aetna®

An Aetna Renewal
Presented to

Brazoria County

Annual Renewal Rating: October 01, 2024 through September 30, 2025
Plan Sponsor Numbers: 838904

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Account Executive - SLS
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April 17, 2024

Brazoria County
Holly Fox
237 E. Locust, Suite 203
Angleton, TX 77515

Dear Holly Fox:

Thank you for allowing us to serve your health insurance and health benefit needs during the past year.

This package provides information to help you develop the future benefits program for Brazoria County. As we approach the anniversary of our relationship in the journey to better health, we are pleased to present you with your medical renewal for the October 01, 2024 through September 30, 2025 contract period.

It's important to understand the full financial picture of your benefit plan. Therefore, the enclosed package provides the following important information about the cost of your current program and the value we bring to you and your company.

- **Self-Funded Medical Plans**
  Your medical fees will increase by 3.0 percent.
- **Programs and Services**
  This section provides a summary of programs and services included in your plan of benefits.
- **Caveats**
  Our renewal offer is contingent upon the parameters outlined here. It is important to note that deviations from these assumptions may result in additional charges and/or adjustments on our Medical quotations. Please review this section thoroughly.

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-notices/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-01-01-2024.pdf

Your renewal package remains in effect until September 30, 2025.
If there are no changes that impact the conditions of this renewal as outlined in our Caveats section, the fees will remain in effect through September 30, 2025. This renewal package is considered an amendment to your existing
Agreement. Continuance of your benefit plan and payment of fees constitutes your acceptance of this renewal. If you'd like to make any plan changes or if you have any questions, please contact me by September 01, 2024 at 281-637-5024. It's been a pleasure working with you and I look forward to our continued relationship.

Sincerely,

Wayne Parker
Account Executive - SLS

Brian Donohue
Ld Dir,Underwriting

Each insurer has sole financial responsibility for its own products.

Health benefits and health insurance plans contain limitations and exclusions.

Brazoria County

Why Aetna? Effective Date: October 01, 2024

We're more than products and programs. **We offer a health care experience that's more caring, more** connected and closer to home. With a holistic approach we join members on their personal health journey, removing barriers along the way. And we work proactively to help every member achieve their goals and stay on a path to better health.

Because you have unique needs we offer customized, tailored solutions. And we have a plan to take care of each of your employees, helping to increase engagement, improve outcomes and boost productivity.

We know health care can be overwhelming. So we work together with you to help make each member of your team a stronger individual. Stronger individuals lead to a stronger workforce. And when you have a stronger workforce, you can achieve stronger results.

You can learn more about Aetna here:
https://www.aetna.com/about-us.html

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

The Aetna companies include:

Aetna Health Inc., Aetna Health of California Inc., Aetna Health of the Carolinas Inc., Aetna Health of Washington Inc., Aetna Health Insurance Company of Connecticut, Aetna Health Insurance Company of New York, Corporate Health Insurance Company; Aetna Life Insurance Company; Aetna Dental Inc.; and/or Aetna Dental of California Inc.; Aetna Health of Utah Inc.
Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Managed care plans may not cover all health care expenses. Contracts should be read carefully to determine which health care services are covered. While this material is believed to be accurate as of the print date, it is subject to change. For more specific information about the coverage details, including limitations, exclusions, and other plan requirements, please contact an Aetna representative.

Aetna has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which Aetna has made to your producer, or other material relationships your producer may have with Aetna, you may contact your producer or your Aetna account representative. Information regarding Aetna's program compensating producers is also available at:
www.aetna.com

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

Brazoria County

Contact Information/Assumptions

Account Manager: Wayne Parker
Email: ParkerAW@aetna.com
Telephone: 281-637-5024

SIC Code: 8322
Mem/EE Ratio: 1.81

Administrative Service Fees Effective Date: October 01, 2024 End Date: September 30, 2025

Medical Fees as Billed (PEPM)*	Estimated Enrollment	Current	Proposed	% Charge
Open Access Aetna Select	594	$39.05	$40.22	3.0%
AHF Open Access Aetna Select	854	$42.19	$43.46	3.0%
Plan Year Service Fees	**1,448**	**$710,712**	**$732,066**	

*Clarifications

- PEPM is defined as Per Employee Per Month
- Please see Programs and Services for additional information. Some services may come at additional cost to the fees shown above.
- Medical Pharmacy rebates are being used for the administration of the program and help to lowere PEPM medical fees.
- 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.

