.00%
Hemophilia	PROFILNINE SD	21.50%
Hemophilia	REBINYN	20.00%
Hemophilia	RECOMBINATE	35.50%
Hemophilia	RIASTAP	21.50%
Hemophilia	RIXUBIS	25.00%
Hemophilia	SEVENFACT	25.00%
Hemophilia	STIMATE	14.50%
Hemophilia	TRETTEN	15.25%
Hemophilia	VONVENDI	10.00%
Hemophilia	WILATE	39.00%
Hemophilia	XYNTHA	35.50%
Hepatitis C	EPCLUSA	19.00%
Hepatitis C	HARVONI	19.00%
Hepatitis C	LEDIPASVIR/SOFOSBUVIR	19.00%
Hepatitis C	MAVYRET	18.50%
Hepatitis C	PEGASYS	15.25%
Hepatitis C	ribavirin	MAC
Hepatitis C	SOFOSBUVIR/VELPATASVIR	19.00%
Hepatitis C	SOVALDI	19.00%
Hepatitis C	VOSEVI	18.50%
Hepatitis C	ZEPATIER	19.25%
Hereditary Angioedema	BERINERT	19.00%



PSUID

Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Hereditary Angioedema	CINRYZE	14.00%
Hereditary Angioedema	FIRAZYR	16.00%
Hereditary Angioedema	HAEGARDA	14.00%
Hereditary Angioedema	icatibant acetate	MAC
Hereditary Angioedema	KALBITOR	14.00%
Hereditary Angioedema	RUCONEST	16.50%
Hereditary Angioedema	TAKHZYRO	15.50%
Hormonal Therapies	AVEED	13.00%
Hormonal Therapies	ELIGARD	14.25%
Hormonal Therapies	FENSOLVI	19.00%
Hormonal Therapies	FIRMAGON	8.25%
Hormonal Therapies	leuprolide acetate	MAC
Hormonal Therapies	LEUPROLIDE ACETATE BRAND	11.50%
Hormonal Therapies	LUPRON DEPOT	16.75%
Hormonal Therapies	SUPPRELIN	18.00%
Hormonal Therapies	TRELSTAR	15.50%
Hormonal Therapies	ZOLADEX	10.50%
I.V.I.G.	ASCENIV	13.50%
I.V.I.G.	BIVIGAM	12.75%
I.V.I.G.	CUTAQUIG	13.50%
I.V.I.G.	CUVITRU	25.00%
I.V.I.G.	CYTOGAM	9.00%
I.V.I.G.	FLEBOGAMMA	16.25%
I.V.I.G.	GAMASTAN S/D	17.00%
I.V.I.G.	GAMMAGARD	32.00%
I.V.I.G.	GAMMAGARD LIQUID	37.00%
I.V.I.G.	GAMMAKED	15.50%
I.V.I.G.	GAMMAPLEX	34.00%
I.V.I.G.	GAMUNEX	27.00%
I.V.I.G.	HEPAGAM B	17.00%
I.V.I.G.	HIZENTRA	40.00%
I.V.I.G.	HYPERHEP B	17.00%
I.V.I.G.	HYPERRHO S/D	17.00%
I.V.I.G.	HYQVIA	28.00%
I.V.I.G.	MICRHOGAM	17.00%
I.V.I.G.	NABI-HB	15.50%
I.V.I.G.	OCTAGAM	36.00%
I.V.I.G.	PANZYGA	15.50%
I.V.I.G.	PRIVIGEN	36.00%
I.V.I.G.	RHOGAM	17.00%
I.V.I.G.	RHOPHYLAC	17.00%
I.V.I.G.	VARIZIG	17.00%
I.V.I.G.	WINRHO	15.50%
I.V.I.G.	XEMBIFY	25.00%
Infectious Disease	ACTIMMUNE	18.00%
Infectious Disease	ALFERON N	10.50%
Infertility	cetorelix acetate	MAC
Infertility	CETROTIDE	12.50%
Infertility	CHORIONIC GONADOTROPIN	17.00%
Infertility	FOLLISTIM AQ	16.50%
Infertility	fyremadel	MAC
Infertility	ganirelix acetate	MAC
Infertility	GANIRELIX ACETATE BRAND	9.25%
Infertility	GONAL-F	16.50%
Infertility	MENOPUR	16.00%
Infertility	NOVAREL	17.00%
Infertility	OVIDREL	17.00%
Infertility	PREGNYL	17.00%
Inflammatory Bowel Disease	CIMZIA	18.25%



Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Inflammatory Bowel Disease	CIMZIA POW	16.50%
Inflammatory Bowel Disease	ENTYVIO	16.75%
Inflammatory Bowel Disease	ENTYVIO SC	10.00%
Inflammatory Bowel Disease	OMVOH	10.00%
Inflammatory Bowel Disease	RENFLEXIS	19.50%
Inflammatory Bowel Disease	VELSIPITY	10.00%
Inflammatory Bowel Disease	ZYMFENTRA	15.00%
Iron Overload	deferasirox	MAC
Iron Overload	deferiprone	MAC
Iron Overload	deferoxamine	17.00%
Iron Overload	DESFERAL	16.25%
Iron Overload	EXJADE	17.25%
Iron Overload	JADENU	17.25%
Lysosomal Storage Diseases	ALDURAZYME	17.00%
Lysosomal Storage Diseases	CERDELGA	15.25%
Lysosomal Storage Diseases	CEREZYME	17.00%
Lysosomal Storage Diseases	CYSTAGON	17.00%
Lysosomal Storage Diseases	ELAPRASE	15.75%
Lysosomal Storage Diseases	ELELYSO	17.00%
Lysosomal Storage Diseases	FABRAZYME	15.75%
Lysosomal Storage Diseases	KANUMA	17.50%
Lysosomal Storage Diseases	LUMIZYME	17.25%
Lysosomal Storage Diseases	miglustat	MAC
Lysosomal Storage Diseases	NAGLAZYME	15.75%
Lysosomal Storage Diseases	NEXVIAZYME	16.50%
Lysosomal Storage Diseases	OPFOLDA	10.00%
Lysosomal Storage Diseases	POMBILITI	10.00%
Lysosomal Storage Diseases	VIMIZIM	15.75%
Lysosomal Storage Diseases	VPRIV	15.25%
Lysosomal Storage Diseases	XENPOZYME	16.50%
Mental Health Conditions	ZULRESSO	17.00%
Mental Health Conditions	ZURZUVAE	10.00%
Movement Disorders	APOKYN	19.50%
Movement Disorders	apomorphine hydrochloride inj	42.00%
Movement Disorders	AUSTEDO	18.00%
Movement Disorders	droxidopa	MAC
Movement Disorders	DUOPA	17.75%
Movement Disorders	INGREZZA	16.50%
Movement Disorders	KYNMOBI	15.25%
Movement Disorders	NORTHERA	16.75%
Movement Disorders	NUPLAZID	18.00%
Movement Disorders	RADICAVA ORS	15.50%
Movement Disorders	RELYVRIO	13.75%
Movement Disorders	tetrabenazine	MAC
Movement Disorders	XENAZINE	17.00%
Multiple Sclerosis	AMPYRA	14.00%
Multiple Sclerosis	AUBAGIO	18.75%
Multiple Sclerosis	AVONEX	18.75%
Multiple Sclerosis	BAFIERTAM	19.25%
Multiple Sclerosis	BETASERON	18.75%
Multiple Sclerosis	BRIUMVI	14.00%
Multiple Sclerosis	COPAXONE 20	17.50%
Multiple Sclerosis	COPAXONE 40	17.50%
Multiple Sclerosis	dalfampridine	MAC
Multiple Sclerosis	dimethyl fumarate	MAC
Multiple Sclerosis	EXTAVIA	17.75%
Multiple Sclerosis	fingolimod	MAC
Multiple Sclerosis	GILENYA	17.75%
Multiple Sclerosis	glatiramer acetate 20	70.00%



PSUID

Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Multiple Sclerosis	glatiramer acetate 40	70.00%
Multiple Sclerosis	glatopa 20	70.00%
Multiple Sclerosis	glatopa 40	70.00%
Multiple Sclerosis	KESIMPTA	19.25%
Multiple Sclerosis	LEMTRADA	17.75%
Multiple Sclerosis	MAVENCLAD	19.25%
Multiple Sclerosis	MAYZENT	17.50%
Multiple Sclerosis	mitoxantrone	17.00%
Multiple Sclerosis	OCREVUS	17.50%
Multiple Sclerosis	PLEGRIDY	18.75%
Multiple Sclerosis	PONVORY	19.25%
Multiple Sclerosis	REBIF	17.25%
Multiple Sclerosis	TECFIDERA	19.25%
Multiple Sclerosis	teriflunomide	MAC
Multiple Sclerosis	TYSABRI	17.00%
Multiple Sclerosis	VUMERITY	18.75%
Multiple Sclerosis	ZEPOSIA	19.25%
Neurological Disorders	ADUHELM	16.00%
Neuromuscular	RYSTIGGO	10.00%
Neuromuscular	VYVGART	18.50%
Neuromuscular	VYVGART HYTRULO	10.00%
Neutropenia	FULPHILA	16.50%
Neutropenia	FYLNETRA	11.00%
Neutropenia	GRANIX	16.00%
Neutropenia	LEUKINE	16.50%
Neutropenia	NEULASTA	17.00%
Neutropenia	NEUPOGEN	16.00%
Neutropenia	NIVESTYM	15.00%
Neutropenia	NYVEPRIA	15.50%
Neutropenia	RELEUKO	12.50%
Neutropenia	ROLVEDON	11.75%
Neutropenia	STIMUFEND	12.75%
Neutropenia	UDENYCA	16.50%
Neutropenia	ZARXIO	15.00%
Neutropenia	ZIEXTENZO	16.25%
Ocular Disorders	SUSVIMO	16.75%
Oncology - Injectable	ABRAXANE	17.00%
Oncology - Injectable	ADCETRIS	17.75%
Oncology - Injectable	ALYMSYS	16.00%
Oncology - Injectable	AVASTIN	16.50%
Oncology - Injectable	azacitidine	48.00%
Oncology - Injectable	BELEODAQ	17.50%
Oncology - Injectable	BELRAPZO	16.25%
Oncology - Injectable	BENDAMUSTINE HYDROCHLORID	17.25%
Oncology - Injectable	bendamustine hydrochloride inj	13.25%
Oncology - Injectable	BENDEKA	17.50%
Oncology - Injectable	BESPONS	17.25%
Oncology - Injectable	BLINCYTO	13.75%
Oncology - Injectable	BORTEZOMIB	17.00%
Oncology - Injectable	bortezomib for inj	12.75%
Oncology - Injectable	BORTEZOMIB FOR INJ BRAND	9.25%
Oncology - Injectable	COLUMVI	10.00%
Oncology - Injectable	CYRAMZA	17.25%
Oncology - Injectable	DACOGEN	17.25%
Oncology - Injectable	DARZALEX	17.50%
Oncology - Injectable	decitabine	21.00%
Oncology - Injectable	EMPLICITI	17.50%
Oncology - Injectable	ENHERTU	13.00%
Oncology - Injectable	ERBITUX	17.25%



