MASTER SERVICES AGREEMENT

MSA -285745

This master services agreement ("**Agreement**") between **AETNA LIFE INSURANCE COMPANY**, a Connecticut corporation located at 151 Farmington Avenue, Hartford, Connecticut ("**Aetna**"), and **Lancaster County**, a Nebraska corporation, located at 555 S. 10th Street Suite 302, Lincoln, NE, 68508 ("**Customer**") is effective as of January 1, 2018 ("**Effective Date**").

The Customer has established one or more self-funded employee benefits plans, described in Exhibit 1, (the "Plan(s)"), for certain covered persons, as defined in the Plan(s) (the "**Plan Participants**").

The Customer wants to make available to Plan Participants one or more products and administrative services ("**Services**") offered by Aetna, as specified in the attached schedules, and Aetna wants to provide those Services to the Customer for the compensation described herein.

The parties therefore agree as follows:

1. TERM

The initial term of this Agreement will be one year beginning on the Effective Date. The Parties may renew the Agreement for two additional one-year terms. The initial term and each successive one year renewal shall be considered an "**Agreement Period**". The schedules may provide for different start and end dates for certain Services.

2. SERVICES

Aetna shall provide the Services described in the attached schedules.

3. STANDARD OF CARE

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

4. SERVICE FEES

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

Aetna shall provide the Customer with a monthly statement indicating the Service Fees owed for that month. The Customer shall pay Aetna the Service Fees no later than 31 calendar days after the last calendar day of the month in which the Services are provided (the "**Payment Due Date**"). The Customer shall provide with their payment either a copy of the Aetna invoice, modified to reflect current eligibility, or a copy of a pre-approved invoice which meets Aetna's billing requirements. The Customer shall also reimburse Aetna for certain additional expenses, as stated in the Service and Fee Schedule(s).

All overdue amounts are subject to the late charges outlined in the Service and Fee Schedule(s).

Aetna shall prepare and submit to the Customer an annual report showing the Service Fees paid.

5. BENEFIT FUNDING

The Customer shall choose one of the banking facilities offered by Aetna through which Plan benefit payments, Service Fees and Plan benefit related charges will be made. All such amounts will be paid through the banking facility by check, electronic funds transfer or other reasonable transfer methods. The Customer shall reimburse the banking facility for all such payments on the day of the request. All such reimbursements will be made by wire transfer in federal funds using the instructions provided by Aetna, or by another transfer method agreed upon by both parties.

Since funding is provided on a checks issued basis, Customer and Aetna agree that outstanding payments to providers (e.g., uncashed checks or checks not presented for payment) will be handled in the manner indicated and memorialized by the Parties in a separate form letter. The terms and conditions of this Agreement shall apply to that letter.

In the event that Aetna has exercised its right to suspend claim payments or terminate this Agreement as stated in section 17(B) (Termination), Aetna may place a stop payment order on all of the Customer's outstanding benefit checks.

6. FIDUCIARY DUTY

It is understood and agreed that the Customer, as plan administrator, retains complete authority and responsibility for the Plan, its operation, and the benefits provided there under, and that Aetna is empowered to act on behalf of the Customer in connection with the Plan only to the extent expressly stated in this Agreement or as agreed to in writing by Aetna and the Customer.

The Customer has the sole and complete authority to determine eligibility of persons to participate in the Plan.

Claim fiduciary responsibility is identified in the applicable Schedule.

7. CUSTOMER'S RESPONSIBILITIES

(A) **Eligibility** – The Customer shall supply Aetna, by electronic medium acceptable to Aetna, with all relevant information identifying Plan Participants and shall notify Aetna by the tenth day of the month following any changes in Plan participation. Aetna is not required to honor a notification of termination of a Plan Participant's eligibility which Aetna receives more than 60 days after termination of such Plan Participant. Aetna has no responsibility for determining whether an individual meets the eligibility requirements of the Plan.

(B) **Plan Document Review** – The Customer shall provide Aetna with all Plan documents at least 30 days prior to the Effective Date. Aetna will review the Plan documents to determine any potential differences that may exist among such Plan documents and Aetna's claim processing systems and internal policies and procedures. Aetna does NOT review the Customer's Summary of Benefits and Coverage ("**SBC**"), Summary Plan Description ("**SPD**") or other Plan documents for compliance with applicable law. The Customer also agrees that it is responsible for satisfying any and all Plan reporting and disclosure requirements imposed by law, including updating the SBC or SPD and other Plan documents and issuing any necessary summaries of material modifications to reflect any changes in benefits.

(C) **Notice of Plan or Benefit Change** – The Customer shall notify Aetna in writing of any changes in Plan documents or Plan benefits (including changes in eligibility requirements) at least 30 days prior to the effective date of such changes. Aetna will have 30 days following receipt of such notice to inform the Customer whether Aetna will

agree to administer the proposed changes. If the proposed changes increase Aetna's costs, alter Aetna's ability to meet any performance standards or otherwise impose substantial operational challenges, Aetna may require an adjustment to the Service Fees or other financial terms.

(D) **Employee Notices** – The Customer shall furnish each employee covered by the Plan written notice that the Customer has complete financial liability for the payment of Plan benefits. The Customer shall inform its Plan Participants, in a manner that satisfies applicable law, that confidential information relating to their benefit claims may be disclosed to third parties in connection with Plan administration.

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

8. RECORDS

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

9. CONFIDENTIALITY

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

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

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

(A) **Plan Participant Information** - Each party will maintain the confidentiality of Plan Participant-identifiable information, in accordance with applicable law and, as appropriate, the terms of the HIPAA business associate

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

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

10. AUDIT RIGHTS

The Customer may, at its own expense, audit Plan claim transactions upon reasonable notice to Aetna. The Customer may conduct one audit per year and the audit must be completed within 2 years of the end of the time period being audited. Audits of any performance guarantees, if applicable, must be completed in the year following the period to which the performance guarantee results apply. Audits must be performed at the location where the Customer's claims are processed.

The Customer may select its own representative to conduct an audit, provided that the representative must be qualified by appropriate training and experience for such work and must perform the audit in accordance with published administrative safeguards or procedures and applicable law. In addition, the representative must not be subject to an Auditor Conflict of Interest which would prevent the representative from performing an independent audit. An "Auditor Conflict of Interest" means any situation in which the designated representative (i) is employed by an entity which is a competitor of Aetna, (ii) has terminated from Aetna or any of its affiliates within the past 12 months, or (iii) is affiliated with a vendor subcontracted by Aetna to adjudicate claims. If the audit firm is not licensed or a member of a national professional group, or if the audit firm has a financial interest in audit findings or results, the audit agent must agree to meet Aetna's standards for professionalism by signing Aetna's Agent Code of Conduct prior to performing the audit. Neither the Customer nor its representative may make or retain any record of provider negotiated rates or information concerning treatment of drug or alcohol abuse, mental/nervous, HIV/AIDs or genetic markers.

The Customer shall provide reasonable advance notice of its intent to audit and shall complete an Audit Request Form providing information reasonably requested by Aetna. No audit may commence until the Audit Request Form is completed and executed by the Customer, the auditor and Aetna. Further, the Customer or its representative shall provide Aetna with a complete listing of the claims chosen for audit at least four weeks prior to the on-site portion of the audit.

The Customer's auditors shall provide their draft audit findings to Aetna, prior to issuing the final report. This draft will provide the basis for discussions between Aetna and the auditors to resolve and finalize any open issues. Aetna shall have a right to review the auditor's final audit report, and include a supplementary statement containing information

and material that Aetna considers pertinent to the audit.

Additional guidelines related to the scope of the audit are included in the applicable schedules.

11. RECOVERY OF OVERPAYMENTS

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

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

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

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

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

12. INDEMNIFICATION

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

(B) The Customer shall indemnify Aetna, its affiliates and their respective directors, officers, and employees for that portion of any Losses caused directly by (i) any material breach of this Agreement by the Customer including a failure to comply with the standard of care in section 3; (ii) the Customer's negligence, willful misconduct, fraud, or breach of fiduciary responsibility; (iii) the release or transfer of Plan Participant-identifiable information to the Customer or its designee, or the use or further disclosure of such information by the Customer or such designee; or (iv) in connection with the design or administration of the Plan by the Customer or any acts or omissions of the Customer as an employer or Plan Sponsor.

(C) The party seeking indemnification under this Agreement must notify the indemnifying party within 20 days in writing of any actual or threatened action, to which it claims such indemnification applies. Failure to so notify the indemnifying party will not be deemed a waiver of the right to seek indemnification, unless the actions of the indemnifying party have been prejudiced by the failure of the other party to provide notice as indicated above.

The indemnifying party may join the party seeking indemnification as a party to such proceeding; however the indemnifying party shall provide and control the defense and settlement with respect to claims to which this section applies.

(D) The Customer and Aetna agree that: (i) health care providers are not the agents or employees of the Customer or Aetna and neither party renders medical services or treatments to Plan Participants; (ii) health care providers are solely responsible for the health care they deliver to Plan Participants, and neither the Customer nor Aetna is responsible for the health care that is delivered by health care providers; and (iii) the indemnification obligations of (A) or (B) above do not apply to any portion of any loss relating to the acts or omissions of health care providers with respect to Plan Participants.

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

13. DEFENSE OF CLAIM LITIGATION

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

such judgment or settlement, including but not limited to legal expenses and punitive damages, except to the extent provided in section 12 (Indemnification).

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

14. REMEDIES

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

15. BINDING ARBITRATION OF CERTAIN DISPUTES

Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration in Lincoln, NE, administered by the American Arbitration Association ("AAA") and conducted by a sole arbitrator in accordance with the AAA's Commercial Arbitration Rules ("Rules"). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. Except as may be required by law or to the extent necessary in connection with a judicial challenge, or enforcement of an award, neither a party nor the arbitrator may disclose the existence, content, record or results of an arbitration. Fourteen (14) calendar days before the hearing, the parties will exchange and provide to the arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) pre-marked copies of all exhibits they intend to use at the hearing. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary relief and is not empowered to award damages other than compensatory damages.

16. COMPLIANCE WITH LAWS

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

17. TERMINATION

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

(A) **Termination by the Customer** – The Customer may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving Aetna at least 90 days' prior written notice of when such termination will become effective.

(B) **Termination by Aetna and Suspension of Claim Payments-**

(1) Aetna may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving the Customer at least 90 days' prior written notice of when such termination will become effective.

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

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

(D) Responsibilities on Termination –

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

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

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

18. GENERAL

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

(B) **Intellectual Property** - Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under this Agreement (the "**Aetna IP**"). Aetna has granted the Customer a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in this Agreement. Nothing in this Agreement shall be deemed to grant any additional ownership rights in the Aetna IP to the Customer.

(C) **Communications** - Aetna and the Customer may rely upon any communication believed by them to be genuine and to have been signed or presented by the proper party or parties. For a notice or other communication under this Agreement to be valid, it must be in writing and delivered (i) by hand, (ii) by e-mail or (iii) by fax to a representative of each party as mutually agreed upon. Notices or communications may also be sent by U.S. mail to the address below.

If to Aetna:	If to the Customer:
Public & Labor	Bill Thoreson
9401 Indian Creek Parkway,	555 S. 10th Street Suite 302
Suite 1300	
Overland Park	Lincoln
KS	NE
66210	68508

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

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

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

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

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

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

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

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

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

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

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

(O) **Subcontractors** -The work to be performed by Aetna under the Agreement may, at its discretion, be performed directly by it or wholly or in any part through a subsidiary, an affiliate, or under a contract with an organization of its choosing. Aetna will remain liable for Services under the Agreement. Upon request, Aetna shall provide a written list of Tier 1 subcontractors to the Customer. Tier 1 subcontractors are defined as a subset of Aetna suppliers for whom a portion of the Services provided may include direct Plan Participant contact or significant access to Plan Participant-identifiable data. Not all Aetna suppliers on the list provided are utilized in providing services to all customers or plan participants. Aetna shall make an updated Tier 1 subcontractor list available to the Customer for informational purposes, as requested by the Customer, but no more frequently than once annually, during the term of the Agreement. For the avoidance of doubt, neither Aetna's obligation to provide, nor the Customer's right to receive a Tier 1 subcontractor list under this paragraph, shall constitute a right of the Customer to pre-approve any Aetna subcontractor or a right to require Aetna to terminate any agreements (or services under any agreements) with any Aetna supplier.

Aetna or its subcontractors will access the Customer or Plan Participant data from locations outside of the jurisdiction of the United States; provided that such access (i) is limited to screen viewing of the data, which

shall, at all times, remain physically stored in the United States, and (ii) is subject to security controls, including limiting such access to devices with no download, print or storage capability.

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

Lancaster County

By:_____

Name: _____

Title: _____

Aetna Life Insurance Company

By:_____

Name: Mark T. Bertolini

Title: Chairman, Chief Executive Officer and President

GENERAL ADMINISTRATION SCHEDULE
TO THE
MASTER SERVICES AGREEMENT-
EFFECTIVE January 1, 2018

This General Administration Schedule describes certain of the Services to be performed by Aetna for the Customer pursuant to the Agreement. The Services described in this schedule apply generally to any medical, dental, pharmacy and behavioral health Plans that are subject to the Agreement. Terms used but not otherwise defined in this schedule shall have the meaning assigned to them in the Agreement.

1. CLAIM SERVICES:

(A) Aetna shall process claims for Plan benefits incurred on or after the Effective Date using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the Plan(s), any applicable provider contract, and the Agreement. Aetna shall issue a payment of benefits and related charges on behalf of the Customer in accordance with section 5 of the Agreement, for such benefits and related charges that are determined to be payable under the Plan(s). With respect to any claims that are denied on behalf of the Customer, Aetna shall notify the Plan Participant of the denial and of the Plan Participant's right of review of the denial in accordance with applicable law.

(B) Where the Plan contains a coordination of benefits clause or antiduplication clause, Aetna shall administer all claims consistent with such provisions and any information concurrently in its possession regarding duplicate or primary coverage. Aetna shall have no obligation to recover sums owed to the Plan by virtue of the Plan's rights to coordinate where the claim was incurred prior to the Effective Date. Aetna has no obligation to bring actions based on subrogation or lien rights, unless the Customer has elected Aetna's subrogation services as indicated in the Service and Fee Schedule.

(C) In circumstances where Aetna may have a contractual, claim or payment dispute with a provider, the settlement of that dispute with the provider may include a one-time payment in settlement to the provider or to Aetna, or may otherwise impact future payments to providers. Aetna, in its discretion, may apportion the settlement to self-funded customers, either as an additional service fee from, or as a credit to, the Customer, as may be the case, based upon specific applicable claims, proportional membership or some other allocation methodology, after taking into account Aetna's cost of recovery. The Customer shall remain liable after termination of the Agreement, for their portion of any settlement payments arising from claims paid while an active customer.

(D) If the Customer wishes to participate in Aetna's enhanced customer servicing framework, the program will be indicated as included in the Service and Fee Schedule. This initiative empowers Aetna's customer service representatives to resolve complex Plan Participant inquiries in a limited number of instances, in accordance with documented guidelines that fall within the context of Aetna's standard claims administration payment and audit procedures. The program allows an authorization of a one-time payment of a previously processed claim. The limits and requirements associated with the program are available to the Customer upon request.

2. MEMBER SERVICES:

Aetna shall establish and maintain one or more service centers, responsible for handling calls and other correspondence from Plan Participants with respect to questions relating to the Plan and Services under the Agreement.

3. PLAN SPONSOR SERVICES:

(A) Aetna shall assign an experienced Account Management Team to the Customer's account. This team will be available to assist the Customer in connection with the Services provided under the Agreement.

(B) Aetna shall design and install a benefit-account structure separately by class of employees, division, subsidiary, associated company, or other classification reasonably requested by the Customer.

(C) Aetna shall assist the Customer in connection with the design of the Customer's Plan, including actuarial and underwriting support reasonably requested by the Customer, provided that the Customer shall have ultimate responsibility for the content of the Plan and compliance with law in connection therewith.

(D) Aetna shall make employee identification cards available to Plan Participants. Upon request, Aetna will arrange for the custom printing of identification cards, with all costs borne by the Customer.

(E) Upon request of the Customer, Aetna shall provide the Customer with information reasonably available to Aetna relating to the administration of the Plans which is necessary for the Customer to prepare reports that are required to be filed with the United States Internal Revenue Service and Department of Labor.