Brazoria County

Programs and Services – Self-Funded	Effective Date:October 01, 2024	
Program Summary	**Open Access Aetna Select**	**AHF Open Access Aetna Select**

Programs & Services Included in the Service Fee

Mature Base Service Fee	**$40.22**	**$43.46**
General Administration		
Experienced Account Management Team	Included	Included
Designated billing, eligibility, plan set up, underwriting	Included	Included
Onsite Open Enrollment Meeting Preparation	Included	Included
Open Enrollment Marketing Material (non-customized)	Included	Included
ID Cards*	Included	Included
Summary of Benefits and Coverage (SBC)	Included	Included
Claim Fiduciary Option 4	Included	Included
External Review	Included	Included
Non-ERISA	Included	Included
Network Services		
Institutes of Quality® (IOQ) Broad Network	Included	Included
Network access	Included	Included
Care Management		
Aetna Compassionate Care℠	Included	Included
Aetna In Touch Care℠ Premier	Included	Included
Utilization Management (Inpatient Precertification, Concurrent Review, Discharge	Included	Included
Member Resources		
Member Website and Mobile Experience	Included	Included
Wellness		
24-Hour Nurse Line: 1-800# Only	Included	Included
Aetna Health Your Way™ Health Assessment and Digital Support	Included	Included
Aetna Health Your Way™ Plus (includes MedQuery and Personal Health Record)	Included	Included
Allowances		
Communication Allowance	Included	Included
Wellness Allowance	Included	Included
Audit Allowance	Included	Included
Reporting and Integration		
Analytic Consultation from Plan Sponsor Insights (50 Hours)	Included	Included
Universal File Feed Outbound (12 total reports)	Included	Included
Monthly 3rd Party Stop Loss Vendor Reports (12 total reports)	Included	Included
Behavioral Health		
Managed Behavioral Health	Included	Included
Behavioral Health Condition Management Program - Standard	Included	Included
AbleTo Network - member cost share may apply	Included	Included
Total Fees	**$40.22**	**$43.46**

Brazoria County

Programs and Services – Self-Funded	Effective Date:October 01, 2024

Program Summary	Open Access Aetna Select	AHF Open Access Aetna Select

Programs & Services Included in the Claim Wire*

No Surprises Act - Fees*		
No Surprises Act (NSA) claim administration fee (per NSA eligible claim) Effective 11/1/24 (Fee will be $50 October 1-31 2024)	$90	$90
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	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	Applicable fees are as set by law and passed through to the plan

Network Services		
Subrogation*	37.5% of savings	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	37.5% of savings
Claim and Code Review Program*	30% of savings	30% of savings
National Advantage™ Program – includes Facility Charge Review and Itemized Bill Review*	We will retain 40% of savings	We will retain 40% of savings

Care Management		
Transform Oncology (per engaged member, per month)*	$79	$79

Wellness		
Aetna Back and Joint Care™ (per engaged member, per year)*	$995	$995

*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/aetnacom/legal-notices/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-01-01-2024.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
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).

Brazoria County

Programs and Services – Self-Funded	Effective Date:October 01, 2024

Program Summary	Open Access Aetna Select	AHF Open Access Aetna Select

Aetna Back and Joint Care™

Includes Aetna predictive analytics and care management coordination and digital MSK therapy programs from Hinge Health. For any single engaged member, the maximum fee per year is $995, regardless of how many programs the member has engaged in.