PSUID

Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Oncology - Injectable	EVOMELA	17.50%
Oncology - Injectable	FOLOTYN	17.50%
Oncology - Injectable	GAZYVA	17.50%
Oncology - Injectable	HALAVEN	17.00%
Oncology - Injectable	HERCEPTIN	17.00%
Oncology - Injectable	HERCEPTIN HYLECTA	17.00%
Oncology - Injectable	HERZUMA	16.50%
Oncology - Injectable	IMDELLTRA	10.00%
Oncology - Injectable	IMFINZI	17.25%
Oncology - Injectable	IMJUDO	16.25%
Oncology - Injectable	ISTODAX	17.50%
Oncology - Injectable	IXEMPRA	17.00%
Oncology - Injectable	JEMPERLI	16.75%
Oncology - Injectable	JEVTANA	17.00%
Oncology - Injectable	KADCYLA	17.00%
Oncology - Injectable	KANJINTI	16.50%
Oncology - Injectable	KEYTRUDA	17.25%
Oncology - Injectable	KHAPZORY	13.00%
Oncology - Injectable	KYPROLIS	17.50%
Oncology - Injectable	levoleucovorin calcium	13.00%
Oncology - Injectable	LOQTORZI	10.00%
Oncology - Injectable	LUNSUMIO	13.75%
Oncology - Injectable	MARGENZA	17.00%
Oncology - Injectable	MVASI	17.00%
Oncology - Injectable	MYLOTARG	16.25%
Oncology - Injectable	OGIVRI	15.75%
Oncology - Injectable	ONIVYDE	11.00%
Oncology - Injectable	ONTRUZANT	13.50%
Oncology - Injectable	OPDIVO	17.25%
Oncology - Injectable	OPDUALAG	17.00%
Oncology - Injectable	paclitaxel protein-bound	14.00%
Oncology - Injectable	PACLITAXEL PROTEIN-BOUND BRAND	17.00%
Oncology - Injectable	PADCEV	16.25%
Oncology - Injectable	PERJETA	17.00%
Oncology - Injectable	PHESGO	17.00%
Oncology - Injectable	POLIVY	17.00%
Oncology - Injectable	PORTRAZZA	17.25%
Oncology - Injectable	POTELIGEO	10.00%
Oncology - Injectable	PROLEUKIN	17.75%
Oncology - Injectable	RIABNI	13.75%
Oncology - Injectable	RITUXAN	17.50%
Oncology - Injectable	RITUXAN HYCELA	17.25%
Oncology - Injectable	romidepsin	14.25%
Oncology - Injectable	ROMIDEPSIN BRAND	16.75%
Oncology - Injectable	RUXIENCE	17.75%
Oncology - Injectable	RYBREVANT	13.75%
Oncology - Injectable	RYLAZE	16.25%
Oncology - Injectable	SARCLISA	13.00%
Oncology - Injectable	SYLVANT	16.50%
Oncology - Injectable	TECENTRIQ	17.00%
Oncology - Injectable	TEMODAR (INJECTABLE)	17.50%
Oncology - Injectable	temsirolimus	32.00%
Oncology - Injectable	TEPADINA	14.00%
Oncology - Injectable	THYROGEN	16.25%
Oncology - Injectable	TIVDAK	16.75%
Oncology - Injectable	TORISEL	17.25%
Oncology - Injectable	TRAZIMERA	16.50%
Oncology - Injectable	TREANDA	17.00%
Oncology - Injectable	TRUXIMA	17.50%



Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Oncology - Injectable	valrubicin	15.25%
Oncology - Injectable	VALSTAR	17.50%
Oncology - Injectable	VECTIBIX	17.00%
Oncology - Injectable	VEGZELMA	13.75%
Oncology - Injectable	VELCADE	17.00%
Oncology - Injectable	VIDAZA	13.00%
Oncology - Injectable	VIVIMUSTA	13.75%
Oncology - Injectable	VYXEOS	17.00%
Oncology - Injectable	XGEVA	15.75%
Oncology - Injectable	YERVOY	17.50%
Oncology - Injectable	YONDELIS	17.25%
Oncology - Injectable	ZALTRAP	17.25%
Oncology - Injectable	ZEPZELCA	17.00%
Oncology - Injectable	ZIRABEV	16.00%
Oncology - Injectable	zoledronic acid onc	45.50%
Oncology - Injectable	ZOLEDRONIC ACID ONC BRAND	17.00%
Oncology - Injectable	ZYNYZ	13.75%
Oncology - Oral	abiraterone acetate	MAC
Oncology - Oral	AFINITOR	17.25%
Oncology - Oral	ALECENSA	17.25%
Oncology - Oral	AUGTYRO	10.00%
Oncology - Oral	BALVERSA	10.00%
Oncology - Oral	bexarotene cap	MAC
Oncology - Oral	bexarotene gel	MAC
Oncology - Oral	BOSULIF	17.25%
Oncology - Oral	BRAFTOVI	16.50%
Oncology - Oral	CABOMETYX	16.00%
Oncology - Oral	capecitabine	MAC
Oncology - Oral	COMETRIQ	15.75%
Oncology - Oral	COPIKTRA	16.25%
Oncology - Oral	COTELLIC	16.75%
Oncology - Oral	DAURISMO	17.50%
Oncology - Oral	ERIVEDGE	17.25%
Oncology - Oral	ERLEADA	17.50%
Oncology - Oral	erlotinib hydrochloride	MAC
Oncology - Oral	everolimus onc	MAC
Oncology - Oral	FARYDAK	17.00%
Oncology - Oral	gefitinib	MAC
Oncology - Oral	GLEEVEC	17.50%
Oncology - Oral	GLEOSTINE	12.50%
Oncology - Oral	HYCAMTIN	17.00%
Oncology - Oral	IBRANCE	17.75%
Oncology - Oral	IDHIFA	15.50%
Oncology - Oral	imatinib mesylate	MAC
Oncology - Oral	INLYTA	17.50%
Oncology - Oral	INQOVI	15.50%
Oncology - Oral	INREBIC	15.75%
Oncology - Oral	IRESSA	17.50%
Oncology - Oral	JAKAFI	16.00%
Oncology - Oral	JAYPIRCA	14.00%
Oncology - Oral	KISQALI	17.50%
Oncology - Oral	lapatinib ditosylate	35.00%
Oncology - Oral	lenalidomide	43.00%
Oncology - Oral	LENVIMA	14.25%
Oncology - Oral	LONSURF	16.00%
Oncology - Oral	LORBRENA	17.50%
Oncology - Oral	LUMAKRAS	16.75%
Oncology - Oral	LYNPARZA	17.25%
Oncology - Oral	MEKINIST	17.25%



