aetna®

An Aetna Renewal
Presented to

Brazoria County

Effective: October 1, 2026
Plan Sponsor Number: 838904

Yolanda Rico-Pyron
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Irving, TX 75039
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June 12, 2026

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

Dear Holly Fox:

Thank you for trusting us to continue to provide your health benefit during the past year. Enclosed is your medical renewal for the October 1, 2026 contract period.

As your partner, we will continue to help you deliver cost savings and offer the right health experiences for every member, on every journey – one that's seamless, easy to access and where you want us to be. Through our unrivaled touchpoints and innovative solutions, we're **creating better health, together**.

This renewal includes the following exhibits and changes:

Outlined below are highlights of the changes to your plan(s) and the information presented in the renewal package.

- **Fee Schedule**
  - Your medical fees will increase by 2.00 percent for 2026,2027,2028. Then they will increase 3.00 percent annually for the remainder of the rate guarantee as listed per the fee schedule.
  - Additional Bundle up Discounts may be available if you purchase additional coverages with us.

- **Medical Programs and Services and Allowance**
  - Your NSA claim administration fee effective October 1, 2026 will be $94. 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.
  - We have converted your existing allowance(s) to the Health Plan Allowance. The Health Plan Allowance provides more flexibility in utilizing your allowance dollars for your health plan needs. Health Plan Allowance includes implementation, communication, wellness, reporting, and audit-related services.
- **Caveats**
- **Performance Guarantee(s)**
  We've included performance guarantee(s) as part of this renewal. Refer to the Guarantee Summary for additional information.

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-06-27-2025.pdf

For the best implementation experience, please notify your Account Team of changes to your plan design, programs and services no later than August 1, 2026. Some programs and services require additional notification prior to effective date for successful implementation. Please discuss with your Account Team for program specific implementation lead times.
We will strive to implement these changes on a timely basis.

This renewal package is effective for the contract period beginning October 1, 2026 and is part of your multi-year Guarantee Period extending through September 30, 2032.

If there are no changes impacting this renewal as outlined in your Caveats, the fees will remain in effect through September 30, 2027. You will receive a renewal package prior to the effective date for each year remaining in your multi-year Guarantee Period. This renewal package beginning with the ASC Fees is considered an amendment to your existing Agreement. Continuance of your benefit plan and payment of fees constitutes acceptance of this renewal. Please contact your Account Manager by July 1, 2026 to ensure they are able to address your questions prior to implementing your renewal.

Sincerely,

Yolanda Rico-Pyron
Account Executive

Brian Donohue
Ld Dir,Underwriting

Brazoria County

Contact Information/Assumptions

Account Executive:	Yolanda Rico-Pyron
Email:	Rico-PyronY@AETNA.com
Telephone:	832-423-8241
Mem/EE Ratio:	1.79

Administrative Service Fees Effective Date: October 1, 2026 End Date: September 30, 2027

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%

Brazoria County

Contact Information/Assumptions

Account Executive:	Yolanda Rico-Pyron
Email:	Rico-PyronY@AETNA.com
Telephone:	832-423-8241
Mem/EE Ratio:	1.79

Administrative Service Fees Effective Date: October 1, 2026 End Date: September 30, 2027

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 administerd and paid through the medical benefit.
Refer to the Caveats for more details.

Brazoria County

Programs and Services – Self-Funded	Effective Date: October 01, 2026		
Program Summary	**OA Aetna Select**	**AHF-OA Aetna Select**	

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

Brazoria County

Programs and Services – Self-Funded	Effective Date: October 01, 2026		
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		

Brazoria County

Programs and Services – Self-Funded	Effective Date: October 01, 2026		
Program Summary	OA Aetna Select	AHF-OA Aetna Select	

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

Brazoria County

Programs and Services – Self-Funded	Effective Date: October 01, 2026		
Program Summary	OA Aetna Select	AHF-OA Aetna Select	

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/aetnacom/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.

Brazoria County

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.

Brazoria County

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.