For Chronic Care - The fee associated with an enrolled member in the Chronic program and their Cohort will be paid in accordance with the 3 milestones for member engagement and pain reduction noted below. "Cohort" means all enrolled members under your plan who sign up for the program within any given month.

Milestone Payments

Milestone 1: A member enrolls in the program, receives the kit, and completes at least 1 exercise therapy session with a Hinge Health coach.

Milestone 2: Cohort completes at least 4 exercise therapy sessions within the first 30 days of enrolling in the program and such Cohort achieves at least a 20 percent reduction in pain.

Milestone 3: Cohort completes at least 8 exercise therapy sessions within the first 60 days of enrolling in the program and such Cohort achieves at least a 30 percent reduction in pain.

With respect to each member enrolled in the program, the Milestone 1 payment of $331 is due once the member achieves Milestone 1; the Milestone 2 payment of $332 is due when the member's Cohort achieves Milestone 2; and the Milestone 3 payment of $332 is due when such Cohort achieves Milestone 3. If the applicable Cohort does not achieve Milestone 2 or Milestone 3 then payment for such Milestone is not due.

For Acute Care - The fee associated with an enrolled member in the Acute program is $250 per year. This fee is not subject to Milestone payments.

For Prevention - There is no fee associated with enrolled members in the Prevention Program.

Institutes of Quality® (IOQ) Narrow Network

This buy-up option provides flexibility to tier benefits, offering different levels of co-insurance and shifting out of pocket costs to the member when IOQs are not utilized thus encouraging use of IOQs. Members will have a higher benefit when selecting care at a facility designated as an IOQ. It is this benefit differential enhancement for which we will apply a charge. Does not apply to Aetna Whole Health or Joint Ventures (including those offered as part of APCN Plus.)

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 Data iSight (DiS) 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 DiS, if elected. This NAP Fee is in addition to the per employee, per month administrative service fees.

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.

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National Advantage™ Program (NAP) — Effective Date: October 01, 2024

Program Type	NAP
NAP retained savings Charged through the claim wire. Not included in the billed Administrative Fees.	40%
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
Maximum PEPM NAP fee*	$3.75
Plan Rate for Facility Services For plans that cover voluntary out-of-network services	Facility Charge Review
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 Data iSight (DiS) 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 DiS, if elected. This NAP Fee is in addition to the per employee, per month administrative service fees.

Brazoria County

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

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

Annual Allowance Type	Year 1
Plan Year Effective Date	**10/01/2024**
Communication	$25,000
Wellness	$125,000
Audit	$35,000
Total	**$185,000**

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

Communication Allowance

- You can use the **communication** allowance to offset expenses applicable to the Guarantee Period(s) for which it is offered. Your allowance can be used for promoting our products, our programs or services and communicating with our members.
- Allowance dollars are for the exclusive benefit of your Aetna medical plan(s) and Aetna medical members.
- Should you terminate your contract with us, the allowance(s) cannot be used to fund implementation/communication expenses related to the new carrier's contract.

Wellness and Audit Allowances

- You can use the **wellness** allowance to pay for reasonable wellness-related programs or activities you received from third-party vendors incurred during the Guarantee Period(s) for which it is offered. Wellness allowance expenses must be for wellness-related programs or activities that are designed to promote the health and well-being of members, or to educate participants about healthy lifestyles and choices. Any wellness-related allowance amounts we pay you directly to offset or reimburse you for any expense or costs you reimbursed a vendor for directly, must comply with these conditions. Examples of reimbursable wellness related activities include programs or activities such as onsite biometric screening and flu vaccination clinics or wellness fairs.
- Your **audit** allowance can be used to offset expenses incurred from third-party vendors for auditing our medical claim adjudication and member eligibility. Expenses must be incurred during the Guarantee Period(s) for which it is offered.
- Allowance dollars are for the exclusive benefit of your Aetna medical plan(s) and Aetna medical members.