(F) Aetna shall provide the following reports to the Customer for no additional charge:

(1) Monthly/Quarterly/Annual Reports - Aetna shall prepare the following reports in accordance with the benefit-account structure for use by the Customer in the financial management and administrative control of the Plan benefits:

(a) a monthly listing of funds requested and received for payment of Plan benefits;

(b) a monthly reconciliation of funds requested to claims paid within the benefit-account structure;

(c) a monthly listing of paid benefits;

(d) online access to monthly, quarterly and annual standard claim analysis reports; and

(e) if applicable, monthly, quarterly, or annual HealthFund product reports for customers with at least 100 enrolled lives in each HealthFund to be used for the financial evaluation and management of each HealthFund plan.

(2) Annual Accounting Reports - Aetna shall prepare standard annual accounting reports detailing product specific financial and plan information including enrollment fees and/or rates for each Agreement Period.

(3) Annual Renewal Reports – Aetna shall prepare standard annual renewal reports detailing product specific financial and plan information, including enrollment fees and/or rates for each Agreement Period.

Any additional reporting formats and the price for any such reports shall be mutually agreed upon by the Customer and Aetna.

(G) Upon request of the Customer, for no additional charge, Aetna shall provide either of the following services in support of the preparation of Plan descriptions:

(1) Prepare an Aetna standard Plan description, including descriptions of benefit revisions; or

(2) Review the Customer-prepared employee Plan descriptions, subject to the Customer's final and sole authority regarding benefits and provisions in the self-insured portion of the Plan.

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

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

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

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

4. NETWORK ACCESS SERVICES

(A) Aetna shall provide Plan Participants with access to Aetna's network hospitals, physicians and other health care providers ("**Network Providers**") who have agreed to provide services at agreed upon rates and who are participating in the applicable Aetna network covering the Plan Participants.

(B) Contracted rates with Network Providers may be based on fee-for-service rates, case rates, per diems and in some circumstances, include performance-based contract arrangements, risk-adjustment mechanisms, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. These mechanisms may include payments to physicians, physician groups, health systems and other provider organizations, including but not limited to organizations that may refer to themselves as accountable care organizations and patient-centered medical homes, in the form of periodic payments and incentive arrangements based on performance. Such payments may be more specifically described in an addendum to the Agreement. The details of such payment arrangements are available upon request. Retroactive adjustments are occasionally made to Aetna's contract rates. Retroactive adjustments may occur, for example, when the federal government does not issue cost of living data in sufficient time for an adjustment to be made on a timely basis, or because contract negotiations were not completed by the end of the prior price period or due to contract dispute settlements. In all cases, Aetna shall adjust the Customer's payments accordingly. The Customer's liability for all such adjustments shall survive the termination of the Agreement.

(C) Aetna may contract with vendors who in turn are responsible for contracting with the providers who perform the health care services, and potentially for certain other services related to those providers such as claims processing, credentialing, and utilization management. Under some of these arrangements, the vendor bills Aetna directly for

those services by its network of providers at the vendor's contracted rate with Aetna, and Aetna pays the vendor for those services. In certain cases, the amount billed by the vendor to Aetna, paid pursuant to the plan, includes an administrative fee for delegated services by the vendor. As a result, the amount the vendor pays to the health care provider through the vendor's contract with the provider may be different than the amount paid pursuant to the Plan because the allowed amount under the Plan will be Aetna's contracted rate with the vendor, and not the contracted amount between the vendor and the health care provider.

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

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

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

(G) Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that might otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan Participants with access to Sutter's services on an in-network basis. Consult your SPD text to ensure that the description of Aetna's services accommodates such arrangements. Sutter also requires that the Customer agree to be bound by the terms of Aetna's contract with Sutter, including, but not limited to, the dispute resolution and binding arbitration provisions. The Customer agrees to be bound by the terms of the Sutter contract, including future amendments. The Customer may request a copy of the Sutter contract for its own use, upon completion of a confidentiality agreement. If a copy is furnished to the Customer, the Customer will hold the terms of the Sutter agreement in strict confidence in accordance with its confidentiality provisions.

MEDICAL
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2018

The Service Fees and Services effective for the period beginning January 1, 2018 and ending December 31, 2020 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement

Administrative Service Fees

Based on the package of services selected and enrollment awarded to Aetna, the per employee per month administrative services fees by plan for each of the three contract periods, as revised and quoted on July 2017, are:

Plan	Projected Enrollment	01/01/2018	01/01/2019	01/01/2020
Choice POS II	796	$34.00	$35.02	$36.07

Please note that we have extended Lancaster County a two-month fee holiday for the Medical fees at the start of the contract period. This is contingent upon Aetna being the Total Replacement medical carrier for Lancaster County. In the event that Lancaster County terminates the existing Aetna coverages in whole or in part prior to the end of the 36-month period, January 1, 2018 through December 31, 2020, an early termination fee payment equivalent to $66,068, will be due and payable to Aetna. Payment will be due to Aetna within 31 days of the invoice.

We will postpone the payment of the Aetna In Touch Care Premier $7.50 PEPM fee during Lancaster County's January 1, 2018 to December 31, 2018 plan year until Aetna demonstrates it has met the AITC 2:1 ROI Guarantee. (Please note: Aetna In Touch Care requires the purchase of MedQuery and PHR). The Lancaster County would then be billed the accrued fees for the policy period. If Aetna fails to achieve the 2 to 1 savings, no fees will be due.

Self Funded Fees include:

Included Services / Programs in Above Administrative Fees
Implementation & Communications
Designated Implementation Manager
Open Enrollment Marketing Material (noncustomized)
Onsite Open Enrollment Meeting Preparation
Standard ID Cards
General Administration

Experienced Account Management Team
Designated billing, eligibility, plan set up, underwriting and drafting services
Review or draft plan documents
Summary of Benefits and Coverage (SBCs)
Aetna Full Claim Fiduciary - Option 1
Aetna provides External Review
Weekly Funding of Claims (Thursday via ACH)
Member and Claim Services
Claim Administration
Member Services
Aetna Voice Advantage
Designated Service Center
Plan Sponsor Liaison
Special Investigations / Zero Tolerance Fraud Unit
Network
Network Access / Full National Reciprocity
Institutes of ExcellenceTM (Transplants)
Care Management
Utilization Management Inpatient Precertification
Utilization Management Outpatient Precertification
Utilization Management Concurrent Review
Utilization Management Discharge Planning
Utilization Management Retrospective Review
Case Management
Aetna Compassionate Care Program (ACCP)
National Medical Excellence®
Institutes of Quality Program (IOQ) (same benefits)
Aetna Custom Care Management Solutions – Aetna In Touch Care℠ Premier - Designated

MedQuery® with Physician Messaging
Personal Health Record
Preventive Care Considerations (Electronic)
Informed Health® Line - 24-hour Nurseline 1-800 #
Simple Steps To A Healthier Life ®- Health Assessment
Behavioral Health
Managed Behavioral Health
Aetna Behavioral Health Basic Conditions Management Program
AbleTo network – subject to member cost share
Web Tools
DocFind® (online provider directory)
Aetna Navigator® - Member Self Service Web
Online Programs
Health Decision Support - Basic
MindCheck℠
Reporting
5 Hours of Ad Hoc Reports, Annual Restoration
Aetna Health Information Advantage
e.Plan Sponsor Monitor – Level B Reporting (Standard Quarterly Utilization Reports)
Monthly Financial Claim Detail Reports
Monthly Banking Reports
Aetna Discount Program
at home products, books, fitness, hearing, national products and services, oral health care, vision and weight management

Services included through the claim wire:

Claim Wire Billing Programs	***Charged through the claim wire. Not included in***

	the PEPM fees above.
Subrogation	30% of recovered amount will be retained
Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, DRG and Implant Audits	30% of recovered amount will be retained
National Advantage™ Program	50% of savings will be retained
Standard Facility Charge Review	50% of savings will be retained
Itemized Bill Review	50% of savings will be retained
Teladoc	$0.95 per employee per month and $40 per Teladoc consultation

Underwriting Assumptions and Caveats

Self Funded Medical Financial Assumptions

Please refer to the Self Funded Medical Financial Assumptions document provided as Attachment I[1] for additional information.

Guarantees

Performance Guarantees – Medical

In total, we will put **15%** of our applicable guarantee period administrative service fees at risk through Performance Guarantees. The guarantee period administrative service fees will be calculated at the end of each guarantee period and will be based on the total number of employees actually enrolled in the plans listed below.

The guarantees described herein will be effective from January 1, 2018 to December 31, 2018 (hereinafter "guarantee period").

The performance guarantees will apply to the self-funded Aetna Choice POS II plans administered under the Administrative Services Only Agreement ("Services Agreement). These guarantees do not apply to non-Aetna benefits or networks.

Performance Category	Minimum Standard	Maximum Fees at Risk
Implementation		

• Implementation	Average evaluation score of 3.0 or higher	2.5%
• ID Card Production & Distribution	97% of ID cards mailed within 15 business days of receiving eligibility file	2.0%
• **Account Management**		
Overall Account Management	Average evaluation score of 3.0 or higher	2.0%
• **Claim Administration**		
Turnaround Time	90.0% of claims processed within 14 *calendar days*	1.5%
• Financial Accuracy	99.0%	1.5%
• Total Claim Accuracy	95.0%	1.5%
• **Member Services**		
Average Speed of Answer	30 Seconds	2.0%
• Abandonment Rate	2.0%	2.0%
• **Total**		**15.0%**

Additional Guarantees

Medical Discount Guarantee

We have placed **15%** of our guarantee period administrative service fees at risk with a Choice POS II Discount Guarantee. In Year 1, January 1, 2018, through December 31, 2018, Aetna will guarantee the discount that result from negotiated arrangements with providers participating in our Choice Point of Service II (CPII) product. The discount achieved will be calculated on an aggregate basis, taking the service type (hospital inpatient, hospital outpatient, physician/other) discounts based upon billed eligible expenses by network. Attachment IV A[2] shows the discounts by network that Aetna is willing to guarantee. It also summarizes the illustrative discount targets based on book of business service type and enrollment by market. Please refer to the Medical Discount Guarantee document provided as Attachment IV[3] for additional information.

Medical Management Guarantee

We have placed guarantee period $10.03 of our program fees at risk on medical management guarantees. Please refer to the Demonstrating Value Scorecard provided as Attachment V[4] for additional information.

Benefit Summaries We have provided plan designs for the quoted Self Insured Choice POS II, . Please refer to the Plan Design and Benefit Documents provided as Attachment X for additional information.

Stop Loss Services

Please refer to the Stop Loss Proposal provided as Attachment VII for additional information

Please let us know if you have any questions or concerns regarding the information outlined in this letter and the attachments. We appreciate City of Lincoln's business and look forward to a successful plan implementation.

For purposes of this document, Aetna may be referred to using 'we', 'our' or 'us' and Customer may be referred to using 'you' or 'your'.

Letter of Understanding

The Letter of Understanding and LOU attachments are hereby attached by reference to this Agreement. The following documents are included:

- Letter of Understanding
- Attachment I – Financial Assumptions
- Attachment II – Performance Guarantee
- Attachment III – Pharmacy Service Performance Guarantee
- Attachment IV – Discount Guarantee
- Attachment IV A – Discount Guarantee
- Attachment V – Demonstrating Value Scorecard
- Attachment VI – Pharmacy Service and Fee Schedule
- Attachment VII – Stop Loss Proposal

PRESCRIPTION DRUG
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2018

The Service Fees and Services effective for the period beginning January 1, 2018 and ending December 31, 2020 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

Pharmacy Discounts & Fees

Pricing Arrangement	Traditional		
Network	Aetna National with Extended Day Supply (Retail 90) Network		
Employees	796		
RETAIL 30			
	01/01/2018	**01/01/2019**	**01/01/2020**
Brand Discount	AWP - 17.00%	AWP - 17.10%	AWP - 17.20%
Generic Discount	AWP - 77.00%	AWP - 77.20%	AWP - 77.40%
Dispensing Fee	$1.00 per script	$1.00 per script	$1.00 per script
RETAIL 90			
	01/01/2018	**01/01/2019**	**01/01/2020**
Brand Discount	AWP - 20.00%	AWP - 20.10%	AWP - 20.20%
Generic Discount	*Included in Retail 30 pricing above*		
Dispensing Fee	$0.90 per script	$0.90 per script	$0.90 per script
MAIL ORDER PHARMACY			
Mail Benefit Type	Mail Order Pharmacy		
	01/01/2018	**01/01/2019**	**01/01/2020**
Brand Discount	AWP - 24.00%	AWP - 24.10%	AWP - 24.20%
Generic Discount	AWP - 80.00%	AWP - 80.20%	AWP - 80.40%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script
AETNA SPECIALTY PHARMACY			
Network	Exclusive Specialty Network		
Price List	Preferred		

Rebates

REBATES			
Formulary	Aetna Premier Plus		
Rebate Terms	Plan sponsor will receive the following minimum rebates:		
	01/01/2018	**01/01/2019**	**01/01/2020**
Retail (30 or 90 Day)	Greater of 100% or $88.75 Per Brand Script	Greater of 100% or $97.75 Per Brand Script	Greater of 100% or $108.25 Per Brand Script

Mail Order	Greater of 100% or $228.25 Per Brand Script	Greater of 100% or $251.50 Per Brand Script	Greater of 100% or $278.75 Per Brand Script

Performance Guarantees – Pharmacy

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **January 1, 2018 through December 31, 2018** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the self-funded Aetna Pharmacy Management plans administered under the Administrative Services Only Agreement ("Services Agreement"). These guarantees do not apply to non-Aetna benefits or networks.

Aggregate Maximum

In total, Aetna agrees to place **$80,000** at risk through the Performance Guarantees outlined in this document. Our offer assumes 796 employee lives. Aetna reserves the right to revisit the guarantees if there is a change in enrollment of more than 15%.

Performance Guarantee Category	Minimum Standard	Proposed Penalty
Retail Claim Administration		
• Pharmacy System Availability	99.9%	$10,000
• Turnaround Time – Paper Claims	97.0% within a weighted average of 5 business days of receipt and 99.5% within a weighted average of 10 business days of receipt	$10,000
Mail Order Claim Administration		
• Turnaround Time – Clean Claims	98.0% within an average of 2 business days of receipt	$10,000
• Turnaround Time – Claims Requiring Intervention	95.0% within an average of 5 business days of receipt	$10,000
• Mail Order Dispensing Accuracy	99.98%	$10,000
Member Services		
• Average Speed of Answer	30 seconds or less	$10,000

Performance Guarantee Category	Minimum Standard	Proposed Penalty
• Abandonment Rate	3.0%	$10,000
• Pharmacy First Call Resolution	95.0% successfully resolved on the first call	$10,000
Total		**$80,000**

Aetna Specialty Pharmacy

Discounts and Dispensing Fees for Specialty Products that are covered under the pharmacy plan and dispensed to Plan Participants through Aetna Specialty Pharmacy (ASRx) are indicated on the ASRx fee schedule. A copy of the Customer's ASRx fee schedule will be provided at renewal and upon request and may be modified by Aetna from time to time.

Limited Distribution Specialty Products

Certain Specialty Products may not be available at Aetna Specialty Pharmacy (ASRx) due to restricted or limited distribution requirements. These Specialty Products are referred to as Limited Distribution Specialty Products. Aetna has contracted with other network pharmacies to dispense Limited Distribution Specialty Products which are excluded from the pricing and terms contained in this Agreement. A copy of the current list of Limited Distribution Specialty Products may be obtained from Aetna upon request.

MEDICAL SERVICES SCHEDULE
TO THE
MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2018

Subject to the terms and conditions of the Agreement, the medical Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by the Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to section 4, Service Fees, of the Agreement) will be provided by Aetna. Additional Services may be provided at the Customer's written request under the terms of the Agreement. This Schedule shall supersede any previous document(s) describing the Services.

Some programs are available to Plan Participants and other eligible employees as determined by Customer not otherwise covered under products provided under this Agreement (**"Employee"**).

I. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, or applicable state law as appropriate, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of fiduciary duties under ERISA, or applicable state law as appropriate, necessarily involves the exercise of discretion on Aetna's part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, the Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between the Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

II. EXTERNAL REVIEW

The external review process will be conducted by an independent clinical reviewer with appropriate expertise in the area in question. External Review shall be available for certain "Adverse Benefit Determinations" as defined in 29 CFR 2560.503-1 as amended by 26 CFR 54.9815-2719. It shall also be available for eligible "Final Internal Adverse Benefit Determinations", which is an eligible Adverse Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal review process or an Adverse Benefit Determination for which the appeal process has been exhausted. The External Review process shall meet the standards of the Federal Affordable Care Act and utilize a minimum of three accredited Independent Review Organizations. Independent reviewers conduct a de novo review of the information provided to them as part of the External Review process. Both Aetna and Customer acknowledge that neither Plan Participants nor providers will be penalized for exercising their right to an External Review.