PSUID

Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Oncology - Oral	MEKTOVI	16.50%
Oncology - Oral	NERLYNX	15.50%
Oncology - Oral	NEXAVAR	16.00%
Oncology - Oral	NINLARO	16.00%
Oncology - Oral	NUBEQA	15.75%
Oncology - Oral	ODOMZO	17.25%
Oncology - Oral	ONUREG	14.00%
Oncology - Oral	pazopanib hydrochloride	MAC
Oncology - Oral	PIQRAY	17.25%
Oncology - Oral	POMALYST	16.00%
Oncology - Oral	PURIXAN	14.00%
Oncology - Oral	RETEVMO	14.00%
Oncology - Oral	REVLIMID	16.00%
Oncology - Oral	ROZLYTREK	17.25%
Oncology - Oral	RUBRACA	16.25%
Oncology - Oral	RYDAPI	14.00%
Oncology - Oral	sorafenib tosylate	MAC
Oncology - Oral	SPRYCEL	18.75%
Oncology - Oral	STIVARGA	16.00%
Oncology - Oral	sunitinib malate	MAC
Oncology - Oral	SUTENT	17.25%
Oncology - Oral	TABRECTA	17.50%
Oncology - Oral	TAFINLAR	17.25%
Oncology - Oral	TAGRISSO	17.50%
Oncology - Oral	TALZENNA	17.50%
Oncology - Oral	TARCEVA	17.00%
Oncology - Oral	TARGRETIN	17.50%
Oncology - Oral	TASIGNA	17.25%
Oncology - Oral	TEMODAR (ORAL)	17.50%
Oncology - Oral	temozolomide	MAC
Oncology - Oral	THALOMID	15.75%
Oncology - Oral	TYKERB	17.00%
Oncology - Oral	VERZENIO	17.25%
Oncology - Oral	VITRAKVI	16.00%
Oncology - Oral	VIZIMPRO	17.50%
Oncology - Oral	VOTRIENT	17.25%
Oncology - Oral	XALKORI	17.25%
Oncology - Oral	XELODA	16.50%
Oncology - Oral	XOSPATA	15.75%
Oncology - Oral	XTANDI	17.25%
Oncology - Oral	YONSA	16.75%
Oncology - Oral	ZEJULA	13.75%
Oncology - Oral	ZELBORAF	17.25%
Oncology - Oral	ZOLINZA	17.25%
Oncology - Oral	ZYDELIG	14.00%
Oncology - Oral	ZYKADIA	17.25%
Oncology - Oral	ZYTIGA	18.50%
Osteoporosis	EVENITY	14.50%
Osteoporosis	FORTEO	16.00%
Osteoporosis	PROLIA	12.75%
Osteoporosis	RECLAST	10.00%
Osteoporosis	TERIPARATIDE	15.25%
Osteoporosis	teriparatide injection	MAC
Osteoporosis	TYMLOS	16.00%
Osteoporosis	zoledronic acid_ost	MAC
Paroxysmal Nocturnal Hemoglobinuria	SOLIRIS	17.50%
Paroxysmal Nocturnal Hemoglobinuria	ULTOMIRIS	17.50%
Phenylketonuria	KUVAN	16.00%
Phenylketonuria	PALYNZIQ	16.00%



PSUID

Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Phenylketonuria	sapropterin dihydrochloride	MAC
Psoriasis	BIMZELX	15.00%
Psoriasis	COSENTYX	17.25%
Psoriasis	ILUMYA	17.25%
Psoriasis	OTZLA	14.75%
Psoriasis	SILIQ	15.50%
Psoriasis	SKYRIZI	19.75%
Psoriasis	SOTYKTU	19.75%
Psoriasis	STELARA	19.00%
Psoriasis	STELARA (SOLN)	18.25%
Psoriasis	STELARA IV	17.00%
Psoriasis	TALTZ	14.25%
Psoriasis	TREMFYA	17.75%
Pulmonary Arterial Hypertension	ADCIRCA	15.25%
Pulmonary Arterial Hypertension	ADEMPAS	15.50%
Pulmonary Arterial Hypertension	alyq	MAC
Pulmonary Arterial Hypertension	ambrisentan	MAC
Pulmonary Arterial Hypertension	bosentan	MAC
Pulmonary Arterial Hypertension	epoprostenol	14.50%
Pulmonary Arterial Hypertension	FLOLAN	14.50%
Pulmonary Arterial Hypertension	LETAIRIS	16.25%
Pulmonary Arterial Hypertension	LIQREV	21.00%
Pulmonary Arterial Hypertension	OPSUMIT	15.50%
Pulmonary Arterial Hypertension	OPSYNVI	10.00%
Pulmonary Arterial Hypertension	ORENITRAM	14.75%
Pulmonary Arterial Hypertension	REMODULIN	14.00%
Pulmonary Arterial Hypertension	REVATIO	16.50%
Pulmonary Arterial Hypertension	sildenafil citrate	MAC
Pulmonary Arterial Hypertension	tadalafil	MAC
Pulmonary Arterial Hypertension	TADLIQ	21.00%
Pulmonary Arterial Hypertension	TRACLEER	14.75%
Pulmonary Arterial Hypertension	treprostinil sodium	24.00%
Pulmonary Arterial Hypertension	TYVASO	13.00%
Pulmonary Arterial Hypertension	UPTRAVI	16.00%
Pulmonary Arterial Hypertension	VELETRI	13.00%
Pulmonary Arterial Hypertension	VENTAVIS	12.00%
Pulmonary Arterial Hypertension	WINREVAIR	10.00%
Pulmonary Disorders	ESBRIET	16.75%
Pulmonary Disorders	OFEV	16.00%
Pulmonary Disorders	pirfenidone	MAC
Rare Disorders	CRYSVITA	15.75%
Rare Disorders	DOJOLVI	15.50%
Rare Disorders	ENSPRYNG	17.00%
Rare Disorders	LITFULO	10.00%
Rare Disorders	VUJOICE	17.25%
Rare Disorders	ZOKINVY	11.00%
Renal Disease	cinacalcet hcl	MAC
Renal Disease	FILSPARI	15.75%
Renal Disease	PARSABIV	15.25%
Renal Disease	RIVFLOZA	10.00%
Renal Disease	SENSIPAR	14.75%
Renal Disease	tiopronin	37.00%
Retinal Disorders	BEOVU	14.75%
Retinal Disorders	BYOOVIZ	12.00%
Retinal Disorders	CIMERLI	8.25%
Retinal Disorders	EYLEA	17.25%
Retinal Disorders	ILUVIEN	17.25%
Retinal Disorders	LUCENTIS	15.25%
Retinal Disorders	OZURDEX	14.75%