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. Our preferred method of payment is directly to the vendor. We will pay allowance related expenses directly to the vendor only after you send us proper documentation outlining the expenses you have incurred. On an exception basis, we can reimburse you directly. In the event the exception is granted, we'll require you to submit detailed paid receipts from the vendor. To facilitate allowance processing, documentation should be submitted within 60 days of the invoice date, whenever possible. All documentation must be submitted no later than 60 days following the end of the plan year for which expenses were incurred. Acceptable documentation includes, but is not limited to:

- Vendor invoice(s) summarizing level of work completed, hourly rate and hours spent
- Invoices or other documentation summarizing any other miscellaneous expenses incurred

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

- Communication
- Wellness
- Audit

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

payments to ensure they comply with applicable accounting principles and laws.

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

Brazoria County

Caveats - Self-Funded — Effective Date: October 01, 2024

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 annual accounting for the Guarantee Period.
If fees are adjusted, the caveats below will be based on the new assumptions.

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

Enrollment

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

Member-to-Employee Ratio

The member-to-employee ratio changes by more than 15 percent from the 1.8 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 Data iSight™ (DiS) programs.

Total Replacement

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

Performance Guarantees

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

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.

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.

Caveats - Self-Funded — Effective Date: October 01, 2024

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 excluded. Your Guaranteed Fees assume the following:

- Integration to support our care management program(s) is excluded
- Integration to support combined medical and pharmacy accumulators (deductibles and out-of-pocket maximums) is excluded
- Your existing benefit plans do not include combined medical and pharmacy accumulators (deductibles and out-of-pocket maximums). If you require combined accumulators, additional fees will apply.

Additional charges may apply if you change your Pharmacy Benefit Manager and/or change the number or frequency of pharmacy data feeds.

Stop Loss Reporting

Our quotation assumes stop loss coverage is not provided by Aetna and reporting to an external vendor is included.

- We've included 12 monthly reports. If your reporting requirements change, additional fees will apply.
- If you require third-party vendor Stop Loss reporting, additional fees may apply.
- The cost for 12 monthly reports is not included in your PEPM fees and is displayed on the Programs & Services exhibit.

Aetna HealthFund® (AHF)

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

Additional Products, Programs and Services

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

Billing Information

Advanced Notification of Fee Change

Caveats - Self-Funded — Effective Date: October 01, 2024

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

Late Payment

We'll assess a late payment charge at a 12 percent interest rates as follows:

- if you fail to pay plan benefit payments within 1 business day of the request
- 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.

Producer Compensation

The quoted fees don't include producer compensation.

Claim and Member Services

Medical Service Center

We've assumed that claim administration and member services for the quoted plans will be managed centrally by the Arlington, TX Service Center. Members will be able to reach the Member Service representatives Monday through Friday, from 8 a.m. to 6 p.m., CT.

For members calling after-hours, calls are handled by an offshore team of customer service representatives.

Reporting and Data Transfer

Aetna Intellectual Property

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

Banking

We've assumed that you provide funds through a bank initiated ACH 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 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 package prevails.

https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/legal-notices/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-01-01-2024.pdf

Legislative and Regulatory Requirements

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

Brazoria County

Caveats - Self-Funded — Effective Date: October 01, 2024

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.

Brazoria County

Guarantee Summary — Effective Date: October 01, 2024

We believe that measuring the activities described below is an important indicator of how well we service your account, as such, we have included the following performance guarantee(s) as part of our proposed offering.

This information pertains to any performance guarantee(s) shown below, or for any additional guarantees which may be offered for the same Guarantee Period. Refer to the guarantee documents for additional conditions and details.

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

Aggregate Maximum

The maximum payout for all guarantees combined is 20 percent of the fees at risk based on the calculation as noted in the provisions below.