The Customer delegates the sole discretionary authority to make the determination regarding the eligibility for

external review, under the Plan, to Aetna. If an appeal is denied through the final level of internal appeal, Aetna will determine if it is eligible for ERO. Then Aetna will inform the Plan Participant of the right to appeal through ERO. If the appeal is upheld, Aetna will inform the Plan Participant the reason for the denial. If the appeal is not eligible for ERO, Aetna will inform the Plan Participant of the reasons for the ineligibility.

The Customer acknowledges that the Independent Review Organizations that make the external review decisions are independent contractors and not agents or employees of Aetna, and that Aetna is not responsible for the decision of the Independent Review Organization.

To assist in conducting such external reviews, the Customer agrees to provide Aetna with the current Plan documents, and any revised, amended, or updated versions no later than the date of any revisions, amendments, or updates.

III. ADDITIONAL AUDIT GUIDELINES

Aetna is not responsible for paying Customers' audit fees or the costs associated with an audit. Aetna will bear its own expenses associated with an audit; provided (i) the on-site portion of the audit is completed within five days, and (ii) the sample size is no more than 250 claims. Aetna will notify the Customer prior to the audit, if an audit request would require an additional payment from the Customer for any audits in excess of the aforementioned thresholds.

IV. CARE MANAGEMENT SERVICES

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

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

   c. **Discharge Planning:**
   This is an interdisciplinary process that assists Plan Participants as their medical condition changes and they transition from the inpatient setting. Discharge planning may be initiated at any stage of the patient

management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences upon identification of post discharge needs during precertification or concurrent review. This program may include evaluation of alternate care settings and identification of care needed after discharge. The goal is to provide continuing quality of care and to avoid delay in discharge due to lack of outpatient support.

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

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

2. Case Management Programs:
The Aetna Case Management program is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs in accordance with the Plan through communication and available resources to promote quality, cost-effective outcomes.

Those Plan Participants with diagnoses and clinical situations for which a specialized nurse, working with the Plan Participant and their physician, can make a material impact to the course or outcome of care and/or reduce medical costs will be accepted into the program at Aetna's discretion. Case management staff strives to enhance the Plan Participant's quality of life, support continuity of care, facilitate provision of services in the appropriate setting and manage cost and resource allocation to promote quality, cost-effective outcomes in accordance with the Plan. Case Managers collaborate with the Plan Participant, family, caregiver, physician and healthcare provider community to coordinate care, with a focus on closing gaps in the Plan Participant's care.

Aetna targets two types of case management opportunities:

- Complex Case Management targets Plan Participants who have already experienced a health event and are likely to have care and benefit coordination needs after the event. The objective for Case Managers is to identify care or benefit coordination needs which lead to faster or more favorable clinical outcomes and/or reduced medical costs.
- Proactive Case Management targets Plan Participants, from Aetna's perspective, who are misusing, over-using or under-utilizing the health care system, leading them towards avoidable and costly health events. This program's objective is to confirm gaps in Plan Participants' care leading to their over-use, misuse, or under-use, and to work with the Plan Participant and their physician to close those gaps.

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

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

- **Dedicated Units, Designated Units and Care Advocate Teams** - These services were created to help coordinate care, support and resources for Plan Participants under one Care Unit.
  - Aetna's Dedicated Unit provides centralized care management services for pre-certification, utilization management and Case Management.
  - Aetna's Designated Unit is a unit team that provides centralized care management services for pre-certification, utilization management, and Case Management for a specific set of Customers, and
  - Aetna's Care Advocate Team has customized workflows based on the Customer's needs, vendor integration, specialized outreach, and program integration. The Care Advocate Team will:
    - Help the Plan Participant understand their doctor's diagnosis and treatment plan
    - Coordinate care across all Aetna programs to help the Plan Participant to optimize use of Aetna programs,
    - Help the Plan Participant decide what questions to ask the doctor or health care provider,
    - Introduce the Plan Participant to a disability specialist if they need to file a disability claim
    - Support the Plan Participant throughout their treatment and recovery by making follow-up calls and helping them get the support they need.

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

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

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

These services are the basis for National Accounts Aetna In Touch Care℠ Solutions and Aetna In Touch Care℠ Premier offerings.

4. **Specialty Case Management Programs:**

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

  ACCP Enhanced Hospice Benefits Package - The enhanced hospice benefits package includes the following:

  - The option for a Plan Participant to continue to seek curative care while in hospice
  - The ability to enroll in a hospice program with a 12-month terminal prognosis
  - The elimination of the current hospice day and dollar maximum plan limits
  - Respite and bereavement services are included as part of the enhanced hospice benefits. The hospice services provided through a hospice regularly include these services and are coordinated by the hospice agency providing care and the Aetna nurse case manager who precertifies care for the Plan Participant. In addition, bereavement services are available through the Aetna Employee Assistance Program ("**EAP**") for Customers without an EAP vendor.

  Bereavement counseling shall be available to Plan Participants upon loss of a loved one, and to family and caregivers of a Plan Participant enrolled in ACCP following the death of such Plan Participant.

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

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

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

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

6. **Aetna Health Connections℠ Disease Management:**
Aetna Health Connections Disease Management is an enhancement to Aetna's medical/disease management spectrum, designed to engage the Plan Participant at the appropriate level of care, and assist the Plan Participant to close gaps in care in order to avoid complications, improve clinical outcomes and demonstrate medical cost savings.

While traditional disease management is focused on delivering education to Plan Participants about a specific chronic condition, Aetna Health Connections focuses on the entire person with specific interventions driven by the CareEngine® System, a patented, analytical technology platform that continuously compares individual patient information against widely accepted evidence-based best medical practices in order to identify gaps in care, medical errors and quality issues.

7. **MedQuery®**
The MedQuery program is a data-mining initiative, aimed at turning Aetna's data into information that physicians can use to improve clinical quality and patient safety. Through the program, Aetna's data is analyzed and the resulting information gives physicians access to a broader view of the Plan Participant's clinical profile. The data which fuels this program includes claim history, current medical claims, pharmacy, physician encounter reports, and patient demographics. Data is mined on a weekly basis and compared with evidence-based treatment recommendations to find possible errors, gaps, omissions (meaning, for example, that a certain accepted treatment regimens may be absent) or co-missions in care (meaning, for example, drug-to-drug or drug-to disease interactions). When MedQuery identifies a Plan Participant whose data indicates that there may be an opportunity to improve care, outreach is made to the treating physician based on the apparent urgency of the situation. For customers who have elected to purchase MedQuery with member messaging feature, in certain situations outreach will be made directly to the Plan Participant by MedQuery, requesting that the Plan Participant discuss with their physician, specific opportunities to improve their care.

When available information reveals lack of compliance with a clinical risk, condition, or demographic-related recommendation for preventive care, a Preventive Care Consideration (**"PCC"**) is generated. The PCC is a preventive/wellness alert sent to the Plan Participant electronically via the Plan Participant's Personal Health Record. Paper copies of a PCC, delivered via U.S. Mail, are also available as an additional purchase option.

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

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

Member Health Engagement Plan ("MHEP") offering aims to help Plan Participants better identify health opportunities and take action to improve their health and wellness. MHEP features include an enhanced Plan Participant specific "to-do" list, which includes personalized tasks unique to each Plan Participant's health status and needs, and a progress bar added to the "My Health Activities" page, which visually shows the percentage of completed "to-do" list tasks. The progress bar is updated when evidence of action is collected from lab data, pharmacy claim data, medical claims data, or self-reported data.

9. **Beginning Right® Maternity Program:**
Through an intensive focus on prevention, early treatment and education, the Beginning Right Maternity Program provides women with the tools to help improve pregnancy outcomes and control maternity-care costs through a variety of services including: risk identification, care coordination by obstetrical nurses and board certified OB/GYNs, and Plan Participant support.

10. **Informed Health® Line:**
Informed Health Line ("IHL") provides Employees with toll-free 24-hour/7 day telephonic access to registered nurses experienced in providing information on a variety of health topics. The nurses can contribute to informed health care decision-making and optimal patient/provider relationships through coaching and support. Informed Health Line has added the Healthwise® Video Library to enhance the Employees access to health information. The Employee can be sent links to health education videos from the Healthwise Video Library, via email.

The range of available service components options include:

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

11. **Healthy Lifestyle Coaching:**
    - **Healthy Lifestyle Coaching** – This program provides online educational materials, web-based tools and telephonic coaching interventions with a primary health coach. The program is designed to help Employees quit smoking, manage their weight, deal more effectively with stress and learn about proper nutrition and physical fitness. Support is provided through one-on-one telephonic coaching and group coaching. Additionally, Plan Participants or Employees can receive peer-to-peer support through clinically moderated online communities.
    - **Healthy Lifestyle Coaching Lite** – This program provides online educational materials, web-based tools and group coaching interventions designed to help Employees quit smoking, manage their weight, deal more effectively with stress and learn about proper nutrition and physical fitness. Support is provided through group coaching. Additionally, Employees can receive peer-to-peer support through clinically moderated online communities
    - **Healthy Lifestyle Coaching Tobacco Free** - This program provides support to Employees and dependents (18 and older) who want to stop using Tobacco. Employees work with a tobacco cessation specialist to examine

the pros and cons of kicking the habit, set a quit date, understand the mental, physical and social aspects of using tobacco, develop strategies to overcome their urges and create a plan for staying tobacco free.

- **Healthy Weight** – This program drives employee engagement, encourages healthier lifestyle choices and helps create lasting behavioral changes. The program targets the risk factors associated with being overweight so Employees and their families can change before disease develops or complications arise.

12. Simple Steps To A Healthier Life®:

Aetna has developed an internet-based comprehensive management information resource, known as "Simple Steps To A Healthier Life" (the "**Simple Steps**"). Employees can access Simple Steps at www.aetna.com, an online support tool which provides advice relating to disease prevention, condition education, behavior modification, and health promotion programs that may contribute to the health and productivity of Employees.

Simple Steps allows users to create a health assessment profile that generates personalized health reports. In addition to generating a health profile/assessment, Employees also have access to an action plan with links to personalized online health programs called Journeys®, offered through a relationship with RedBrick Health®. Through RedBrick Health, there is also an alternative health assessment option called RedBrick Compass™.

13. Aetna Healthy Actions℠:

Aetna Healthy Actions provides participation tracking for many of Aetna's wellness and care management programs. The participation reports generated may be used for incentive administration. Customers can use the reports to provide their own incentives, which may be HSA deposits, payroll credits, premium reductions/credits, raffles, etc. Additionally, Aetna can provide incentive administration through gift cards and credits to Employee's Health Reimbursement Arrangements (HRAs) and Health Incentive Credit (HIC) accounts.

14. Get Active℠ Program:

Get Active is an evidence-based Employee health and wellness program that focuses on bringing employees together on teams to pursue healthy lifestyles. The program takes the form of a company-wide, multi-week exercise, walking, and weight loss competition that promotes friendly competition, group support, and camaraderie in the workplace. The site also allows for the ability to create personal challenges (exercise, sports, nutrition, smoking cessation, relaxation, etc.), find activity partners, form health-related interest groups (e.g. healthy cooking club, lunch-time walking group), and share fitness plans with colleagues.

15. Enhanced Clinical Review:

This radiology program is designed, through a clinical prior authorization process, to promote appropriate and effective use of outpatient diagnostic imaging services and procedures. Aetna will provide these services nationally and/or regionally, and interact with, free-standing radiology and/or outpatient network facilities that provide the following services: Computed Tomography/Coronary Computed Tomography Angiograph (CT/CTA), Magnetic Resonance Tomography, Magnetic Resonance Angiography (MRIs/MRAs), Nuclear Medicine and Positron Emission Tomography (PET) and/or PET/CT Fusion, Stress Echocardiography (Stress Echo), and Diagnostic Cardiac Catherization, Sleep Studies and Cardiac Rhythm Implantable procedures (Pacemakers, Implantable Cardioverter-Defibrillators, and Cardiac Resynchronization Therapy). The Enhanced Clinical Review program will typically be administered through relationships with third parties.

16. Newtopia

Aetna has partnered with Newtopia, to provide a high-touch, personalized health program to Employees and eligible dependents, which is focused on obesity and reducing an individual's metabolic syndrome risk factors. The program includes a genetic saliva testing for 3 genes (unless prohibited by state law) related to obesity, appetite and eating behavior. The program is tailored to the individual's genetic profile and health assessment, and is paired with live coaching (either online or via phone) to motivate and engage the individual.

17. Aetna Oncology Solutions℠

The Aetna Oncology Solutions program works with medical oncologists/hematologists, either directly or through a vendor relationship, to identify factors that can make cancer care more effective, more affordable and safer for the Plan Participant. Plan Participants utilize providers who use tools and technology (data analysis and decision-support tools) to assist them with treatment using the most current medical guidelines and drug therapies considered to be best practices.

V. BEHAVIORAL HEALTH SERVICES

1. Managed Behavioral Health:

A set of services that includes both inpatient and outpatient care management.

- Inpatient Care Management provides phone-based utilization review of inpatient behavioral health (mental health and chemical dependency) admissions intended to contain confinements to appropriate lengths, assure medical necessity and appropriateness of care, and control costs. Inpatient Care Management provides precertification, concurrent review and discharge planning of inpatient behavioral health admissions. These services also include identification of Plan Participants for referral to a Behavioral Health Condition Management program.
- Outpatient Care Management includes precertification on a limited number of selected services. Where precertification is required, the request for services is reviewed against a set of criteria established by clinical experts and administered by trained staff, in order to determine coverage of the proposed treatment. Where precertification is not required, cases are identified for Outpatient Case Management through the application of clinical algorithms.

2. Behavioral Health Condition Management

The Aetna Behavioral Health Condition Management program identifies and engages Employees diagnosed with high-risk acute and chronic behavioral health conditions. Employees enrolled in the program get support with behavior change to improve overall functioning and wellness, which keeps them involved in and compliant with their treatment. The program promotes active collaboration and coordination of everyone involved in the Employee's medical and behavioral health care, including providers, family, friends and other Aetna clinical programs.

Base Level Program (Embedded) - Triggers include: high cost claimants, re-admissions, and multiple diagnoses/co-morbidities.

High Level Program (Optional)

This option includes quarterly utilization reports. Triggers include: base embedded triggers plus, medical or behavioral health diagnosed conditions, inpatient admission, emergency room ("ER") visits for behavioral health.

3. **AbleTo**

AbleTo performs outreach, on behalf of Aetna, to offer Plan Participants with certain medical conditions or those going through certain life changes, an alternative treatment setting. Outreach is made to offer behavioral health support to Plan Participants using web-based videoconferencing, online interface or telephone support, instead of a face-to-face office visit. AbleTo provides condition-specific, structured, fixed duration support. AbleTo is an in-network provider and its clinical team consists of therapists and behavioral health coaches. Each web-based videoconferencing session, online interface or telephone support session, is subject to Plan terms applicable to a behavioral health office visit, including cost share, deductible, etc.

VI. TECHNOLOGY/WEB TOOLS

1. **DocFind®**
Aetna's online participating provider directory--updated daily -- that anyone can use to locate network physicians and other health care providers such as dentists, optometrists, hospitals and pharmacies.

2. **Aetna Navigator®**
Aetna Navigator is a secure Employee website that can be used as an online resource for personalized health and financial information.

3. **Web-Chat Technology – Virtual Assistant Ann**
Aetna's virtual assistant, nicknamed Ann, assists Plan Participants with the Aetna Navigator registration process, log in questions, or assists those who have forgotten their user name or password.

4. **Health Decision Support:**
Health Decision Support provides educational support so Employees can better understand their conditions and treatment options, including tests, procedures and surgery. This helps Employees make more informed decisions for their health care.

Health Decision Support has two options for customers. Both options offer programs for treatment, procedure and surgery decision support.

- **Basic** -- Offers 30 programs. It is available to all Aetna Navigator® registered users at no additional cost to customers or employees.
- **Premium** – (optional additional purchase) Offers over 200 programs and plan sponsor-specific engagement reporting. Aetna Healthy Actions℠ incentive tracking is available for program completion in the premium option.

5. **Metabolic Health in Small Bytes:**
Metabolic Health in Small Bytes is a program promoting metabolic syndrome risk reduction and reversal. This program targets the root cause of obesity by using a holistic approach (mental, emotional, and physiological) to help Employees identify underlying reasons for their weight and what barriers may exist which impede weight

loss. This program was created through a collaborative effort with Aetna, Duke Diet and Fitness, Duke Integrative Medicine and eMindful.