PSUID

Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Retinal Disorders	RETISERT	17.50%
Retinal Disorders	VABYSMO	14.75%
Retinal Disorders	VISUDYNE	11.75%
Rheumatoid Arthritis	ABRILADA	15.00%
Rheumatoid Arthritis	ABRILADA_NS	15.00%
Rheumatoid Arthritis	ACTEMRA	16.25%
Rheumatoid Arthritis	ADALIMUMAB-AACF	15.00%
Rheumatoid Arthritis	ADALIMUMAB-AATY	15.00%
Rheumatoid Arthritis	ADALIMUMAB-ADAZ	15.00%
Rheumatoid Arthritis	ADALIMUMAB-ADBM	15.00%
Rheumatoid Arthritis	ADALIMUMAB-FKJP	15.00%
Rheumatoid Arthritis	ADALIMUMAB-RYVK	15.00%
Rheumatoid Arthritis	AMJEVITA	19.50%
Rheumatoid Arthritis	AMJEVITA_NS	12.00%
Rheumatoid Arthritis	AVSOLA	15.50%
Rheumatoid Arthritis	CYLTEZO	15.00%
Rheumatoid Arthritis	ENBREL	18.25%
Rheumatoid Arthritis	HADLIMA	15.00%
Rheumatoid Arthritis	HULIO	15.00%
Rheumatoid Arthritis	HUMIRA	18.00%
Rheumatoid Arthritis	HUMIRA_CORDAVIS	18.00%
Rheumatoid Arthritis	HYRIMOZ	15.00%
Rheumatoid Arthritis	HYRIMOZ_CORDAVIS	15.00%
Rheumatoid Arthritis	IDACIO	15.00%
Rheumatoid Arthritis	INFLECTRA	16.00%
Rheumatoid Arthritis	INFLIXIMAB	16.00%
Rheumatoid Arthritis	KEVZARA	15.75%
Rheumatoid Arthritis	OLUMIANT	16.75%
Rheumatoid Arthritis	ORENCIA	18.00%
Rheumatoid Arthritis	OTREXUP	11.50%
Rheumatoid Arthritis	RASUVO	9.00%
Rheumatoid Arthritis	REDITREX	17.00%
Rheumatoid Arthritis	REMICADE	17.00%
Rheumatoid Arthritis	RINVOQ	19.00%
Rheumatoid Arthritis	SIMLANDI	15.00%
Rheumatoid Arthritis	SIMPONI	17.75%
Rheumatoid Arthritis	TOFIDENCE	10.00%
Rheumatoid Arthritis	TYENNE	15.00%
Rheumatoid Arthritis	XELJANZ	16.75%
Rheumatoid Arthritis	YUFLYMA	15.00%
Rheumatoid Arthritis	YUSIMRY	15.00%
RSV	SYNAGIS	18.00%
Seizure Disorders	EPIDIOLEX	15.00%
Seizure Disorders	HP ACTHAR GEL	16.25%
Seizure Disorders	SABRIL	17.00%
Sickle Cell Disease	ADAKVEO	16.75%
Sickle Cell Disease	ENDARI	13.50%
Sickle Cell Disease	OXBRYTA	15.00%
Sleep Disorder	LUMRYZ	17.00%
Sleep Disorder	tasimelteon	MAC
Sleep Disorder	WAKIX	15.25%
Systemic Lupus Erythematosus	BENLYSTA	16.50%
Systemic Lupus Erythematosus	SAPHNELO	14.50%
Thrombocytopenia	ALVAIZ	15.00%
Thrombocytopenia	DOPILET	16.25%
Thrombocytopenia	MULPLETA	17.50%
Thrombocytopenia	NPLATE	17.50%
Thrombocytopenia	PROMACTA	17.50%
Urea Cycle Disorders	BUPHENYL	15.75%



Brazoria County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Urea Cycle Disorders	carglumic acid	MAC
Urea Cycle Disorders	RAVICTI	16.25%
Urea Cycle Disorders	sodium phenylbutyrate	MAC
Wilson's Disease	clovique	MAC
Wilson's Disease	CUPRIMINE	18.00%
Wilson's Disease	DEPEN TITRA	17.50%
Wilson's Disease	penicillamine	MAC
Wilson's Disease	SYPRINE	17.75%
Wilson's Disease	trientine hcl	MAC
Default Rate:		17.00%
Dispensing Fee:		\$0.00

NOTES:

- New to Market Brand Specialty Products will be priced at: AWP – 16.00%
- New to Market Generic Specialty Products will be Priced at AWP - 35.00%
- New to Market Limited and exclusive distribution drugs will be priced at AWP – 15.00%
- MAC: Certain dosage forms and strengths may not be included on the MAC list and shall be priced at the specialty default rate.

PRODUCT SHORTAGE:

- In the event of an industry-wide product shortage, we reserve the right to adjust pricing upon notice to the customer.

CONFIDENTIALITY:

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

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COBRA ADMINISTRATIVE SERVICES
SERVICE AND FEE SCHEDULE
PER OCCURRENCE
MASTER SERVICES AGREEMENT MSA- 0838904
EFFECTIVE October 1, 2026

The Service Fees and Services effective for the period beginning October 1, 2026 and ending September 30, 2029 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement.