General Guarantee Provisions

1. Fees at risk are calculated at the year-end reconciliation, using the paid medical administrative service fees for employees covered under each guarantee for the Guarantee Period and excludes:
   - Allowance(s)
   - Any charges for services performed which are not included on the monthly administrative service fee bill
2. Results are estimated to be available at the end of the quarter noted below, following the close of the Guarantee Period:
   Second Quarter
   - Service Performance Guarantee
   - Aetna Back and Joint Care ROI
3. If the guarantee(s) have not been met, we will either:
   - Provide reimbursement to you for the amount due, or
   - Reduce future administrative fee payment(s) by the amount due to you.
4. These guarantee(s) are considered an amendment to your existing services Agreement. Continuance of your benefit plan and payment of fees constitutes an acceptance of these guarantee(s).
5. We reserve the right to revise or remove these guarantee(s) if a material change to the plan is initiated by you or legislative or regulatory action which:
   - Impacts our standard claim adjudication process, member services functions, medical management or network management
   - Changes the products, programs and services we offer you
6. The guarantee(s) are considered met if:
   - You terminate participation in products, programs and services tied directly to guarantee(s), prior to the end of the Guarantee Period.
   - You terminate your Aetna medical plan in whole or in part (defined as 50 percent or greater membership reduction from the membership we assumed in this renewal) prior to the end of the Guarantee Period, September 30, 2025.
   - You fail to meet your obligations under the Agreement (for example, a submission of incomplete eligibility or failure to fund claim payments)

Brazoria County

Guarantee Summary — Effective Date: October 01, 2024

Service Performance Guarantees

We guarantee the administration of your medical and behavioral health product(s) in the following areas:

Performance Category	Minimum Standard	Maximum Fees at Risk
Implementation		
Implementation	Average score of 3.0	2.0%
ID Card Production & Distribution	97% within 15 days	1.0%
Account Management		
Overall Account Management	Average score of 3.0	3.0%
Claim Administration		
Turnaround Time (TAT)	14 days for 90.0%	2.0%
Financial Accuracy	99.0%	2.0%
Total Claim Accuracy	95.0%	2.0%
Member Satisfaction		
Member Satisfaction	80.0%	2.0%
Member Services		
Average Speed of Answer (ASA)	30 seconds	2.5%
Abandonment Rate	2.0%	2.5%
First Call Resolution (FCR)	90.0%	1.0%
Total		**20.0%**

Brazoria County

Medical Service Guarantees — Effective Date: October 01, 2024

Guarantee Period: October 1, 2024 through September 30, 2025
Fees at Risk: 20.0%

We guarantee the administration of your medical and behavioral health product(s) in the following areas:

Category	Guarantee	Fees at Risk	Criteria
Implementation			
Implementation	An average score of 3.0 on the Implementation Evaluation Tool survey(s). Each question has a rating scale of 1 to 5 (1 = lowest, 5 = highest). The results of the surveys are used to facilitate a discussion between you, your Implementation Manager and your Account Team regarding the results achieved and opportunities for improvement. The implementation period begins at the initial implementation meeting and runs through the implementation sign-off. If the Implementation Evaluation Tool is not completed and returned within 30 business days of receipt, it is assumed that the service provided to you is satisfactory and the guarantee is deemed met.	Mutually agreed upon adjustment if the final evaluation score falls below a 3.0, (meaning that service levels have not improved), up to a maximum of 2.0%.	Measurement basis Customer specific Measurement period Annually Reporting period Annually
Open Enrollment ID Card Production & Distribution	97% of Open Enrollment ID cards will be produced and mailed within 15 business days following the receipt of complete, accurate and viable electronic enrollment files. Digital ID cards are available via the member website or the Aetna Mobile Application (iPhone and Android) for members with non-critical changes. Digital ID cards are not included in this guarantee.	0.20% for each full business day that we fail to produce and mail ID cards within 15 business days, up to a maximum of 1.0%.	Measurement basis Customer specific Measurement period Annually Reporting period Annually
Account Management			
	An average score of 3.0 on the semi-annual surveys for on-going account management, financial, eligibility, drafting and benefit administration. The average is based on 24 questions with a rating scale of 1 to 5 (1 = lowest, 5 = highest).	Mutually agreed upon adjustment if the final	Measurement basis Customer specific