Allowances - Self-Funded

Effective Date: October 01, 2026

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.

Brazoria County

Caveats - Self-Funded — Effective Date: October 01, 2026

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.

Brazoria County

Caveats - Self-Funded — Effective Date: October 01, 2026

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.

Caveats - Self-Funded

Effective Date: October 01, 2026

Caveats - Self-Funded

Effective Date: October 01, 2026

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.

Brazoria County

Caveats - Self-Funded — Effective Date: October 01, 2026

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, 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.

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.

Brazoria County

Caveats - Self-Funded — Effective Date: October 01, 2026

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/aetnacom/legal-notices/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.

Brazoria County

Guarantee Summary — Effective Date: October 01, 2026

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 before Pharmacy Prefund Rebate Programfor 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 multi-year Fee Guarantee Period, September 30, 2031.
   - You fail to meet your obligations under the Agreement (for example, a submission of incomplete eligibility or failure to fund claim payments)
7. If you do not purchase a product, program or service tied directly to a guarantee, the guarantee will be removed.

Medical Service Performance Guarantee

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		

Brazoria County

Guarantee Summary — Effective Date: October 01, 2026

Implementation	Average score of 3.0	2.00%
Account Management		
Overall Account Management	Average score of 3.0	3.00%
Plan Sponsor Services		
ID Card Production & Distribution	97% within 15 days	1.00%
Claim Administration		
Turnaround Time (TAT)	14 days for 90.0%	2.00%
Financial Accuracy	99.0%	2.00%
Total Claim Accuracy	95.0%	2.00%
Member Satisfaction		
Member Satisfaction	80.0%	2.00%
Member Services		
Average Speed of Answer (ASA)	30 seconds	2.50%
Abandonment Rate	2.0%	2.50%
First Call Resolution (FCR)	90.0%	1.00%
Total		**20.00%**

Aetna Back and Joint Care ROI Guarantee

Guaranteed Medical Metric	Guaranteed Target	Fees at Risk
Back and Joint Care ROI	1.5:1	**$995 per engaged member**
Back and Joint Care Performance Guarantee		**% of ABJC Fees at Risk**
Participant Satisfaction	8	**5.0%**
Engagement	20 treatment sessions	**5.0%**
Surgery Reduction	30%	**5.0%**
Mental Health (Clinical Depression Levels)	30%	**2.5%**
Mental Health (Clinical Anxiety Levels)	30%	**2.5%**
Pain Minimal Clinically Important Difference (MCID)	50%	**5.0%**

Brazoria County

Medical Service Guarantees — Effective Date: October 01, 2026

Guarantee Period: October 1, 2026 through September 30, 2027
Medical Fees at Risk: 20.0%

We guarantee the administration of your MHA self-funded 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% of medical fees.	Measurement basis Customer specific Measurement period Annually Reporting period Annually
Account Management			
Overall 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). 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.	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 3.0% of medical fees.	Measurement basis Customer specific Measurement period Annually Reporting period Annually
Plan Sponsor Services			
Open Enrollment ID Card	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.	0.20% for each full business day that we fail to produce and mail ID	Measurement basis Customer specific Measurement period

Medical Service Guarantees			Effective Date: October 01, 2026
Open Enrollment ID Card Production & Distribution	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.	to produce and mail ID cards within 15 business days, up to a maximum of 1.0% of medical fees.	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 14 calendar days for 90.0% of the processed claims, up to a maximum of 2.0% of medical fees.	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% of medical fees.	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 Total number of claims audited	0.40% for each full 1.0% that total claim accuracy drops below 95.0%, up to a maximum of 2.0% of medical fees.	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
Member Satisfaction			

Brazoria County

Medical Service Guarantees			Effective Date: October 01, 2026
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% of medical fees.	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 2.50% of medical fees.	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 2.50% of medical fees.	Measurement basis Phone skill(s) providing your customer service Measurement period Annually Reporting period Quarterly
	90.0%		

Brazoria County

Medical Service Guarantees			Effective Date: October 01, 2026
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 1.00% of medical fees.	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, 2026**

Guarantee Period: October 01, 2026 through September 30, 2027
Guaranteed ROI: 1.5:1

Hinge Health has committed to providing the following Aetna Back and Joint Care program Guarantees exclusively for participants in the **Chronic Program.** These guarantees do not apply to the Preventive or Acute programs. Hinge Health assumes full responsibility for the design, calculation, and financial fulfillment of these guarantees. Should any guarantee metrics not be met, we will coordinate with Hinge Health to ensure timely payment is facilitated to you.