6. **iTriage®**
iTriage is a mobile decision support tool that is designed to increase in-network usage by Plan Participants and assist employers in managing health care costs, while providing employees with a range of appropriate treatment options. It is designed to assist Plan Participants answer the three most common medical questions: *What could be wrong?; Where can I go for treatment?; Where can I go according to my plan?* It is a unique symptom-to-provider pathway that helps Plan Participants search symptoms, conditions, and treatment options and helps them determine the most appropriate level of care in or out of their Aetna provider network.

Customer Requirements:

- Customer will be responsible for coordinating the marketing of the iTriage application to their employees for adoptions, including communicating iTriage marketing materials to employees.
- If Customer Co-Branding is included, Customer shall provide Aetna with two forms of their logo (one for use with a dark background, and another for use with a light background) in vector format no later than 30 days prior to the iTriage launch date, or as mutually agreed by the Parties. Failure to do so may result in delay in implementation.
- Customer must provide all input and materials reasonably necessary for implementation of any customizations, if applicable, no later than 30 days prior to the iTriage launch date, or as mutually agreed by the Parties. Failure to do so may result in delay in implementation.

7. **NeoCare Solutions℠**
Aetna, through its subsidiary Healthagen, LLC, ("**Healthagen**") will provide a consumer application, NeoCare Solutions (the "**Application**") to Employees whose infants have been admitted to a Neonatal Intensive Care Unit ("**NICU**"). The Application will include tools, content, and access to a Nurse Coach via phone or tablet device, to better engage Employee parents of NICU children and enable them to be more involved in the infant's care. A "Nurse Coach" is a Healthagen-employed, Aetna-employed, or independently contracted resource made available to Employees through the Application via chat and telephone, to provide support, answer questions, and select and send educational content that is relevant to an infant's care. A Nurse Coach is not a provider of health care services. The Application will be made available to Employees for up to the first year of their infant's life.

8. **WellMatch®**
WellMatch is a web-based tool that allows Employees to shop for health care services by comparing aspects of price, quality, and convenience. WellMatch users can search for nearby in-network providers to see what their out-of-pocket cost will be, as well as applicable quality designations and patient reviews.

VII. OTHER SERVICES

1. **Teladoc**
Teladoc is a vendor that provides access to physicians who are under contract with Teladoc, to provide consultations for non-urgent care needs by telephone. The physicians made available through the Teladoc

program are independent contractors and are neither employees nor agents of Teladoc or Aetna.

2. **ALEX® Benefits Advisor**
ALEX Benefits Advisor ("**ABA**") is an interactive, online decision support tool designed to assist employees in making their benefits elections during open enrollment. A virtual host ("ALEX") asks employees questions relevant to the type of coverage the employee may wish to buy (regarding health care needs, lifestyle, financial status, etc.) and makes plan recommendations based on those responses and Customer's benefit options. There are also several modules available for the Customer for an additional charge: Dental, Life (includes Basic/Supplemental/AD&D/Spouse/Child), Disability (includes STD/LTD), Vision (when integrated with medical coverage) and Aetna Pharmacy Savings. The Customer will have use of ABA throughout Customer's open enrollment period, and during the plan year as well for new hires or others eligible to make benefit changes during the year. Customization options are also available for purchase.

3. **Aetna Concierge:**

Aetna Concierge is a level of customer service that provides a dedicated team of Aetna employees to support the delivery of high-touch, tailored service for Customers. The dedicated Aetna Concierges obtain Customer-specific training in order to serve as a single point of contact across the full-spectrum of plan and benefit offerings available to Plan Participants, even if such offerings are external to Aetna. The dedicated team is staffed with more customer service representatives than Aetna's traditional Customer Service Model, without call handle time guidelines, thereby allowing for longer, more relevant Plan Participant interactions. Aetna Concierges use their skills and training to listen for opportunities to educate and empower Plan Participants by sharing insights, providing useful information, and offering guidance through the use of Aetna tools and resources so that Plan Participants become more informed health care consumers. Aetna Concierge include a dedicated team, individual Aetna Concierges can serve as an extension of the Customer benefits team, and as an available single point of contact for Plan Participants via a dedicated, toll-free 800-number, as well as via live web chat through Aetna Navigator®.

4. **Onsite Health Screening Services:**
Aetna's Onsite Health Screening Services help employers engage and educate their Employees about wellness at the workplace. These offerings provide turnkey solutions to support employers' overall wellness strategies, increase consumerism and promote informed-decision making. Offerings include Onsite Health Screenings, Workshops, Special Awareness Campaigns; and Educational Resources. Aetna may contract with nationally recognized vendors to administer Onsite Health Screening Services, and such vendors may be subject to change.

5. **Mindfulness at Work** (in coordination with eMindful Inc.):

Aetna's Mindfulness at Work program is an evidence-based mind-body solution that targets Employees with stress. The program teaches evidence-based stress management skills, including mindfulness awareness, breathing techniques and emotions management. Employee participants are required to have online access to participate. Customer can choose from a 12-week class; a monthly class; or combined weekly and monthly classes. All three options can be offered in a single Customer dedicated or public class setting.

6. **Aetna Fitness Reimbursement Program:**

The Aetna Fitness Reimbursement Program (the "**Program**"), powered by GlobalFit®, is available to Employees. The Program provides reporting and reimbursement for fitness expenses, including fitness club/gym dues, group exercise class fees for classes led by certified instructor; fitness equipment purchases; personal training; and weight management and nutrition counseling sessions.

7. **ID Cards:**
Upon the Customer's request, Aetna will include third party vendor information on Plan Participant identification cards. In such event, the Customer shall indemnify Aetna, its affiliates and their respective directors, officers, and employees from that portion of any actual third party loss (including reasonable attorney's fees) resulting from the inclusion of such third party vendor information on identification cards.

8. **Subrogation Services:**
Aetna will provide subrogation/reimbursement services when the Customer's summary plan description (SPD) is finalized, available to the Customer's employees, and includes subrogation/reimbursement language.

Aetna does not delay processing or deny claims for subrogation/reimbursement purposes.

Aetna has the exclusive discretion to: (a) decide whether to pursue potential recoveries on subrogation/reimbursement claims; (b) determine the reasonable methods used to pursue recoveries on such claims, except with respect to initiation of formal litigation; and (c) decide whether to accept any settlement offer relating to a subrogation/reimbursement claim. Aetna shall advise the Customer if the pursuit of recovery requires initiation of formal litigation. In such event, the Customer shall have the option to approve or disapprove the initiation of litigation. Subrogation /reimbursement services will be delegated to an organization of Aetna's choosing.

The subrogation/reimbursement fee is outlined in the Service and Fee Schedule and includes reasonable expenses such as (a) collection agency fees, (b) police and fire reports, (c) asset checks, (d) locate reports and (e) attorneys' fees. If no monies are recovered as a result of the subrogation/reimbursement service, no fee will be charged to the Customer.

Subrogation/reimbursement recoveries will be credited to the Customer net of fees charged by Aetna. Aetna does not credit individual Plan Participant claims for subrogation/reimbursement recoveries.

The Customer must notify Aetna should the Customer pursue, recover by settlement or otherwise waive any subrogation/ reimbursement claim, or instruct Aetna to cease pursuit of a potential subrogation claim. Aetna will be entitled to the subrogation/reimbursement fee, which will be calculated based on the full amount of claims paid at the time the Customer settles the file or instructs Aetna to cease pursuit.

The Customer must notify Aetna of its election to terminate the subrogation/reimbursement services provided by Aetna. All claims identified for potential subrogation/reimbursement recovery prior to the date notification of such election is received, including both open subrogation files and matters under investigation, shall be handled to conclusion by Aetna and shall be governed by the terms of this provision. Aetna does not handle new subrogation/reimbursement cases on matters identified after the Customer's termination date.

9. **National Advantage Program (NAP):**
The National Advantage Program includes three components, Contracted Rates, Facility Charge Review and Itemized Bill Review. Unless otherwise agreed in writing, only the NAP components selected by the Customer in the Service and Fee Schedule will be provided by Aetna. In order to elect the Facility Charge Review or Itemized Bill Review components, the Contracted Rates component must be selected.

A. **Contracted Rates Component**
Through the Contracted Rates component of NAP, Aetna either contracts with third-party vendors to access their contracted rates with providers, or directly contracts with providers (collectively "**NAP Providers**") for (i) medical claims paid under non-network indemnity plans, (ii) claims covered under the out-of-network portion of network-based plans ("**Voluntary Out-of-Network Claims**"), and (iii) claims from out-of-network providers covered as in-network benefits under the Plan because the claims are for emergency services, because the services are provided by out-of-network providers at in-network facilities, or because Aetna otherwise determines that the Plan Participant received the services out-of-network because of circumstances outside the Plan Participant's control ("**Involuntary Out-of-Network Claims**").

When Aetna accesses rates through direct contracts or third-party vendors, the Provider is contractually bound not to balance bill Plan Participants. To limit balance billing for Plan Participants, contracted rates will apply even if the contracted rate exceeds the amount determined by the benefit level under the Plan.

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

B. **Facility Charge Review ("FCR") Component**
FCR applies to inpatient and outpatient facility claims for which a contracted rate is not available and for which the claim amount exceeds a certain threshold as determined by Aetna. Through the FCR component, Aetna establishes a reasonable charge for a Plan benefit in the geographic area where such benefit was provided to the Plan Participant ("**Reasonable Charge Amount**"). The Reasonable Charge Amount is based on the Provider's estimated cost, including an anticipated profit margin. The claim will be paid based on the Reasonable Charge Amount.

C. **Itemized Bill Review ("IBR") Component**
IBR applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology. Aetna refers to these as "**IBR Claims**."

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

D. **Terms and Conditions**

(i) Access Fees

As compensation for the services provided by Aetna under NAP, the Customer shall pay a percentage of the amount of Savings for a claim paid under NAP (**"Access Fee"**) to Aetna as described in the Service and Fee Schedule.

(a). The Customer shall not owe any Access Fees with respect to any portion of a claim that is the financial responsibility of Aetna, such as when Aetna writes stop loss insurance and the claim exceeds the stop loss individual or aggregate attachment point

(b). Aetna shall provide a quarterly report of Savings and Access Fees. Access Fees may be included with claims in other reports

(ii) Plan Participant Information Regarding National Advantage Program

The Customer shall inform Plan Participants of the availability of NAP Providers. Further, the Customer's Summary Plan Description specifying coverage for out-of-network health services must conform to Aetna requirements. Aetna shall provide information regarding NAP Providers on DocFind®, Aetna's online provider listing, on Aetna's website at www.Aetna.com or by other comparable means.

(iii) Definitions applicable to the National Advantage Program:

"Ad Hoc Rate" means the rate defined in subsection A above.

"Involuntary Out-of Network Claims" means the claims defined in subsection A above.

"Reasonable Charge Amount" means the amount defined in subsection B above.

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

"Savings" means the difference between (i) the Reference Price, and (ii) the amount Aetna allows the provider under NAP, for services or benefits covered under the Plan affected by NAP. If Aetna pays more than the Reference Price, the Savings will be defined as zero.

"Voluntary Out-of Network Claim" means the claims defined in subsection A above.

(iv) Customer Acknowledgements

Customer acknowledges that:

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

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

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

(v) General Provisions

(a). Aetna's only liability to the Customer for any loss of access to a discount arising under or related to NAP, regardless of the form of action, shall be limited to the Access Fees actually paid to Aetna by the Customer for services rendered; provided, however, this limitation will not apply to or affect any performance standards set forth in the Agreement.

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

Rx DRUG SERVICES SCHEDULE
TO THE
MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2018

Subject to the terms and conditions of the Agreement, the Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by the Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to section 4, Service Fees, of the Agreement) will be provided by Aetna. Additional Services may be provided at the Customer's written request under the terms of the Agreement. This Schedule shall supersede any previous document(s) describing the Services.

I. SCHEDULE TERM

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

II. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, or applicable state law as appropriate, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. The Customer understands that the performance of fiduciary duties under ERISA, or applicable state law as appropriate, necessarily involves the exercise of discretion on Aetna's part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, the Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between the Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

III. EXTERNAL REVIEW

The external review process will be conducted by an independent clinical reviewer with appropriate expertise in the area in question. External Review shall be available for certain "Adverse Benefit Determinations" as defined in 29 CFR 2560.503-1 as amended by 26 CFR 54.9815-2719. It shall also be available for eligible "Final Internal Adverse Benefit Determinations", which is an eligible Adverse Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal review process or an Adverse Benefit Determination for which the appeal process has been exhausted. The External Review process shall meet the standards of the Federal Affordable Care Act and utilize a minimum of three accredited Independent Review Organizations. Independent reviewers conduct a de novo review of the information provided to them as part of the External Review process. Both Aetna and Customer acknowledge that neither Plan Participants nor providers will be penalized for exercising their right to an External Review.

The Customer delegates the sole discretionary authority to make the determination regarding the eligibility for external review, under the Plan, to Aetna. If an appeal is denied through the final level of internal appeal, Aetna will determine if it is eligible for ERO. Then Aetna will inform the Plan Participant of the right to appeal through

ERO. If the appeal is upheld, Aetna will inform the Plan Participant the reason for the denial. If the appeal is not eligible for ERO, Aetna will inform the Plan Participant of the reasons for the ineligibility.

The Customer acknowledges that the Independent Review Organizations that make the external review decisions are independent contractors and not agents or employees of Aetna, and that Aetna is not responsible for the decision of the Independent Review Organization.

To assist in conducting such external reviews, the Customer agrees to provide Aetna with the current Plan documents, and any revised, amended, or updated versions no later than the date of any revisions, amendments, or updates.

IV. DEFINITIONS

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

"Aetna Mail Order Pharmacy" or **"Aetna Specialty Pharmacy"** means a licensed pharmacy designated by Aetna to provide or arrange for Covered Services to Plan Participants and shall include a subcontractor of its choosing for the purposes of services to be performed under this Schedule and/or the Service and Fee Schedule.

"Average Wholesale Price" or **"AWP"** means the average wholesale price of a Prescription Drug as identified by Medispan (or other drug pricing service determined by Aetna). The applicable AWP for Prescription Drugs filled in any Participating Pharmacy will be the AWP on the date the drug was dispensed for the 11-digit NDC for the package size from which the drug was actually dispensed as reported to Aetna by such Participating Pharmacy

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

"Benefit Plan Design" means the terms, scope and conditions for Prescription Drug or device benefits under a Plan, including Formularies, exclusions, days or supply limitations, prior authorization or similar requirements, applicable Cost Share, benefit maximums and any other features or specifications as may be included in Plan documents, as communicated by the Customer to Aetna in accordance with any implementation procedures described herein. The Customer shall disclose to Plan Participants any and all matters relating to the Benefit Plan Design that are required by law to be disclosed, including information relating to the calculation of Cost Share or any other amounts that are payable by a Plan Participant in connection with the Benefit Plan Design.

"Brand Drug" means a Prescription Drug with a proprietary name assigned to it by the manufacturer and distributor. Brand Drug does not include those drugs classified as a Generic Drug hereunder.

"Calculated Ingredient Cost" means the lesser of:

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

The Calculated Ingredient Cost does not include the Dispensing Fee or sales tax, if any. The amount of the Calculated Ingredient Cost payable by the Customer is net of the applicable Cost Share.

"Claim" or **"Claims"** means any electronic or paper request for payment or reimbursement arising from a Participating Pharmacy providing Covered Services to a Plan Participant.

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

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

"Cost Share" means that portion of the charge for a Prescription Drug or device dispensed to a Plan Participant that is the responsibility of the Plan Participant as provided in the applicable Plan, including coinsurance, copayments, deductibles and penalties, and may be a fixed amount or a percentage of an applicable amount. Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services except as required by law to be otherwise.

"Covered Services" means Prescription Drugs, Specialty Products, over-the-counter medications or other services or supplies that are covered under the terms and conditions set forth in the description of the Plan.

"Discount" means the percentage deduction from AWP that is to be taken into account by Aetna in determining the Calculated Ingredient Cost.

"Dispensing Fee" means an amount agreed by the Customer and Aetna in consideration of the costs associated with a Participating Pharmacy dispensing medication to a Plan Participant.