<u>Implementation and Annual Fees</u>	
Implementation Fee	Waived
Annual Fees	\$0.00
<u>Ongoing Service Fees</u>	
New hire COBRA/HIPAA general rights notice and re-notification	\$3.40
Qualifying Event Notification	\$18.08 per event
<u>COBRA member termination notice</u>	\$4.75 per notice
<u>Minimum Monthly Billing per employer</u>	
	\$150.00 per month
<u>Optional Service Fees</u> - NOTE: Only applicable if the service is requested by the Customer and performed by Aetna. Optional Service Fee pricing is fixed during the Initial Term of the Agreement and are listed below for transparency.	
Annual Open Enrollment Services (*Per package with a \$300.00 minimum plus postage, available after Aetna has been providing administration for a minimum of 90 days.)	\$15.00 per package plus postage*
Annual Open-Enrollment Election Form Processing (Service offered if the Plan Sponsor administers the open-enrollment but wants the Open Enrollment form returned to Aetna for processing.)	\$5.00 per form processed
Custom Mailings (Non-Standard Notices)	\$5.00 per notice
Custom Mailings (Set Up Fee)	\$150.00 per hour
Manual Notification Form Processing	\$10.00 per form
Summary of Benefits and Coverage Form	\$0.60 per page plus postage*
Late Payment Notice	\$3.00 per notice
New Hire COBRA/HIPAA General Rights Notice and Renotification	\$4.00 per notice
COBRA Participant Termination Notice	\$4.75 per notice
Non-Commencement Notice	\$3.00 per notice
Optional Government Mandated Notice	\$10.00 per notice
Custom Letter Fee	\$250.00 flat charge (cannot be waived or reduced)
Premium Disbursement to Carriers (No Fee for remittance to Aetna)	\$50.00 per carrier per remittance
Customized Reporting and Web Development	\$150.00 per hour - \$2,500 Minimum
Special Requests	As mutually agreed upon by the Plan Administrator and Aetna
Rejected/NSF Customer Funding ACH transactions	\$50.00 per occurrence of any Customer

	funding ACH pull that is rejected
By the 5th working day of each month, Aetna will provide a bill for all administration from the prior month. Reports detailing the prior month’s activity will also be provided for your records. PFS shall retain the 2% administrative fee on the total premium administered for COBRA Participants. Fee shall remain unchanged during the initial twelve (12) months of the term of the Agreement; thereafter fees are subject to change every twelve (12) months and shall not exceed a three (3) percent net increase per year for the Initial Term of the agreement.	

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**MEDICAL SERVICES SCHEDULE
TO THE MASTER SERVICES AGREEMENT- MSA-0838904
EFFECTIVE October 1, 2026**

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 first two levels of appeal for purpose of reviewing denied claims under the Plan. The Customer understands that the performance of such 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 initial 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. The Customer shall be the "appropriate named fiduciary" of the Plan for the final voluntary level of appeal conducted by the Customer.

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 ModelSM** - 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 CareSM 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 commissions 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 Catheterization, 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 SolutionsSM:**

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 Dietitians 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 Dietitians 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 aetna.com/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. 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.

B. 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.

C. 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.

- (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.

**DENTAL SERVICES SCHEDULE
TO THE MASTER SERVICES AGREEMENT- MSA-0838904
EFFECTIVE October 1, 2026**

Subject to the terms and conditions of the Agreement, the Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by the Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to section 4 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 documents describing the Services.

I. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, or applicable state law as appropriate, Aetna will be the "appropriate named fiduciary" of the Plan for the first two levels of appeal for purpose of reviewing denied claims under the Plan. The Customer understands that the performance of such 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 initial 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. The Customer shall be the "appropriate named fiduciary" of the Plan for the final voluntary level of appeal conducted by the Customer.

II. 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.

III. DENTAL MANAGEMENT SERVICES

1. Dental Utilization Management:

The Dental utilization management program provides for appropriate review, by licensed dentists and other dental professionals, of certain dental claims, as well as of voluntary predeterminations, in order to assist in making coverage determinations based on the necessity and appropriateness of services rendered to treat Plan Participants' dental conditions.

2. Dental/Medical Integration (DMI) Program:

The DMI program is designed to educate Plan Participants on the impact of good oral health care on the management of certain diseases and conditions. Plan Participants identified with diabetes, coronary artery disease/cerebrovascular disease or who are pregnant, are sent educational materials

explaining the correlation between their disease or condition and periodontal disease. The following programs are included:

- Enhanced Benefit Program for Pregnant Women (offers additional benefits, i.e., an additional cleaning).
- Enhanced Benefit Program for Diabetes and Coronary Artery Disease (offers additional benefits, i.e., an additional cleaning).
- Member Outreach Program (educational materials sent to Plan Participants or outreach phone calls made to Plan Participants encouraging the importance of oral care).

IV. 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

- Aetna's secure member portal is a Plan Participant website that can be used as an online resource for personalized health and financial information.

V. ID CARDS

Dental ID cards are not required to obtain dental services; therefore Aetna does not mail ID cards to Plan Participants. However, Plan Participants can print their card by going to their secure website at www.aetna.com.

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.

VI. DENTAL SAVINGS PROGRAM

1. Available Program

Dental PPO II Network Program (PPO II).

PPO II dental Providers are considered participating providers in the Customer's Plan, and Covered Services rendered by such Providers will be paid as in-network services in accordance with the terms of the Customer's Plan. When available, the Contracted Rates with PPO II Providers may result in savings for the Customer and Plan Participants. Aetna contracts with one or more third-party network vendors to access their Contracted Rates with Providers. The Providers have agreed to accept the Contracted Rate and not to balance bill Plan Participants.

2. Terms and Conditions Applicable to the Program

A. Customer Charges For Provider Payments

For Plan benefits rendered by a Provider for which Aetna has accessed a Contracted Rate, the Customer shall be charged the amount paid to the Provider, less any applicable coinsurance and/or deductible owed by the Plan Participant under the Plan.