Back and Joint Care Return on Investment (ROI) 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 greater than or equal to one and a half (1.5) times the Guarantee Period administrative service fee maximum average 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] x $995,000 = $426,280).

Brazoria County

Aetna Back and Joint Care ROI Guarantee — Effective Date: October 01, 2026

Back and Joint Care Performance Guarantee

Performance Guarantee Metric	Guarantee Definition and Target	Percent of AB&JC Fees at Risk
Participant Satisfaction	Achieve an average score of 8 out of 10 on the Participant Satisfaction report	Up to 5.0% of fees if the average score is below 8
Engagement	Participants will complete an average of 20 treatment sessions across the cohort at the end of 12 months	Up to 5.0% of fees if the treatment sessions average is below 20
Surgery Reduction	Achieve a 30% average reduction in one-year surgery likelihood from baseline across the cohort of participants at the end of 12 months	Up to 5.0% of fees if the average reduction is below 30%
Mental Health	Achieve a 30% reduction in clinical depression levels from baseline across the cohort of participants at the end of 12 months	Up to 2.5% of fees if the average reduction is below 30%
Mental Health	Achieve a 30% reduction in clinical anxiety levels from baseline across the cohort of participants at the end of 12 months	Up to 2.5% of fees if the average reduction is below 30%
Pain MCID*	50% of participants will achieve MCID for pain (>34% relative pain reduction or at least 23 point absolute decrease from baseline pain)	Up to 5.0% of fees if the percent of participants that achieve MCID for pain is below 50%

*Minimal Clinically Important Difference

Payment and Measurement Criteria:

If Hinge Health does not achieve the targets as shown in the grid above, you will receive a prorated refund based on percentage achieved relative to target outcome.

Prorated refund calculation is: Total paid amount x Percent of Fees at Risk x Percentage miss for each metric.

Example (using the Engagement Metric): Assuming $20,000 in Fees Paid for the **Chronic Program** in the Guarantee Period but the cohort only achieved an average of 10 Treatment Sessions per participant.

Percentage Miss Calculation:

Cohort's average treatment sessions achieved per participant / target treatment sessions = Percent Miss

Using this example, the percent miss and refund would be calculated as follows:

10 / 20 = 50% Miss

$20,000 paid x 5% Fees at Risk x 50% miss = $500 refund

Brazoria County

Aetna Back and Joint Care ROI Guarantee — Effective Date: October 01, 2026

Additional Details

- Performance Guarantees and ROI apply to Enrolled Members in the **Chronic Program** only.
- Performance Guarantees and ROI will be reconciled on a customer-specific basis, assuming all conditions are met.
- Reconciliation Results for the ROI and Performance Guarantees will be available by the end of the first quarter following the end of the Guarantee Period.
- The Performance Guarantees include all Enrolled Members in the **Chronic Program**. If an Enrolled Member becomes inactive or does not complete the **Chronic Program**, their last applicable measurement will be used towards the calculating the guarantees.
- The ROI Guarantee includes all Enrolled Members who begin and complete the 12-week program during the Guarantee Period.

Conditions for the guarantee

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

- The ROI Guarantee requires a minimum of 50 participants complete the 12-week program by the end of the Guarantee Period otherwise the ROI Guarantee will be removed.
- The Performance Guarantees require a minimum of 2,000 members eligible for the program (18 years of age or older).
- The Performance Guarantees do not apply if fewer than 2.5% of eligible members who have engaged in the **Chronic Program** within the prior year.
- 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.