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

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

"Generic Drug" means a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that (a) is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and

interchangeable with drugs having an identical amount of the same active ingredient, or (b) is deemed by Aetna to be pharmaceutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

"Implementation Credit" if applicable, is a credit provided to the Customer to cover specific costs related to the transition from another vendor to Aetna and further described in the Service and Fee Schedule

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

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

"Mail Order Exception List" means the list of Prescription Drugs established by Aetna that includes Brand Drugs adjudicating as Generic Drugs, trademark Generic Drugs, any Generic Drug that is manufactured by one (1) manufacturer (or multiple manufacturers, for example, in the case of "authorized" Generic Drugs), and any Generic Drug that has an AWP within twenty-five percent (25%) of the AWP of the equivalent Brand Drug. The Mail Order Exception List is subject to change.

"National Drug Code" or **"NDC"** means a universal product identifier for human drugs. The National Drug Code Query (NDCQ) content is limited to Prescription Drugs and a few selected OTC products. The National Drug Code (NDC) Number is a unique, eleven-digit, three-segment number that identifies the labeler/vendor, product, and trade package size.

"On-Line Claim" means a claim that (i) meets all applicable requirements, is submitted in the proper timeframe and format, and contains all necessary information, and (ii) is submitted electronically for payment to Aetna by a Participating Pharmacy as a result of provision of Covered Services to a Plan Participant.

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

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

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

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

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

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

"Rebates" shall mean certain monetary distributions made to the Customer by Aetna under the pharmacy benefit and funded from retrospective amounts paid to Aetna (i) pursuant to the terms of an agreement with a pharmaceutical manufacturer, (ii) in consideration for the inclusion of such manufacturer's drug(s) on Aetna's Formulary, and (iii) which are directly related and attributable to, and calculated based upon, the specific and identifiable utilization of certain Prescription Drugs by Plan Participants.

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

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

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

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

"Specialty Products" means those injectable and non-injectable Prescription Drugs, other medicines, agents, substances and other therapeutic products that are designated in the Service and Fee Schedule and modified by Aetna from time to time in its sole discretion as Specialty Products on account of their having particular characteristics, including one or more of the following: (i) they address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis), (ii) they require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste, (iii) they have limited pharmaceutical supply chain distribution as determined by the drug's manufacturer and/or (iv) their relative expense.

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

for coverage is obtained.

"Usual and Customary Retail Price" or **"U&C Price"** means the cash price less all applicable Customer discounts which Participating Pharmacy usually charges customers for providing pharmaceutical services.

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

V. ADMINISTRATIVE SERVICES

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

1. General Responsibilities and Obligations

a. Exclusivity

During the term of this Schedule, the Customer shall use Aetna as the exclusive provider of the Benefit Plan Design for Plan Participants covered thereby, including without limitation, for pharmacy claims processing, pharmacy network management, clinical programs, formulary management and rebate management. All terms under this Schedule and on the attached Service and Fee Schedule are conditioned on Aetna's status as the exclusive provider of the Benefit Plan Design. Any failure by the Customer to comply with this Section shall constitute a material breach of this Schedule and the Agreement. Without limiting Aetna's other rights or remedies, in the event the Customer fails to comply with this section, Aetna shall have the right to modify the terms and conditions of this Schedule, including without limitation, the financial terms set forth in the Service and Fee Schedule and any Performance Guarantees attached hereto.

2. Pharmacy Benefit Management Services

a. Pharmacy Claims Processing

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

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

such DMR Claim; or (ii) the amount the Plan Participant is entitled to be reimbursed for such claim pursuant to the description of Plan benefits.

b. Pharmacy Network Management

(i) Participating Retail Pharmacies. Any additions or deletions to the network of Participating Retail Pharmacies shall be made in Aetna's sole discretion. Aetna shall provide notice to the Customer of any deletions that have a material adverse impact on Plan Participants' access to Participating Retail Pharmacies. Aetna shall direct each Participating Retail Pharmacy to (a) verify the Plan Participant's eligibility using Aetna's on-line claims system, and (b) charge and collect the applicable Cost Share from Plan Participants for each Covered Service. Aetna will adjudicate On-Line Claims for Covered Services from Participating Retail Pharmacies using the negotiated rates that Aetna has in place with the applicable Participating Retail Pharmacy.

- Aetna shall require each Participating Retail Pharmacy to comply with Aetna's applicable network participation requirements. Aetna does not direct or otherwise exercise any control over the professional judgment exercised by any pharmacist dispensing prescriptions or providing pharmacy services. Participating Retail Pharmacies are independent contractors of Aetna and Aetna shall have no liability to the Customer, any Plan Participant or any other person or entity for any act or omission of a Participating Retail Pharmacy or its agents, employees or representatives.

- Aetna shall adjudicate each On-Line Claim for services rendered by a Participating Retail Pharmacy at the applicable Discount and Dispensing Fee negotiated between Aetna and the Customer. For the avoidance of doubt, the Benefit Cost paid by the Customer in connection with On-Line Claims for services rendered by Participating Retail Pharmacies may or may not be equal to the Discount and Dispensing Fees negotiated between Aetna and such pharmacies. This is considered "traditional" or "lock in" pricing.

(ii) Aetna Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Aetna Mail Order Pharmacy on its internet website and via its member services call center. The Aetna Mail Order Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Aetna Mail Order Pharmacy generally will require that medications and supplies be dispensed in quantities not to exceed a 90-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable law do not prohibit substitution of a Generic Drug equivalent, if any, for the prescribed drug, or if the Aetna Mail Order Pharmacy obtains consent of the Prescriber, the Aetna Mail Order Pharmacy

shall require that the Generic Drug equivalent be dispensed to the Plan Participant. Certain Specialty Products, some acute drug products or certain compounds cannot be ordered through the Aetna Mail Order Pharmacy. The Aetna Mail Order Pharmacy shall make refill reminder and on-line ordering services available to Plan Participants. Aetna and/or the Aetna Mail Order Pharmacy may promote the use of the Aetna Mail Order Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Aetna Mail Order Pharmacy's cost, unless otherwise agreed upon by Aetna and the Customer.

(iii) Aetna Specialty Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Aetna Specialty Pharmacy on its internet website and via its member services call center. The Aetna Specialty Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Aetna Specialty Pharmacy generally will require that Specialty Drug medications and supplies be dispensed in quantities not to exceed a 30-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable law do not prohibit substitution of a Generic Drug equivalent, if any, to the prescribed drug, or if the Aetna Specialty Pharmacy obtains consent of the Prescriber, the Aetna Specialty Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. The Aetna Specialty Pharmacy shall make refill reminder services available to Plan Participants. Aetna and/or the Aetna Specialty Pharmacy may promote the use of the Aetna Specialty Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Aetna Specialty Pharmacy's cost, unless otherwise agreed upon by Aetna and the Customer. Further information regarding Specialty Product pricing and limitations is provided in the Service and Fee Schedule.

c. Clinical Programs

(i) Formulary Management. Aetna offers several versions of formulary options ("Formulary"). The formulary options implemented will be determined and communicated prior to the implementation date. Aetna grants the Customer the right to use the Formulary during the term of this Schedule solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. The Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary for the Plan. The Customer further acknowledges and agrees that the Formulary is subject to change at Aetna's sole discretion as a result of a variety of factors, including without limitation, market conditions, clinical information, cost, rebates and other factors. The Customer also acknowledges and agrees that the Formulary is the Business Confidential Information of Aetna and is subject to the requirements set forth in this Schedule and the Agreement.

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

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

(iv) Retrospective Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan benefits its standard Retrospective DUR programs with respect to On-Line Claims. Aetna's Retrospective DUR programs are designed to help providers and Plan Participants identify circumstances where prescription drug therapy may be clinically inappropriate or other cost-effective drug alternatives may be available. Aetna's Retrospective DUR programs are educational programs and program results may be communicated to Plan Participants, providers and plan sponsors. Aetna's Retrospective DUR programs are administered using information submitted to and available in Aetna's On-Line Claims system, as well as On-Line Claims information submitted by the Participating Pharmacy.

(v) Aetna Rx Check Program. If purchased by the Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Aetna Rx Check Program. Aetna Rx Check programs use a rapid Retrospective DUR approach. Claims are systematically analyzed, often within 24 hours of adjudication, for possible physician outreach based on program algorithms. The specific outreach programs are designed to promote quality, cost-

effective care in accordance with accepted clinical guidelines through mailings or telephone calls to physicians and Plan Participants.

Aetna Rx Check will analyze Claims on a daily basis, identify potential opportunities for quality and cost improvements, and will notify physicians or Plan Participants of those opportunities. The physician-based Aetna Rx Check programs will identify:

- Certain medications that may duplicate each other's effect;
- Certain drug to drug interactions;
- Multiple prescriptions and/or Prescribers for certain medications with the potential for misuse;
- Prescriptions for a multiple daily dose of a targeted Prescription Drug when symptoms might be controlled with a once-daily dosing; and
- Plan Participants who have filled prescriptions for brand-new medications that have an A-rated generic equivalent available that could save Plan Participants money.

Another Aetna Rx Check program will notify Plan Participants in selected plans with mail-order drug benefits when they can save money by filling maintenance prescriptions at Aetna Rx Home Delivery versus filling prescriptions at a Participating Retail Pharmacy.

(vi) Disease Management Educational Program. If purchased by the Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Disease Management Educational Program. The Disease Management Educational Program is available to customers who purchase Aetna managed prescription drug benefit management services, but not Aetna medical benefit plan services. The program consists of Plan Participant identification and outreach based on active Claims analysis for targeted risk conditions, such as asthma and diabetes. Upon identification, Plan Participants will receive a welcome kit introducing the program, complete with important information including educational materials and resources. The Customer may choose either the Asthma or Diabetes program or a combination of the two programs.

(vii) Aetna Rx Step®. If included as indicated on the Service and Fee Schedule, Aetna Rx Step steers Plan Participants to preferred products within 13 key drug classes that have significant savings opportunities. The Customer will have the option to select all of the 13 of these drug classes, or just choose which of the 13 they want. The goal is to help keep members safe and save money, when possible.

(viii) Aetna Rx Healthy Outcomes. If purchased by the Customer as indicated on the Service and Fee Schedule, Aetna Rx Healthy Outcomes is designed to promote drug adherence

and sustained positive health outcomes for Plan Participants who survive an Acute Myocardial Infarction (heart attack), Coronary Artery Stent Placement or Acute coronary syndrome.

(ix) Aetna Healthy Actions℠ Rx Savings. If purchased by the Customer as indicated on the Service and Fee Schedule, the Aetna Healthy Actions Rx Savings program helps to reduce a Plan Participant's cost share for certain prescription drugs and can include outreach to Plan Participants and prescribing doctor to help promote adherence. It targets drugs for which compliance has been found to be most critical to realize cost savings for Plan Participants and plan sponsors. The targeted drugs treat certain chronic conditions such as diabetes, hypertension, and asthma.

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

d. Plan Participant Services and Programs

Internet services including Aetna Navigator and Aetna Pharmacy Website.

Through Aetna Navigator, Plan Participants have access to the following:

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

Through the Aetna Pharmacy website, Plan Participants have access to the following:

- Find-A-Pharmacy – This service helps locate an Aetna participating chain or independent pharmacy on hundreds of medications and herbal remedies.
- Tips on drug safety and prevention of drug interactions.
- Answers to commonly asked questions about prescription drug benefits and access to educational videos.

- Preferred Drug List and Generic Substitution List.
- Step Therapy List.

e. Rebate Administration

(i) The Customer acknowledges that Aetna contracts for its own account with pharmaceutical manufacturers to obtain Rebates attributable to the utilization of certain prescription products by Plan Participants who receive benefits from customers for whom Aetna provides pharmacy benefit management services. Subject to the terms and conditions set forth in this Schedule, including without limitation, Aetna may pay to the Customer, Rebates based on the utilization by Plan Participants of rebateable Prescription Drugs administered and paid through the Plan Participant's pharmacy benefits.

(ii) If the Customer is eligible to receive Rebates under this Schedule, the Customer acknowledges and agrees that Aetna shall retain the interest (if any) on, or the time value of, any Rebates received by Aetna prior to Aetna's payment of such Rebates to the Customer in accordance with this Schedule. Aetna may delay payment of Rebates to the Customer to allow for final adjustments or reconciliation of Service Fees or other amounts owed by the Customer upon termination of this Schedule.

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

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

The Customer further acknowledges and agrees that if it is eligible to receive a portion of Rebates under this Schedule, such eligibility shall be subject to the condition that the Customer, its affiliates, representatives and agents do not contract directly or indirectly with any other person or entity for discounts, utilization limits, Rebates or other financial incentives on pharmaceutical products or formulary programs for Claims processed by Aetna pursuant to this Agreement, without the prior written consent of Aetna. Without limiting Aetna's right to other remedies, failure by the Customer to

obtain Aetna's prior written consent in accordance with the immediately preceding sentence shall constitute a material breach of the Agreement, entitling Aetna to (a) suspend payment of Rebates hereunder and to renegotiate the terms and conditions of this Agreement, and/or (b) immediately withhold any Rebates earned by, but not yet paid to, the Customer as necessary to prevent duplicative Rebates on such drugs.

VI. IMPORTANT INFORMATION ABOUT THE PHARMACY BENEFIT MANAGEMENT SERVICES

1. The Customer acknowledges that Aetna contracts for its own account with pharmaceutical manufacturers to obtain Prescription Drug Formulary Rebates directly attributable to the utilization of certain Prescription Drugs by Plan Participants who receive Covered Services. The Rebate amounts negotiated by Aetna with pharmaceutical manufacturers vary based on several factors, including the volume of utilization, benefit plan design, and Formulary or preferred coverage terms. Aetna may offer the Customer an amount of Rebates on Prescription Drugs that are administered and paid through the Plan Participant's pharmacy benefit. These Rebates are earned when members use drugs listed on Aetna's Formulary and preferred Specialty Products. Aetna determines each customer's Rebates based on actual Plan Participant utilization of those Formulary and preferred Specialty Products for which Aetna also has manufacturer Rebate contracts. The amount of Rebates will be determined in accordance with the terms set forth in the Customer's Pharmacy Service and Fee Schedule.

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

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

   Any material plan changes impacting administration, utilization or demographics may impact Rebate projections and actual Rebates received. Aetna reserves the right to terminate or change this program prior to the end of any Agreement Period for which it is offered if: (a) there is any legal, legislative or regulatory action that materially affects or could affect the manner in which Aetna conducts its Rebate program; (b) any material manufacturer Rebate contracts with Aetna are terminated or modified in whole or in part; or (c) the Rebates actually received under any material manufacturer Rebate contract are less than the level of Rebates assumed by Aetna for the applicable Agreement Period. If there is any legal action, law or regulation that prohibits, or could prohibit, the continuance of the Rebate program, or an existing law is interpreted to prohibit the program, the program shall terminate automatically as to the state or jurisdiction of such law or regulation on the effective date of such law, regulation or interpretation.

2. The Customer acknowledges that from time to time, Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates and which are paid separately to Aetna or designated third parties (e.g., mailing vendors, printers). These payments are to reimburse Aetna for the cost of various educational programs. These programs are designed to reinforce Aetna's goals of maintaining access to quality, affordable health care for Plan Participants and the Customer. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates as compensation for bona fide services it performs, such as the analysis or provision of aggregated information regarding utilization of health care services and the administration of therapy or disease management programs.

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

3. The Customer acknowledges that in evaluating clinically and therapeutically similar Prescription Drugs for selection for the Formulary, Aetna reviews the costs of Prescription Drugs and takes into account Rebates negotiated between Aetna and Prescription Drug manufacturers. Consequently, a Prescription Drug may be included on the Formulary that is more expensive than a non-Formulary alternative before any Rebates Aetna may receive from a Prescription Drug manufacturer are taken into account. In addition, certain Prescription Drugs may be chosen for Formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-Formulary alternatives. The net cost to the Customer for Covered Services will vary based on: (i) the terms of Aetna's arrangements with Participating Pharmacies; (ii) the amount of the Cost Share obligation under the terms of the Plan; and (iii) the amount, if any, of Rebates to which the Customer is entitled under this Schedule and Service and Fee Schedule. As a result, the Customer's actual claim expense per prescription for a particular Formulary Prescription Drug may in some circumstances be higher than for a non-Formulary alternative.

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

4. The Customer acknowledges that Aetna contracts with Participating Retail Pharmacies directly or through a pharmacy benefit management ("**PBM**") subcontract to provide the Customer and Plan

Participants with access to Covered Services. The prices negotiated and paid by Aetna or PBM to Participating Retail Pharmacies vary among Participating Retail Pharmacies in Aetna's network, and can vary from one pharmacy product, plan or network to another.