B. Access Fees

- (i) As compensation for the services provided by Aetna under the program for Savings achieved, the Customer shall pay an Access Fee to Aetna as described in the Service and Fee Schedule (excluding Savings with respect to claims for which Aetna is liable for funding, e.g., claims in excess of an individual or aggregate stop loss point).
- (ii) Aetna shall provide a quarterly report of Savings and Access Fees. Access Fees may be included with claims in other reports.

C. Plan Participant Information Regarding the Program

The Customer is responsible for informing Plan Participants of the availability of the program.

D. Definitions

As used in this section VI:

“Access Fee” means the amount to be paid by the Customer to Aetna for access to the Savings provided under the program, as indicated in the Service and Fee Schedule.

“Contracted Rate” means the amount the Provider has agreed to accept as payment under the Provider’s contract with a third party network vendor.

“Provider” means those dentists and other dental care providers who have agreed pursuant to a contract with a third-party network vendor to provide Plan benefits at a Contracted Rate under the program.

“Recognized Charge” is defined in the Customer’s Plan. Where a similar term (such as “reasonable charge amount”) is used in the Customer’s Plan instead of “recognized charge”, it will have the same meaning as Recognized Charge.

“Savings” means, for the PPOII Program, the difference between the average charges for the area as identified in the FAIR Health claims database and the Contracted Rate. For any Plan benefit where the Recognized Charge is lower than the Contracted Rate, the Savings will be zero.

The Customer acknowledges that:

- (i) Aetna does not credential, monitor or oversee those Providers who participate through third party contracts. Providers in the program may not necessarily be available or convenient.
- (ii) For the Dental PPO II Network Program, information about participating PPO II Providers can be found on Aetna’s online provider listing, on our website at www.Aetna.com or by other comparable means. PPO II Providers listed on the online provider listing may not necessarily be available or convenient.

- (iii) The following claim situations may not be eligible for the program:
- Claims involving Medicare when Aetna is the secondary payer
 - Claims involving coordination of benefits (COB) when Aetna is the secondary payer

E. General Provisions

- (i) Aetna's only liability to the Customer for any loss of access to a discount arising under or related to the program, regardless of the form of action.
- (ii) The terms and conditions of the program shall remain in effect for any claims incurred prior to the termination date that are administered by Aetna after the termination date.

DRAFT

**COALITION PRESCRIPTION DRUG SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA- 0838904
EFFECTIVE October 1, 2026 ("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 36 months beginning on the Schedule Effective Date (referred to as an "Agreement Period"). This Schedule will automatically renew for additional Agreement Periods (successive one-year terms) unless otherwise terminated pursuant to the Agreement.

II. 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.

IV. DEFINITIONS

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

“AWP” means the “average wholesale price” for a standard package size of a Prescription Drug from the most current pricing information provided to us by Medi-Span Master Drug Database (MDDDB) (with supplements) or any other nationally available reporting service of pharmaceutical prices as selected by us. We use a single data reporting source for determining a Pharmacy Group’s AWP pricing. The standard package size applicable to a Mail Order Pharmacy shall mean the actual package size dispensed. The standard package size applicable to a Participating Retail Pharmacy shall be the actual package size dispensed as reported by the Participating Retail Pharmacy to CVS Caremark. The AWP for individual Claims will not be an average and will not in any way be calculated, altered, adjusted or assigned an alternate National Drug Code (NDC) number. This includes products with a new NDC number assigned by a re-packager, manufacturer, or mail order facility that differs from the original manufacturer AWP price for the same product.

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

“Benefit Plan Design” means the terms, scope and conditions for Prescription Drug or device benefits under a Plan, including Formularies, exclusions, days or supply limitations, prior authorization or similar requirements, applicable Cost Share, benefit maximums and

any other features or specifications as may be included in Plan documents, as communicated by Participating Group to Aetna in accordance with any implementation procedures described herein. Participating Group shall disclose to Plan Participants any and all matters relating to the Benefit Plan Design that are required by law to be disclosed, including information relating to the calculation of Cost Share or any other amounts that are payable by a Plan Participant in connection with the Benefit Plan Design. Participating Group acknowledges that it is responsible for determining whether products or services added by Participating Group to the Benefit Plan Design are compliant with the laws applicable to Participating Group's plan.

"Biosimilar Drug" means a biological product that is highly similar to a biological product already approved by the FDA (i.e. reference product) and is licensed and approved by the FDA as a biosimilar under Section 351(k) of the Public Health Service Act, as added by the Biologics Price Competition and Innovation Act of 2009, notwithstanding minor differences in clinically inactive components but otherwise no clinically meaningful differences between the biologic product and the reference products in terms of safety, purity and potency of the product.

"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.

“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 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.

(ii) Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Mail Order Pharmacy on its internet website and via its member services call center. The Mail Order Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Mail Order Pharmacy generally will require that medications and supplies be dispensed in quantities not to exceed a 90-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable law do not prohibit substitution of a Generic Drug equivalent, if any, for the prescribed drug, or if the Mail Order Pharmacy obtains consent of the Prescriber, the Mail Order Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. Certain Specialty Products, some acute drug products or certain compounds cannot be ordered through the 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 ActionsSM 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 steering levels. In other instances, a Brand Drug may not be eligible for a corresponding MAC amount due to supply and/or pricing considerations.

(ix) Disclaimer Regarding Clinical Programs. Aetna's clinical programs do not dictate or control providers' decisions regarding the treatment of care of Plan Participants. Aetna assumes no liability from 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 DrugSM).
- 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. Customer pays the actual prices paid by Aetna or the PBM to Participating Retail Pharmacies. When Aetna receives payment from the Customer before payment to a Participating Pharmacy or the PBM, Aetna retains the benefit of the use of the funds between these payments.

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.

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.

COBRA SERVICES SCHEDULE

MASTER SERVICES AGREEMENT MSA-0838904

EFFECTIVE October 1, 2026

Subject to the terms and conditions of the Agreement, the COBRA Administrative Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by the Customer in 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.