Brazoria County

Medical Service Guarantees			Effective Date: October 01, 2024
Overall Account Management	The results of the surveys are used to facilitate a discussion between you and your Account Team regarding the results achieved and opportunities for improvement. If the online surveys are not completed within 15 business days of receipt, it is assumed that the service provided to you is satisfactory and the guarantee is deemed met.	evaluation score falls below a 3.0, (meaning that service levels have not improved), up to a maximum of 3.0%.	Measurement period Annually Reporting period Annually
Claim Administration			
Turnaround Time (TAT)	14 calendar days for 90.0% of the processed claims on a cumulative basis. We measure TAT from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied or pended). TAT excludes those claims identified as rework**. Weekends and holidays are included in turnaround time.**	0.40% for each full day that the TAT exceeds 90.0% of the processed claims, up to a maximum of 2.0%.	Measurement basis Customer specific: *≥ 3,000 enrolled members* Site Level: *< 3,000 enrolled members* Measurement period Annually Reporting period Quarterly
Financial Accuracy	99.0% Financial accuracy is measured using industry accepted stratified audit methodology. The results are determined by calculating the financial accuracy for a subset of claims (a stratum). We extrapolate the results based on the size of the population and combine them with the extrapolated results of the other strata. Each overpayment and underpayment is considered an error; they do not offset each other. Financial accuracy includes both manual and auto adjudicated claims. Dollars Paid Correctly Total Dollars Paid	0.40% for each full 1.0% that financial accuracy drops below 99.0%, up to a maximum of 2.0%.	Measurement basis Unit(s) processing your claims (all customers' claims handled in that unit, not just your plan's claims) Measurement period Annually Reporting period Quarterly
Total Claim Accuracy	95.0% Total claim accuracy is measured using industry accepted stratified audit methodology. We extrapolate the results based on the size of the population and combine them with the extrapolated results of the other strata. Accuracy in each stratum (a subset of the claim population) is calculated by: Number of claims processed correctly	0.40% for each full 1.0% that total claim accuracy drops below 95.0%, up to a maximum of 2.0%.	Measurement basis Unit(s) processing your claims (all customers' claims handled in that unit, not just your plan's claims) Measurement period Annually Reporting period

	Total number of claims audited		Quarterly
Member Satisfaction			
Member Satisfaction	Positive response rate of 80.0% or higher on the following question "please rate your overall satisfaction with Aetna". The survey assumes a 5-point scale with the top 3 responses viewed as positive. The survey is based on a statistically valid, randomly selected sample of actively enrolled members aged 18-64. Interviews are conducted on a continuous basis throughout the year.	0.40% for each full 1.0% that the member satisfaction response rate falls below 80.0%, up to a maximum of 2.0%.	Measurement basis Book of business Measurement period Annually Reporting period Quarterly
Member Services			
Average Speed of Answer (ASA)	30 seconds ASA is the amount of time that elapses between the time a call is received into the telephone system and the time a Customer Service Professional (CSP) responds to the call. The result is calculated as follows: Sum of all waiting times (in seconds) for all calls answered by the queue Number of incoming calls answered ASA measures the average speed of answer for all call answered. Interactive Voice Response (IVR) system calls are not included in the measurement of ASA.	0.50% for each full second that the ASA exceeds 30 seconds, up to a maximum of 2.5%.	Measurement basis Phone skill(s) providing your customer service Measurement period Annually Reporting period Quarterly
Abandonment Rate	2.0% The result is calculated as follows: Total number of calls abandoned Number of calls accepted into the skill(s)	0.50% for each full 1.0% that the average abandonment rate exceeds 2.0%, up to a maximum of 2.5%.	Measurement basis Phone skill(s) providing your customer service Measurement period Annually Reporting period Quarterly
	90.0%		Measurement basis