Under this Schedule and Service and Fee Schedule, the Customer and Aetna have negotiated and agreed upon a uniform or "lock-in" price to be paid by the Customer for all claims for Covered Services dispensed by Participating Retail Pharmacies. This uniform price may exceed or be less than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services. Where the uniform price exceeds the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, Aetna realizes a positive margin. In cases where the uniform price is lower than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, Aetna realizes a negative margin. Overall, lock-in pricing arrangements result in a positive margin for Aetna. Such margin is retained by Aetna in addition to any other fees, charges or other amounts agreed upon by Aetna and the Customer, as compensation for the pharmacy benefit management services Aetna provides to the Customer. Also, when Aetna receives payment from the Customer before payment to a Participating Pharmacy or the PBM, Aetna retains the benefit of the use of the funds between these payments.

5. The Customer acknowledges that Covered Services under a Plan may be provided by Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy. In such circumstances, Aetna Mail Order Pharmacy refers to Aetna Rx Home Delivery, LLC, and Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, both of which are subsidiaries of Aetna that are licensed Participating Pharmacies. Aetna's negotiated reimbursement rates with Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy, which are the rates made available to the Customer, generally are higher than the pharmacies' cost of fulfilling orders of Prescription Drugs and Specialty Products and providing Covered Services and therefore these pharmacies realize an overall positive margin for the Covered Services they provide. To the extent Aetna Mail Order Pharmacy and Aetna Specialty Pharmacy purchase Prescription Drugs and Specialty Products for their own account, the cost therefor takes into account both up-front and retrospective purchase discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors. Such purchase discounts, credits and other amounts are negotiated by Aetna Mail Order Pharmacy, Aetna Specialty Pharmacy or their affiliates for their own account and are not considered Rebates paid to Aetna by manufacturers in connection with Aetna's Rebate program.

6. The Customer acknowledges that Aetna generally pays Participating Pharmacies (either directly or through PBM) for Brand Drugs whose patents have expired and their Generic Drug equivalents at a single, fixed price established by Aetna (Maximum Allowable Cost or MAC). MAC pricing is designed to help promote appropriate, cost-effective dispensing by encouraging Participating Pharmacies to dispense equivalent Generic Drugs where clinically appropriate. When a Brand Drug patent expires and one or more generic alternatives first become available, the price for the Generic Drug(s) may not be significantly less than the price for the Brand Drug. Aetna reviews the drugs to determine whether to pay Participating Pharmacies (or PBM) based on MAC or continue to pay Participating Pharmacies (or PBM) on a discounted fee-for-service basis, typically a percentage discount off of the listed Average

Wholesale Price of the drug (AWP Discount). This determination is based in part on a comparison under both the MAC and AWP Discount methodologies of the relative pricing of the Brand and Generic Drugs, taking into account any Rebates Aetna may receive from Prescription Drug manufacturers in connection with the Brand Drug. If Aetna determines that under AWP Discount pricing the Brand Drug is less expensive (after taking into account manufacturer Rebates Aetna receives) than the generic alternative(s), Aetna may elect not to establish a MAC price for such Prescription Drugs and continue to pay Participating Pharmacies (or PBM) according to an AWP Discount.

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

Prescription Drugs falling within the definition of the Mail Order Exceptions List may be excluded from the reconciliation of its standard pharmacy Discount and Dispensing Fee financial guarantees.

VII. AUDIT RIGHTS

1. General Pharmacy Audit Terms and Conditions

a. Subject to the terms and conditions set forth in the Agreement and disclosures made in the Service and Fee Schedule, the Customer shall be entitled to have audits performed on its behalf (hereinafter **"Pharmacy Audits"**) to verify that Aetna has (a) processed Claims submitted by participating pharmacies or a pharmacy benefits manager under contract with Aetna, (b) paid Rebates in accordance with this Schedule and the Service and Fee Schedule. Pharmacy Audits may be performed at Aetna's Minnetonka, MN or Hartford, CT location.

b. Additional Terms and Conditions

(i) Auditor Qualifications and Requirements specific to Pharmacy Audits

All Pharmacy Audits shall be performed solely by third party auditors meeting the qualifications and requirements of the Agreement, this Schedule and the Service and Fee Schedule. In addition the requirements set forth in section 11, Audit Rights of the Agreement, the auditor chosen by the Customer must be mutually agreeable to both the Customer and Aetna. Auditors may not be compensated on the basis of a contingency fee or a percentage of overpayments identified, in accordance with the

provisions of Section 8.207 through 8.209 of the International Federation of Accountant's (IFAC) Code of Ethics For Professional Accountants (Revised 2004).

(ii) Auditor Qualifications and Requirements specific to Rebate Audits

Any audit of Aetna's agreements with pharmaceutical manufacturers will be conducted by (a) one of the major public accounting firms (currently the "Big 4") approved by Aetna whose audit department is a separate stand alone function of its business, or (b) a national CPA firm approved by Aetna whose audit department is a separate stand alone function of its business.

(iii) Closing Meeting

In the event that Aetna and the Customer's auditors are unable to resolve any such disagreement regarding draft Pharmacy Audit findings, either Aetna or the Customer shall have the right to refer such dispute to an independent third-party auditor meeting the requirements of the Agreement, this section VII and the Service and Fee Schedule and selected by mutual agreement of Aetna and the Customer. The parties shall bear equally the fees and charges of any such independent third-party auditor, provided however that if such auditor determines that Aetna or the Customer's auditor is correct, the non-prevailing party shall bear all fees and charges of such auditor. The determination by any such independent third-party auditor shall be final and binding upon the parties, absent manifest error, and shall be reflected in the final Pharmacy Audit report.

2. Additional Claim and Rebate Audit Terms and Conditions

a. Rebate Audits

Subject to the terms and limitations of this Schedule, the Agreement, and the Service and Fee Schedule including without limitation the general Pharmacy Audit terms and conditions set forth in this section VII, the Customer shall be entitled to audit Aetna's calculation of Rebates received by the Customer as set forth below. Aetna will share the relevant portions of the applicable formulary rebate contracts, including the manufacturer names, drug names and rebate percentages for the drugs being audited. The drugs to be audited will be selected by mutual agreement of the parties. The parties will reasonably cooperate to select drugs for each audit that (a) represent the fewest unique manufacturer rebate contracts required for audit so that the selected drugs represent a maximum of 15% of the Customer's Rebates; which are attributable to the drugs most highly utilized by Plan Participants (b) shall be limited to (two) 2 consecutive quarters and (c) are subject to manufacturer rebate agreements that do not contain restrictions prohibiting Aetna from disclosing to the Customer portions of such contracts concerning the rebates, payments or fees payable there under. Aetna will also provide access to all documents reasonably necessary to verify that Rebates have been invoiced, calculated, and

paid by Aetna in accordance with this Schedule. The Customer is entitled to only one annual Rebate audit. Prior to the commencement of such audit, the Customer and auditor shall enter into a rebate audit confidentiality agreement acceptable to Aetna.

b. Pharmacy Claim Audits. Claim audits are subject to the above referenced audit standards for Rebates in the case of a physical, on-site, Claim-based audit. In the case of electronic Claim audits that follow standard pharmacy benefit audit practices where electronic re-adjudication of Claims is requested and processed off-site, the Customer may elect to audit 100% of claims. The Customer is entitled to only one annual Claim audit.

TEMPORARY EXHIBIT 1 –HEALTH COVERAGE
PLAN OF BENEFITS
TO THE
MASTER SERVICES AGREEMENT
EFFECTIVE January 1, 2018

The Plan(s) described in this Temporary Exhibit are benefit plans of the Customer. These benefits are not insured with Aetna but will be paid from the Customer's funds. Until this Temporary Exhibit is otherwise modified or replaced in its entirety by agreement between Aetna and the Customer:

1. Aetna will provide certain administrative services to the Plan as outlined in the Letter of Understanding signed by Aetna.
2. Aetna will use the description of covered benefits, services and programs outlined in the Plan Design(s), including any subsequent changes agreed to by Aetna and the Customer, in the administration of the Plan(s).
3. Further, in the administration of the Plan(s), Aetna will use Aetna's standard plan General Exclusions and standard Glossary definitions of terms.

The terms of this Temporary Exhibit control until superseded by a subsequent Plan document or Summary Plan Description, for any specific benefits applicable to any class(es) of employees, as indicated therein.

a

Brian Donohue
Aetna
151 Farmington Ave,
RE11
Hartford, CT 06156
860-273-6820

December 8, 2017

Lancaster County
555 S. 10th St.
Lincoln, NE 68508

Re: Lancaster County - Confirmation of Services and Administrative Services Only Fees

Dear Lancaster County:

Thank you for selecting Aetna and we look forward to beginning our business relationship with Lancaster County. Based on our original proposal and subsequent discussions, we have outlined the products and services Lancaster County has purchased for the plan effective January 1, 2018. Please review and confirm this information accurately reflects Lancaster County's understanding. If you have any questions, you may contact Michael Boden to discuss any necessary changes.

The initial term of this Agreement will be one year beginning on the Effective Date. The Parties may renew the Agreement for two additional one-year terms. The initial term and each successive one year renewal shall be considered an "Agreement Period". The schedules may provide for different start and end dates for certain Services.

The contract period begins on the effective date of January 1, 2018. Our contracts provide for automatic renewal upon the completion of each contract period unless either party invokes the termination provision, which requires 31 days advance written notice of termination to the other party. This provision may be invoked at any time during the continuance of the contract and is not limited to termination occurring on the renewal date, subject to the terms of the contract(s).

Coverages and Financial Arrangements

The following illustrates the funding arrangements by line of coverage:

Coverage	Funding Arrangement
Choice POS II	Self-Funded

Administrative Service Fees

Based on the package of services selected and enrollment awarded to Aetna, the per employee per month administrative services fees by plan for each of the three contract periods, as revised and quoted on July 2017, are:

Plan	Projected Enrollment	01/01/2018	01/01/2019	01/01/2020
Choice POS II	796	$34.00	$35.02	$36.07

Please note that we have extended Lancaster County a two-month fee holiday for the Medical fees at the start of the contract period. This is contingent upon Aetna being the Total Replacement medical carrier for Lancaster County. In the event that Lancaster County terminates the existing Aetna coverages in whole or in part prior to the end of the 36-month period, January 1, 2018 through December 31, 2020, an early termination fee payment equivalent to $66,068, will be due and payable to Aetna. Payment will be due to Aetna within 31 days of the invoice.

We will postpone the payment of the Aetna In Touch Care Premier $7.50 PEPM fee during Lancaster County's January 1, 2018 to December 31, 2018 plan year until Aetna demonstrates it has met the AITC 2:1 ROI Guarantee. (Please note: Aetna In Touch Care requires the purchase of MedQuery and PHR). The Lancaster County would then be billed the accrued fees for the policy period. If Aetna fails to achieve the 2 to 1 savings, no fees will be due.

Self Funded Fees include:

Included Services / Programs in Above Administrative Fees
Implementation & Communications
Designated Implementation Manager
Open Enrollment Marketing Material (noncustomized)
Onsite Open Enrollment Meeting Preparation
Standard ID Cards
General Administration
Experienced Account Management Team
Designated billing, eligibility, plan set up, underwriting and drafting services
Review or draft plan documents
Summary of Benefits and Coverage (SBCs)
Aetna Full Claim Fiduciary - Option 1

Aetna provides External Review
Weekly Funding of Claims (Thursday via ACH)
Member and Claim Services
Claim Administration
Member Services
Aetna Voice Advantage
Designated Service Center
Plan Sponsor Liaison
Special Investigations / Zero Tolerance Fraud Unit
Network
Network Access / Full National Reciprocity
Institutes of ExcellenceTM (Transplants)
Care Management
Utilization Management Inpatient Precertification
Utilization Management Outpatient Precertification
Utilization Management Concurrent Review
Utilization Management Discharge Planning
Utilization Management Retrospective Review
Case Management
Aetna Compassionate Care Program (ACCP)
National Medical Excellence®
Institutes of Quality Program (IOQ) (same benefits)
Aetna Custom Care Management Solutions – Aetna In Touch Care℠ Premier - Designated
MedQuery® with Physician Messaging
Personal Health Record
Preventive Care Considerations (Electronic)
Informed Health® Line - 24-hour Nurseline 1-800 #
Simple Steps To A Healthier Life ®- Health Assessment
Behavioral Health
Managed Behavioral Health
Aetna Behavioral Health Basic Conditions Management Program
AbleTo network – subject to member cost share
Web Tools
DocFind® (online provider directory)
Aetna Navigator® - Member Self Service Web
Online Programs
Health Decision Support - Basic
MindCheck℠
Reporting
5 Hours of Ad Hoc Reports, Annual Restoration
Aetna Health Information Advantage
e.Plan Sponsor Monitor – Level B Reporting (Standard Quarterly Utilization Reports)
Monthly Financial Claim Detail Reports
Monthly Banking Reports
Aetna Discount Program
at home products, books, fitness, hearing, national products and services, oral health care, vision and weight management

Services included through the claim wire:

Claim Wire Billing Programs	***Charged through the claim wire. Not included in the PEPM fees above.***
Subrogation	30% of recovered amount will be retained
Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, DRG and Implant Audits	30% of recovered amount will be retained
National Advantage™ Program	50% of savings will be retained
Standard Facility Charge Review	50% of savings will be retained
Itemized Bill Review	50% of savings will be retained
Teladoc	$0.95 per employee per month and $40 per Teladoc consultation

Underwriting Assumptions and Caveats

Self Funded Medical Financial Assumptions

Please refer to the Self Funded Medical Financial Assumptions document provided as Attachment I[1] for additional information.

Guarantees

Performance Guarantees – Medical

In total, we will put **15%** of our applicable guarantee period administrative service fees at risk through Performance Guarantees. The guarantee period administrative service fees will be calculated at the end of each guarantee period and will be based on the total number of employees actually enrolled in the plans listed below.

The guarantees described herein will be effective from January 1, 2018 to December 31, 2018 (hereinafter "guarantee period").

The performance guarantees will apply to the self-funded Aetna Choice POS II plans administered under the Administrative Services Only Agreement ("Services Agreement). These guarantees do not apply to non-Aetna benefits or networks.

[1] Refer to *Attachment I – Financial Assumptions*

Performance Category	Minimum Standard	Maximum Fees at Risk
Implementation		
• Implementation	Average evaluation score of 3.0 or higher	2.5%
• ID Card Production & Distribution	97% of ID cards mailed within 15 business days of receiving eligibility file	2.0%
• **Account Management**		
Overall Account Management	Average evaluation score of 3.0 or higher	2.0%
• **Claim Administration**		
Turnaround Time	90.0% of claims processed within 14 *calendar days*	1.5%
• Financial Accuracy	99.0%	1.5%
• Total Claim Accuracy	95.0%	1.5%
• **Member Services**		
Average Speed of Answer	30 Seconds	2.0%
• Abandonment Rate	2.0%	2.0%
• **Total**		**15.0%**

Please refer to the Medical Performance Guarantee document provided as Attachment II[2] for additional information.

[2] Refer to *Attachment II – Performance Guarantee*

Performance Guarantees – Pharmacy

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **January 1, 2018 through December 31, 2018** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the self-funded Aetna Pharmacy Management plans administered under the Administrative Services Only Agreement ("Services Agreement"). These guarantees do not apply to non-Aetna benefits or networks.

Aggregate Maximum

In total, Aetna agrees to place **$80,000** at risk through the Performance Guarantees outlined in this document. Our offer assumes 796 employee lives. Aetna reserves the right to revisit the guarantees if there is a change in enrollment of more than 15%.

Performance Guarantee Category	Minimum Standard	Proposed Penalty
Retail Claim Administration		
• Pharmacy System Availability	99.9%	$10,000
• Turnaround Time – Paper Claims	97.0% within a weighted average of 5 business days of receipt and 99.5% within a weighted average of 10 business days of receipt	$10,000
Mail Order Claim Administration		
• Turnaround Time – Clean Claims	98.0% within an average of 2 business days of receipt	$10,000
• Turnaround Time – Claims Requiring Intervention	95.0% within an average of 5 business days of receipt	$10,000
• Mail Order Dispensing Accuracy	99.98%	$10,000
Member Services		
• Average Speed of Answer	30 seconds or less	$10,000
• Abandonment Rate	3.0%	$10,000
• Pharmacy First Call Resolution	95.0% successfully resolved on the first call	$10,000
Total		**$80,000**

Please refer to the Pharmacy Performance Guarantee document provided as Attachment III[3] for additional information.