SECTION 1 - DUTIES OF THE PARTIES

Aetna Responsibilities

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

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

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

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

Customer's Responsibilities

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

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

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

- (a) The Customer having its own administration functions and controls so users are removed promptly when they no longer need access to system resources.
- (b) The Customer having controls to ensure that all Aetna-generated reports and information received from Aetna are reviewed for accuracy and Participant activity on a timely basis, with any inaccuracies or discrepancies being communicated in writing to Aetna no later than thirty (30) days after such report or information is first generated by Aetna.
- (c) The Customer having controls to ensure that any erroneous data is re-submitted to Aetna within thirty (30) days from the time it is first inputted erroneously.
- (d) The Customer shall reconcile all cash activity to Aetna-generated reports as soon as reasonably possible (and in any event within ten (10) days after such report is first delivered by Aetna to the Customer). Customer shall advise Aetna in writing of any discrepancies or inaccuracies in connection with such reconciliation within twenty (20) days thereafter.

SECTION 2 - PAYMENTS

2.1 The Customer agrees to pay Aetna the amounts set forth in the Fee and Expense Exhibit.

Such amounts are payable via an ACH debit which shall be initiated by Aetna ten (10) days after the invoice is delivered to the Customer. Aetna shall initiate the ACH debit against an account designated for this purpose by the Customer. This may be the same account designated for ACH funding, or may be a unique account, at the Customer's discretion.

Customer shall promptly review and verify the accuracy of each invoice and notify Aetna in writing of any inaccuracy or discrepancy with respect to any amount referenced therein within sixty (60) days after receipt of such invoice, failing which such invoice shall be deemed final, complete and correct for all purposes. Any payments which are not timely paid hereunder shall, at the option of Aetna, bear interest at a rate of eighteen percent (18%) per annum until paid.

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

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

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

SECTION 3 – UNDERTAKING OF OBLIGATIONS AT DIRECTION OF CUSTOMER

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

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

SECTION 4 - INITIAL/GENERAL COBRA NOTICE

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

- (a) the date and type of enrollment;
- (b) the names and addresses of each new qualified beneficiary(ies), and
- (c) the names and addresses of family members of qualified beneficiary(ies).

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

SECTION 5- QUALIFYING EVENT NOTICE

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

- (a) the date and type of qualifying event (as set forth in 26 U.S. Code Section 4980B(f)(3)(A) through (F);
- (b) the names, social security numbers, addresses and birth dates of all qualified beneficiaries (and the covered Participant if not a qualified beneficiary) and their relationship to each other and to the covered Participant; and
- (c) the specific group health plan(s) and combinations of such plans under which the qualified beneficiaries are entitled to COBRA continuation coverage.

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

SECTION 6 - NOTICE TO QUALIFIED BENEFICIARIES OF ENROLLMENT

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

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

SECTION 7 - NOTICE OF SUBSEQUENT QUALIFYING EVENT

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

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

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

SECTION 8 - NOTICE OF TOTALLY DISABLED QUALIFIED BENEFICIARIES

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

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

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

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

- (a) failure of the COBRA Participant to timely pay the correct premium for COBRA continuation coverage;
 - i. For purposes of this Schedule "timely pay" means the initial premium payment is made within forty-five (45) calendar days from the date of the COBRA election, thereafter premium payments will be considered timely if they are made within a thirty (30) calendar day grace period after the first day of the coverage period to which the premiums relate.
- (b) coverage of the COBRA Participant under another group health plan, if such plan does not contain any exclusions or limitations with respect to the COBRA participant health coverage;
- (c) expiration of the maximum period for COBRA continuation coverage;
- (d) the Customer ceasing to provide any group health plan to any Customer employees and all of its commonly controlled trades or businesses (within the meaning of Code Section 414);
- (e) the qualified beneficiary, after having elected COBRA continuation coverage, becomes eligible for Medicare;
- (f) the Social Security Administrator issues a final determination that the qualified beneficiary is no longer disabled; or
- (g) any other event that would cause a qualified beneficiary to lose coverage, such as filing fraudulent or false claims, omitting a material fact or making a misrepresentation of

a material fact in connection with the group health plans.9.2 If the reason for notice is the expiration of the maximum period for COBRA continuation coverage, a notice of conversion rights (if available) shall be sent 180 days prior to expiration of COBRA continuation coverage.

SECTION 10 - PREMIUMS FOR COBRA CONTINUATION COVERAGE

10.1 COBRA Participants shall make premium payments, for COBRA continuation coverage and who have made a valid election of COBRA continuation coverage, via mail to Aetna; electronic funds transfer through the Participant's bank to Aetna; or online through the Aetna website. Alternatively, Aetna may accept payments on behalf of the COBRA Participant from other third-parties. Aetna shall deposit such funds received from COBRA Participants into a custodial account established for such purpose at a financial institution of Aetna's choosing. Any interest generated on such account shall generally be at federal funds rates. Such interest shall be used to pay the fees of the financial institution with respect to such account. To the extent that such interest is not sufficient to pay such fees, Aetna shall pay such fees. To the extent that such interest is in excess of such fees, Aetna shall be entitled to retain such interest as compensation for services provided. Premium payments collected by Aetna belong to the Customer, except that Aetna shall retain the two percent (2%) surcharge administrative fee paid by such COBRA Participants. Aetna shall act solely as an administrative collection agent for the Customer in collecting premium payments and will remit payments to the Customer, appropriate insurance carrier, or other entity directed by the Customer by the 15th day of the month following the month in which payment was received.

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

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

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

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

SECTION 11 -ANNUAL OPEN ENROLLMENT SERVICE

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

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

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

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TEMPORARY EXHIBIT 1 –HEALTH COVERAGE
PLAN OF BENEFITS
TO THE MASTER SERVICES AGREEMENT- MSA-0838904
EFFECTIVE October 1, 2026

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.

EXHIBIT 2
PERFORMANCE GUARANTEES
FOR
MASTER SERVICES AGREEMENT No. MSA-0838904
EFFECTIVE October 1, 2026

An agreement between

Aetna Life Insurance Company ("Aetna")

and

Brazoria County

(Customer)

There are Performance Guarantees between the Customer and Aetna, which are attached by reference and made part of this Services Agreement.

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