Brazoria County

Medical Service Guarantees			Effective Date: October 01, 2024
First Call Resolution (FCR)	We define the first call resolution rate as percentage of member calls resolved on the first call.	0.20% for each full 1.0% that the first call resolution rate falls below 90.0%, up to a maximum of 1.0%.	Measurement basis Accountable unit or the business segment level that services your plan in effect at the time of the member's call Measurement period Annually Reporting period Quarterly

General Guarantee Provisions

- For purposes of the performance guarantees, the term "Business Day" is defined as Aetna's normal business hours on any day other than a Saturday or Sunday or a day on which Aetna is closed for general business purposes.
- These guarantees do not apply to third party benefit administrators contracted by Aetna.
- This offer does not contemplate significant changes in volume of claims and calls that may occur with novel conditions or circumstances affecting broad populations that place a significant strain on the health care system and/or your plan(s). These conditions include but are not limited to COVID-19. We reserve the right to adjust the terms and factors of this guarantee in response to these conditions and/or circumstances if necessary.
- In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply, and a payment may not be made if results are not achieved due to severe weather events which directly or indirectly impact performance during the Guarantee Period.
- If we process runoff claims from a prior carrier or administrator, the performance guarantees described in this document (other than Account Management Guarantees) will begin 3 months after the Guarantee Period effective date.
- If we process runoff claims upon termination of the Agreement, the Turnaround Time, Financial Accuracy, and/or Total Claim Accuracy performance guarantee(s) will not apply to runoff claims.

Brazoria County

Aetna Back and Joint Care ROI Guarantee **Effective Date: October 01, 2024**

Guarantee Period: October 01, 2024 through September 30, 2025
Guaranteed ROI: 1.5:1

Aetna is providing this Back and Joint Care ROI Guarantee **on the Chronic Program** on Hinge Health's behalf. This guarantee does not include the Prevention and Acute programs. We have no legal or other responsibility for meeting this ROI guarantee and/or any payments due to you for missing the guarantee. If the guarantee is missed and you are due any payment from Hinge Health, we agree to reasonably help you in settling any related payment issues that may arise with Hinge Health.

Guarantee:

Hinge Health guarantees that the projected savings associated **with the Chronic Program**, also known as the Core Digital Care Program, of the Aetna Back and Joint Care program will be equal to one and a half (1.5) times the Guarantee Period administrative service fee of $995 per engaged member.

Cost savings are assessed based on the reduction of pain as measured by the visual analog scale (VAS), before and after participating in the Hinge Health intensive 12-week phase.

To achieve a 1.5:1 ROI, the following calculated value needs to equal one and a half times the cost of the program:

[((Pain at screening) - (Pain at 12 weeks) / (Pain at screening)) x 100] x $71.09* x number of participants = projected total cost saved

*Based on Hinge Health's published clinical studies, the Chronic digital care pathway saves $71.09 in Musculoskeletal (MSK) costs per participant per year for every 1 percent decrease in pain.

Example: By way of example, assume 1,000 participants go through the Chronic Program the total cost would be $995,000 (1,000 participants multiplied by $995). If the average pain reduction is 12% per participant, then the total program savings would equal (12 x $71.09 x 1,000) = $853,080. Thus the Program did not achieve the guaranteed ROI of 1.5:1.

Payment and Measurement Criteria:

If Hinge Health does not achieve a 1.5:1 ROI according to the metric above, you will receive a prorated refund up to 100 percent of the **Chronic Program** of the Aetna Back and Joint Care Guarantee Period administrative service fee.

Example: By way of example, based on the scenario described above the formula set forth would yield you a refund of $426,280 (calculated by [(1,492,500 - $853,080) / $1,492,500]*$995,000 = $426,280.

Conditions for the guarantee

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

- This guarantee requires a minimum of 50 participants engage in the Hinge Health Chronic Program by the end of the Guarantee Period.
- Member eligibility (complete, accurate and viable enrollment data; including member phone numbers) is fully loaded in our eligibility system at least 35 days prior to the effective date.