[3] Refer to *Attachment III – Pharmacy Service Performance Guarantee*

Additional Guarantees

Medical Discount Guarantee

We have placed **15%** of our guarantee period administrative service fees at risk with a Choice POS II Discount Guarantee. In Year 1, January 1, 2018, through December 31, 2018, Aetna will guarantee the discount that result from negotiated arrangements with providers participating in our Choice Point of Service II (CPII) product. The discount achieved will be calculated on an aggregate basis, taking the service type (hospital inpatient, hospital outpatient, physician/other) discounts based upon billed eligible expenses by network. Attachment IV A[4] shows the discounts by network that Aetna is willing to guarantee. It also summarizes the illustrative discount targets based on book of business service type and enrollment by market. Please refer to the Medical Discount Guarantee document provided as Attachment IV[5] for additional information.

Medical Management Guarantee

We have placed guarantee period $10.03 of our program fees at risk on medical management guarantees. Please refer to the Demonstrating Value Scorecard provided as Attachment V[6] for additional information.

Benefit Summaries We have provided plan designs for the quoted Self Insured Choice POS II, . Please refer to the Plan Design and Benefit Documents provided as Attachment X for additional information.

Pharmacy Services

Please refer to the Pharmacy service and fee schedule provided as Attachment VI[7] for additional information

[4] Refer to *Attachment IV A – Discount Guarantee*
[5] Refer to *Attachment IV – Discount Guarantee*
[6] Refer to *Attachment V – DV Scorecard*
[7] Refer to *Attachment VI – Pharmacy Service and Fee Schedule*

Stop Loss Services

Please refer to the Stop Loss Proposal provided as Attachment VII[8] for additional information

Please let us know if you have any questions or concerns regarding the information outlined in this letter and the attachments. We appreciate Lancaster County's business and look forward to a successful plan implementation.

Sincerely,

Brian Donohue
Public & Labor Underwriting
Aetna

cc: Michael Schlosser
Michael Boden
Craig Baker
Jessica Rubin

[8] Refer to *Attachment VII – Stop Loss Proposal*

Self-Funded Medical Financial Assumptions and Caveats

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

We have made every effort to respond to Lancaster County's request in a manner that reflects our existing and expected business practices for the period of January 1, 2018 continuing through December 31, 2018. If you decide to establish a business relationship with us, we'll send you a Letter of Understanding confirming agreed upon benefits, services and fees. Then you will need to enter into an administrative services agreement (the "Agreement") with us.

Fee Guarantee Period

The first-year fees for the period January 1, 2018 through December 31, 2018 are guaranteed as shown on the attached financial exhibit(s). Medical in years 2 and 3 will increase annually by 3 percent over the prior year mature fees. We guarantee that the second-year medical fees will increase over the first-year mature fees by 3 percent. We also guarantee that the third-year medical fees will increase over the second-year fees by 3 percent. Performance Guarantees are included.

Fee Holiday - We have provided you a two-month fee holiday for the Medical products at the start of the period contingent upon the group purchasing Aetna In Touch Care Premier. This is subject to Aetna being the sole medical carrier for Lancaster County.

If you terminate your Aetna medical plans in whole or in part (defined as a 50 percent or greater membership reduction) prior to the end of the 36-month period, January 1, 2018 through December 31, 2020, a transition fee of $66,068 for the two-month fee holiday will apply. This transition fee is to compensate us for the cost of transitioning your programs to a new administrator. Payment will be due to us within 31 days of the invoice.

Self-Funded Medical Financial Assumptions and Caveats

Underwriting Caveats

Your pricing takes into account all of the multiple products, programs and services included in this proposal. We also assume the quoted products, programs and services will be in effect for the full 12 months of the plan year.

If any of the changes outlined below occur, we reserve the right to recalculate your guaranteed fees, using the Guarantee Period formulas. If this happens, you will be required to pay any difference between the fees collected and the new fees calculated back to the start of the Guarantee Period.

During the Guarantee Period we may recalculate:

1. If, for any product:

    a. There is a 10 percent decrease in the number of enrolled employees in aggregate from our enrollment assumptions or from any subsequently reset enrollment assumptions.

    b. The member-to-employee ratio increases by more than 10 percent. We have assumed a member-to-employee ratio of:
    - 2.10 for Choice POS II.

2. Maximum account structure exceeds 60units per product. Account structure determines the reporting format. During the installation process, we will work with you to finalize the account structure and determine which report formats will be most meaningful. Maximum total account structure includes Experience Rating Groups (ERGs), controls, suffixes, billing and claim accounts.

3. A material change in the plan of benefits is initiated by Lancaster County or by legislative or regulatory action.

4. A material change in the claim payment requirements or procedures, claim fiduciary option, account structure or any other change materially affecting the manner or cost of paying benefits initiated by Lancaster County or by legislative or regulatory action.

5. The National Advantage™ Program (NAP), Facility Charge Review (FCR) or Itemized Bill Review (IBR) programs are changed or terminated by Lancaster County.

6. There are any changes to the Aetna programs and services offered to Lancaster County.

Self-Funded Medical Financial Assumptions and Caveats

7. Lancaster County terminates any of our other products not addressed within this financial package including, but not limited to Pharmacy products.

8. Lancaster County places the products and services included in this multi-year fee guarantee out to bid, this guarantee is nullified.

9. Legislation, regulation or requests of government authorities result in material changes to plan benefits, we reserve the right to collect any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

Late Payment

If you do not provide funds on a timely basis to cover benefit payments as provided in the Agreement, and/or fail to pay fees on a timely basis as provided in such Agreement, we will assess a late payment charge. The current charges are:

- late funds to cover benefit payments (e.g., late wire transfers after 24-hour request): 12.0 percent annual rate

- late payments of service fees after 31 day grace period: 12.0 percent annual rate

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

We will notify you of any change to late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Agreement or at law or in equity for failure to pay.

Self-Funded Medical Financial Assumptions and Caveats

Underwriting Assumptions

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

- The attached financial exhibit outlines the programs and services we offer.

- **Pricing and Underwriting Basis** – We have assumed that the proposed plan of benefits will be extended to the employee group(s) included on the census file that was submitted with the request for proposal. Our enrollment assumptions are shown on the attached financial exhibit(s). Our proposal assumes coverage will not be extended to additional employee groups without review of supplemental census information and other underwriting information for appropriate financial review.

- **Participation Requirement** – There is a minimum requirement of 250 enrolled employees for administration of the proposed products and services on a self-funded plan basis. However, any performance guarantee is contingent upon the total number of covered lives (i.e., the total number of Lancaster County employees enrolled for coverage) outlined in our proposal.

- **Plan Design** – These products are offered subject to the terms of our Benefit Review Document.

- **Claim Fiduciary** – Our proposal assumes we have been delegated claim fiduciary responsibilities. As claim fiduciary, we will be responsible for final claim determination and the legal defense of disputed benefit payments. Our appeal administrative services are automatically included when we assume claim fiduciary responsibility. The fee included for this service assumes a member-to-employee ratio range of 2.01 to 2.30.

- **External Review** – We have included external review in our proposal. External review uses outside vendors who coordinate a medical review through their network of outside physician reviewers.

- **Non-ERISA** – For a non-ERISA plan, the risks and responsibilities are different from those under ERISA plans, since the ERISA preemption and ERISA standard of performance do not apply. Our charge for non-ERISA plans must take into account the additional liability risk as compared to known risks under an ERISA plan. An additional $0.35 per-employee, per-month is charged for non-ERISA plans and has been included in our fees as shown on the financial exhibit(s).

Self-Funded Medical Financial Assumptions and Caveats

- **Eligibility Transmission** – Our proposal assumes we will receive eligibility information weekly or biweekly, from your location(s) and/or by your designated vendor. Our preferred method of submission is via electronic connectivity. We do not charge for the first four Electronic Reporting (ELRs)/segments whether associated with one transmission or by multiple methods. Costs associated with more than four ELRs/segments or with any custom programming necessary to accept your eligibility information and/or information coming from a designated vendor are not included in this proposal and will be assessed separately. During the installation, we will review all available methods of submitting eligibility information and identify the approach that best meets your needs or the needs of your designated vendor.

- **Third-Party Audits** – We do not typically charge to recoup internal costs associated with a third-party audit. We reserve the right to recover these expenses if significant time and materials are required.

- **Mental Health/Substance Abuse Benefits** – Our quotation assumes that mental health/substance abuse benefits are included

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

Self-Funded Medical Financial Assumptions and Caveats

Banking

We have assumed that you will provide funds through a Fed drawdown by Aetnawire transfer for drafts issued under the self-funded arrangement assumed in this proposal.

When paid claims have accumulated to more than $20,000, a request will be sent to you and/or your bank requesting funds for the total paid 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.

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

Compensation

The quoted fees do not include consultant compensation.

Disclosure Statement – We have various programs for compensating agents, brokers and consultants. If you would like information about compensation programs for which your agent, broker, or consultant is eligible; payments (if any) that we have made to your agent, broker, or consultant; or other material relationships your agent, broker, or consultant may have with us, you may contact your agent, broker, or consultant or your Aetna account representative. Information about our programs for compensating agents, brokers, or consultants is also available at **www.aetna.com**.

Self-Funded Medical Financial Assumptions and Caveats

Billing Information

- **Advance Notification of Fee Change** – We will notify you of any fee change within 31 days of the fee change.

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

- **Teladoc** – Teladoc offers members access to quality, affordable care for routine common illnesses via telephonic and online video consultation. Telephonic consults are available in 48 states (not available in AR and ID), and video consults are available in 49 states (not available in AR). Teladoc offers a low cost alternative to more expensive emergency room and urgent-care centers when the member's PCP is unavailable.

  You will be charged $0.95 PEPM through the claim wire. These fees are billed to all medical employees on a claim wire billing account and will be outlined on your monthly claim detail reports. There is also a $40 claim charge for each Teladoc consultation paid to the provider through claim wire after consideration of member cost share.

  This charge assumes the member cost share is a custom $10 copay and that Teladoc is offered to the entire population.

Self-Funded Medical Financial Assumptions and Caveats

Claim and Member Services

- **Policies and Claim Settlement Practices** – Our quotation assumes that our standard contract provisions and claim settlement practices will apply. If a material change is initiated by Lancaster County or by legislative or regulatory action in the claim payment requirements or procedures, account structure, or any changes materially affecting the manner or cost of paying benefits, we reserve the right to adjust our proposal accordingly

- **Run-In Claim Processing** – Our proposal excludes run-in claim processing from the prior carrier (claims incurred before the effective date of the plan).

- **Run-Off Claims Processing** –The expenses associated with processing runoff claims following cancellation are covered for one year.

- **Medical EOB Suppression** – Unless required by state law, we do not produce EOBs for Aetna Choice® POS II claims when there is no member liability. Our claim system automatically suppresses an EOB where benefits are assigned and the member's liability is either zero or consists of a copayment only. Additionally, EOBs are always available electronically through Aetna Navigator.

- **Medical Service Center** – We have assumed that claim administration and member services for the quoted plans will be managed centrally by the New Albany Service Center. Members will be able to reach the Member Service representatives Monday through Friday, from 8 a.m. to 6 p.m., local time.

- **Patient Management Center** – Patient Management services for Lancaster County will be administered by our regional Patient Management Centers.

- **Alternate Office Processing (AOP)** – We regularly use both internal and external claim adjudication services to meet service requirements of our business. These services may be located inside or outside of the United States. Our quality standards and controls apply to all claims regardless of where they are processed. Standard pricing assumptions are in effect based on type of product, auto-adjudication, plan design, and customer specific requirements. We may adjust fees based on the above factors and/or where you wish to limit use of Alternative Office Processing (AOP).

- **Claims Subrogation** – We have entered into an agreement with Rawlings & Associates to provide comprehensive subrogation services. A contingency fee of 30 percent is retained upon recovery for self-funded customers.

Self-Funded Medical Financial Assumptions and Caveats

- **Contracted Services** – A contingency fee up to 30 percent is paid to a vendor upon recovery of self-funded customers' claims for certain claim overpayment programs such as the following:
  - Coordination of benefits
  - Retroactive termination
  - Audits (Hospital, DRG, High Cost Drugs, etc.)
  - Duplicate Bills
  - Contract Compliance
- **Specialty Pharmaceutical Rebates** – We will retain (as compensation for our efforts in administering the Preferred Specialty Pharmaceutical Program) all specialty pharmaceutical rebates earned on drug claims that we administer and pay through the medical benefit rather than the pharmacy benefit.

Network Services

- **Sutter Health Contracting Requirement** – Sutter Health and Affiliates, the dominant health system in much of Northern California, uses its bargaining power to insist on unique requirements to participate in our network. Our contract with Sutter requires us to pay claims we otherwise would deny such as those not medically necessary or experimental or investigational (but does not require us to pay for services your plan expressly excludes from coverage, such as for cosmetic surgery). We will charge your plan for these claims in order to be able to continue providing your plan's participants with access to Sutter's services on an in-network basis. Your Summary of Plan Document (SPD) text should ensure that the description of our services accommodates such arrangements. Sutter also requires that you agree to be bound by the terms of our contract with them, including, but not limited to, the dispute resolution and binding arbitration provisions. You agree to be bound by the terms of the Sutter contract, including future amendments. You may request a copy of the Sutter contract for your use upon your completion of a confidentiality agreement. If a copy is furnished to you, you will hold the terms of the Sutter agreement in strict confidence in accordance with its confidentiality provisions. You must sign an attestation letter or Master Services Agreement, agreeing to these conditions; otherwise Sutter providers will be excluded from your network.

Self-Funded Medical Financial Assumptions and Caveats

- **Value-Based Contracting**

1. Introduction
   Value-Based Contracting (VBC) incentivizes providers to use evidence-based medicine, improve patient engagement, upgrade health IT and use data analytics. VBC is a way of contracting with health care providers that rewards them based on the value they deliver, usually through effective population health management and their focus on health outcomes for their patient base as a whole. Stated more simply, when patients receive more coordinated, appropriate and effective care, providers share in the medical cost savings generated and members and plan sponsors benefit.

2. Contracting Models
   We view VBC as a spectrum, ranging from bundled payments and simple pay-for-performance approaches to more advanced forms of collaborative arrangements that include integrated technology and case management, aligned incentives and risk sharing. Our VBC models include:

   (A) Pay for Performance (P4P). Under P4P programs, providers (doctors and hospitals) and Aetna together develop and agree to a set of quality and efficiency measures. Physicians and hospitals continue to receive fee-for-service (FFS) payments and also have the opportunity to share in savings resulting from efficiency and clinical improvements. If the physician or hospital meets or exceeds the efficiency and clinical improvement goals, the physician or hospital receives a share of savings generated.

   (B) Bundled Payments. In a Bundled Payment model, a single payment is made to doctors or health care facilities (or jointly to both) for all services associated with an episode-of-care. Bundled payment rates are determined based on the total expected costs for a particular treatment, including pre- and post-treatment services, and are set to incentivize efficient medical treatment.

   (C) Patient Centered Medical Home (PCMH). In a PCMH, a primary care doctor leads a clinical team that oversees the care of each patient in a practice. The medical practice receives data about their patients' quality and costs of care in order to improve care delivery. Financial incentives can be earned based upon performance on specific quality and efficiency measures.

Self-Funded Medical Financial Assumptions and Caveats

(D) Accountable Care Organizations (ACOs). In an ACO, Aetna teams up with systems of doctors, hospitals and other health care providers to help these organizations manage risk, improve clinical care management, and implement data and technology to connect providers, health plans and patients. The ACO arrangements include financial incentives for the organization to improve the quality of patient care and health outcomes, while controlling costs.

In each of the VBC models, self-funded plan sponsors reimburse Aetna for any financial incentives attributable to their plan when the payments are made. Aetna will continue to evolve its value-based contracting arrangements over time. Aetna is likely to employ a broad spectrum of different financial incentives with providers in furtherance of the goals of improving the quality of patient care and health outcomes, while controlling costs.

3. How it operates

VBC is rapidly becoming the standard way we contract with our network providers, and is embedded as part of health plan administration. Each VBC model requires a different level of implementation and effort, or in some cases, no effort at all on the part of the plan sponsor.

In most VBC arrangements, the plan sponsor does not need to take any affirmative action to benefit from the arrangement: the participating provider is automatically compensated in accordance with their provider agreement. Aetna's attribution ACO and PCMH arrangements fall under this category. In other cases, the plan sponsor must make an affirmative decision to opt-in. Aetna's product model ACO arrangements require an opt-in.

4. Example Calculations

The methodology for determining customers' potential financial responsibility under each of such VBC arrangements are determined, and then charged using the same system used to charge claims and capitation costs, using an allocation method appropriate for each particular performance program. Methods include:

A. Percentage of allowed claims dollars and percentage of paid capitation dollars;
B. Percentage of member months;
C. Number of members.

Additional detail on any/all VBC arrangements impacting a plan sponsor is available upon request. A report of VBC charges to a plan sponsor will be available on a quarterly basis.

Self-Funded Medical Financial Assumptions and Caveats

Examples

A. Percentage of allowed claims dollars and percentage of paid capitation dollars **(P4P)**:
Achieving agreed upon clinical and efficiency performance goals by comparing performance year end to performance year baseline or an industry standard.

i. Provider earns $100,000 reward for assessment period January 2016 to December 2016;
ii. Plan sponsor incurred $150,000 in claims with the provider for assessment period January 2016 to December 2016;
iii. All plan sponsors, incurred $8,500,000 in claims with the provider for assessment period January 2016 to December 2016;
iv. Plan sponsor's share of claims costs is ($150,000/$8,500,000) = 1.7647 %. Formula: (Plan sponsor incurred claims/All plan sponsors incurred claims);
v. Aetna would create a payment of $100,000 to the provider;
vi. Plan sponsor's share of the $100,000 reward is 1.7647 % * $100,000) = $1,764.70;
vii. Plan sponsor will incur a charge of $1,764.70 upon the check issue date or the check clearing date, based on plan sponsor's set up with Aetna.

B. Percentage of member months **(PCMH and ACO)**:
Achieving agreed upon clinical and efficiency goals as measured by performance year end to performance year baseline or an industry standard.

i. Provider earns $100,000 reward for assessment period January 2016 to December 2016;
ii. Plan sponsor had 9,500 member months (for 850 unique members) attributed to the provider for assessment period January 2016 to December 2016;
iii. All plan sponsors, had 100,500 member months with the provider for assessment period January 2016 to December 2016;
iv. Plan sponsor's share of the member months is (9,500/$100,500) = 9.4527 %. Formula: (Plan sponsor incurred claims/All plan sponsors incurred claims);
v. Aetna would create a P4P payment for $100,000 to the provider;
vi. Plan sponsor's share of the $100,000 reward is (9.4527 % * $100,000) = $9,452.73;
vii. Plan sponsor will incur a charge of $9,452.73 upon the check issue date or the check clearing date, based on plan sponsor's set up with Aetna.

Self-Funded Medical Financial Assumptions and Caveats

C. Number of Members **(PCMH and ACO):**
In addition to Example B above, a quarterly Accountable Care Payment (ACP) may be made to the provider to fund activities necessary to meet the financial and clinical objectives. These are paid quarterly either during, or after the end of each quarter. The financial impact is considered in the total financial package negotiated with the provider.

i. Aetna determines the attributed patients for the provider for the quarter April 2016 through June 2016;
ii. Aetna applies the agreed upon rate to the attributed patients; i.e. $2.00 per member per month (PMPM) = $6.00 per quarter per member, to determine a payment to the provider;
iii. Plan sponsor had 850 members attributed to the provider for the quarter April 2016 through June 2016;
iv. Plan sponsor's calculated share is $5,100 ($6.00 * 850);
v. Plan sponsor will incur a charge of $5,100 upon the check issue date or the check clearing date, based on plan sponsor's set up with Aetna.
vi. ACP and FFS payments are incorporated into the final analysis of provider performance against the medical claims target

5. Disclaimers
VBC models are designed for population-based efficiency and clinical improvements. Provider performance is measured at the level of population served by the provider to ensure statistical validity, and funding is supported by plan sponsors on a proportional membership and/or financial basis. Each plan sponsor's results will vary. It is possible that incentives paid to a particular provider or health system may be required even if the plan sponsor's own population did not experience the same financial or qualitative improvements. It is also possible that incentives will not be paid to a provider even if the plan sponsor's own population did experience financial and quality improvements.

Self-Funded Medical Financial Assumptions and Caveats

- **Out-of-Network Program and Reimbursement** – Aetna has several programs to help you and your members save money when obtaining care out-of-network. Outlined below is the out-of-network program we have included in this proposal.

  National Advantage™ Program including the Contracted Rates, Facility Charge Review and Itemized Bill Review Components
  The National Advantage Program includes three components, Contracted Rates, Facility Charge Review and Itemized Bill Review. The 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.

  National Advantage Program fees
  We'll retain 50 percent of savings from the Contracted Rates National Advantage Program. We retain the same percentage of savings from the Facility Charge Review (FCR) and Itemized Bill Review (IBR) components of the National Advantage Program. These fees are in addition to the per-employee, per-month administrative service fees.

  How NAP fees are charged
  Fees for the program are charged as a percentage of savings achieved by NAP. Fees are credited back to you if savings are subsequently reduced or eliminated. Savings are generally defined as the difference between the reference price and the NAP priced amount, where the reference price is typically defined as:

  (a) For facility services, the amount billed by the provider.

  (b) For voluntary out-of-network professional services, the 80th percentile of the applicable FAIR Health database.

  (c) For involuntary out-of-network professional services, the amount billed by the provider.

  (d) For claims reviewed under Itemized Bill Review, the in-network rate prior to removal of any non-payable charges identified through the claim review.

  Additional details and any exceptions to the general savings definition above are available upon request.

  The FCR rate will be set as your plan rate for non-par, voluntary facility claims. Your Summary Plan Description will need to reflect this.

Self-Funded Medical Financial Assumptions and Caveats

Facility Charge Review (FCR)
FCR is a component of NAP. This component provides reasonable charge allowance review for most inpatient and outpatient facility claims where a NAP contracted rate is not available. Though many facilities accept the reasonable charge amount as payment in full, others may not and may balance bill the member.

In the event that a member is balance billed, Aetna has a review process and will initiate negotiations with the facility in an attempt to come to a mutually agreeable payment amount. For claims that are to be paid at the preferred/in-network level under the terms of the member's plan of benefits (e.g., emergency services), Aetna will negotiate with the facility so that the member is not responsible for any charges in excess of any applicable deductible and coinsurance/copayments. However, for non-emergency out-of-network services, should Aetna be unable to negotiate a mutually acceptable rate, the member may be responsible for any charges in excess of the reasonable charge.

Even with FCR, if a provider refuses to agree to a negotiated rate, claims may be paid at billed charges in certain circumstances. The program is only available in conjunction with NAP.

Itemized Bill Review (IBR)
IBR applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology.

Aetna will forward IBR Claims to a vendor to review and identify any billing inconsistencies and errors. The vendor reports back the amount of eligible charges after adjusting for any identified inconsistencies and errors. Aetna then pays the claim based on the adjusted bill. IBR supplements Aetna's standard bill review procedures prior to claim adjudication, and currently applies to inpatient facility bills with submitted expenses of $20,000.

Self-Funded Medical Financial Assumptions and Caveats

- **Institutes of Excellence™ Transplant Network** – As part of our National Transplant Program, a registered nurse is assigned to each member to assist with every phase of the transplant process, from evaluation through post-transplant recovery. The nurse coordinates care and assists your employees in accessing covered treatment through our contracted Institutes of Excellence (IOE) transplant network. The program also features dedicated claims and member services staff for special handling of patient claims and benefits issues. The IOE transplant network is our national network of facilities for transplants and transplant related services. Hospitals that are selected to participate in our IOE transplant network have met enhanced quality thresholds for volumes and outcomes.

Self-Funded Medical Financial Assumptions and Caveats

Reporting and Data Transfers

- **Aetna Informatics® Reporting and Consulting** – In addition to our electronic tool, Aetna Health Information Advantage, you will receive 5 hours of support for report generation and/or consulting services for customer data housed in Aetna Health Information Advantage.

- **Data Integration (Set-up)** – Our proposal assumes one historical medical and one historical pharmacy data integration feed. For an additional fee, historical medical and pharmacy data integration feeds may be added.

- **Data Integration (On-Going)** - 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.

- **Claims History Transfer (set up)** – These files are used to administer deductible and internal maximums. There is no cost associated with receiving claim history files electronically from the prior carrier for initial implementation. There will be a charge for files received in a format other than electronically; costs are based on the complexity and format of the data.

- **States' All payer Claims database (APCD) reporting** – In 2016, the U.S. Supreme Court determined in the case of Gobeille v. Liberty Mutual Insurance Co., No. 14 181, that the Federal Employee Retirement Income Security Act of 1970 (ERISA) preempts states from mandating that self-funded ERISA health plans or their third party administrators submit claim information from those plans to state-run "All Payer Claim Databases" (APCDs). As a result, no self-funded ERISA Plan data will be provided to any state APCD by Aetna unless such a plan affirmatively instructs Aetna in writing to submit their data to the state APCDs.

Self-Funded Medical Financial Assumptions and Caveats

Legislative & Regulatory Requirements

We believe this proposal to be compliant with all applicable state and federal laws, including health care reform.

- **Employer Reporting Requirements** – Under Internal Revenue Code (IRC) Section 6055 health insurance issuers, certain employers, government agencies and other entities that provide Minimum Essential Coverage (MEC) to individuals must report to the IRS information about the type and period of coverage and furnish related statements to covered individuals. This information is used by the IRS to administer the individual shared responsibility provision and by individuals to show compliance with the individual shared responsibility provision.

  IRC Section 6056 requires applicable large employers (those having employed an average of 50 or more full-time employees during the preceding calendar year) to report to the IRS information about the health care coverage they have offered and also furnish applicable statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions.

  Self-funded employers will be responsible for collecting and reporting the information to both the IRS and their employee pursuant to their obligations under both Sections 6055 and 6056s. For the collection, they may use a combined form for their 6055 and 6056 reporting. Entities must file their 6055 and 6056 requirements with the IRS no later than February 28 of the year following coverage (if filing on paper) or March 31 if filing electronically. A statement must be furnished to individuals by January 31 of the year succeeding the calendar year to which the return relates.

- **Support for SBC Draft Documents** – At your request and expense, we'll provide assistance in connection with the preparation of draft Summary of Benefits and Coverage (SBC) documents subject to your direction, review and final approval. If we are asked to develop draft SBCs, they will be based on the benefits information you provide. We'll include plan design information in the draft SBC relating to products or services administered under your Agreement with us as well as any additional pharmacy or behavioral health carve out information you or your delegates provide. SBCs are not required for "retiree-only plans" as defined by the Affordable Care Act (ACA) and we won't be supporting generation of SBCs for "retiree-only plans."

  You are responsible for reviewing and approving any SBCs with your legal counsel. We have no responsibility or liability for the content or distribution of any of your SBCs, regardless of the role we have played in the preparation of the documents. The production of SBCs will not be subject to Service or Performance Guarantees.

Self-Funded Medical Financial Assumptions and Caveats

For applicable plans and policies with effective dates of January 1, 2014, and later, the SBC must include statements about whether the plan or coverage provides minimum essential coverage (MEC) and if the coverage meets minimum value (MV) requirements.

Under the ACA, minimum value and minimum essential coverage determinations are your responsibility. We will include the MV and MEC statements in SBCs produced for plans with effective dates of January 1, 2014, and later. However, Aetna won't make the final MV or MEC determinations. We'll review the minimum value standard for the plans based on the minimum value calculator criteria provided by the Department of Health and Humans Services (HHS). We'll provide the SBC in editable format so you can update MV and MEC statements within the document to reflect your determination for each plan. We don't provide legal or tax advice, and suggest you consult with your legal and tax consultants when making determinations. We don't have responsibility or liability regarding the MV or MEC evaluation, regardless of the role we may have played in reviewing/producing the SBC documents.

Transitional Reinsurance Contribution:

- **ACA Taxes and Fees – Notice of Self-Funded Group Health Plan's Financial Liability** – Any taxes or fees (assessments) related to the Affordable Care Act that apply to self-funded benefit plans will be your obligation.

- **Benefit Mandates – Essential Health Benefits** – The ACA prohibits the application of annual dollar limits for any Essential Health Benefits for all plans effective on or after January 1, 2014 (the prohibition of lifetime dollar limits on Essential Health Benefits has been in effect since 2010). To the extent that your current benefit plan includes such limits, this proposal quote includes the removal of those limits.

- **Benefit Mandates –Out of Pocket Requirements** – For non-grandfathered plans, all in-network medical, behavioral health, and pharmacy member cost sharing, which includes all copays, coinsurance and deductibles, must apply to a member out-of pocket (OOP) maximums. The OOP maximum limit cannot exceed the limits set by the Department of Health and Human Services, or under the tax law for high deductible health plans (HDHPs) paired with Health Savings Accounts (HSAs). This is regardless of whether the individual is enrolled in self-only coverage or non-self only (family) coverage.

Self-Funded Medical Financial Assumptions and Caveats

A plan may maintain separate OOP maximums for different benefit categories, as long as the combined totals do not exceed the statutory limit. For plans renewing on or after January 1, 2015 plans will have two options to maintain compliance:

- Integrated medical and pharmacy OOP maximum that does not exceed the statutory limit
- Non-integrated medical and pharmacy OOP maximums that collectively do not exceed the statutory limit – this option is not available for high deductible health plans paired with HSAs

Employers who offer self-funded plans are responsible for ensuring compliance with these regulations. We recommend that you review your pharmacy OOP maximum to ensure compliance. Contact your Aetna Account Executive to inform us of any required changes that Lancaster County will make to these plans to ensure compliance or with questions on this requirement.

High deductible health plans paired with HSAs are still required to integrate all accumulators for medical, behavioral health and pharmacy benefits.

Aetna has automated integration support with the following vendors:

- Pharmacy: Express Scripts ESI, CVS/Caremark – Supported integration with all medical plans, including HDHP plans with an HSA and Health Reimbursement Arrangements (HRAs). These interfaces also support HRA inquiry for the actual account balances.
- Pharmacy: Catamaran, OptumRX, EnvisionRX, MaxorPlus, Navitus – Supported integration with all medical plans, including HDHPs with HSAs. Automated integration is not supported for HRAs.
- Behavioral Health: OptumHealth Behavioral Solutions (United Behavioral Health), Beacon Health Options (formerly Value Options), Magellan Health Services, ComPsych, Cigna Behavioral Health – Supported integration with all medical plans including HDHP plans with HSAs. Automated integration is not supported for HRAs.

If you utilize a vendor not listed above, this will require manual intervention through the submission of batch files or manual support by the service center. Manual intervention will require an additional charge. Support by the service center requires prior approval.

Medical Performance Guarantees

General Performance Guarantee Provisions

Aetna Life Insurance Company, on behalf of itself and its affiliates ("Aetna", "our" or "we") provides health benefits administration and other services (set forth in this document) for the self-funded Medical and Behavioral Health plan(s) operated on behalf of Lancaster County (also "you" or "your").

Guarantee Period

The guarantees described herein will be effective for the 12-month period from January 1, 2018 through December 31, 2018 (hereinafter "guarantee period").

The performance guarantees below will apply to the following self-funded medical plans serviced under the Administrative Services Only arrangement (through a 'Services Agreement' or 'Master Services Agreement', as the case may be, but each from this point on referred to as "Agreement").

- Aetna Choice POS II (CPII)
- Behavioral Health

These guarantees **do not** apply to non-Aetna benefits or non-Aetna networks.

If we process runoff claims upon termination of the Agreement, the Turnaround Time, Financial Accuracy, and/or Total Claim Accuracy performance guarantees will not apply to runoff claims.

Medical Performance Guarantees

Performance Objectives

We believe that measuring the activities described below is an important indicator of how well we service your account. We're confident that the Claim Administration and Member Services provided to you will meet your high standards of performance. To reinforce your confidence in our ability to administer your program, we are offering guarantees in the following areas:

Performance Category	Minimum Standard	Maximum Fees at Risk
Implementation		
• Implementation	Average evaluation score of 3.0 or higher	2.5%
• ID Card Production & Distribution	97% of ID cards mailed within 15 business days of receiving eligibility file	2.0%
• **Account Management**		
Overall Account Management	Average evaluation score of 3.0 or higher	2.0%
• **Claim Administration**		
Turnaround Time	90.0% of claims processed within 14 *calendar days*	1.5%
• Financial Accuracy	99.0%	1.5%
• Total Claim Accuracy	95.0%	1.5%
• **Member Services**		
Average Speed of Answer	30 Seconds	2.0%
• Abandonment Rate	2.0%	2.0%
• **Total**		**15.0%**

Medical Service Guarantee Maximum

The maximum medical service performance guarantee penalty adjustment will be equal to **15.0 percent** of actual collected administrative service fees. Administrative service fees at risk exclude:

Aggregate Guarantee Maximum

In no event will total collected administrative service fees be adjusted by more than **30.0** percent due to the results of this guarantee and all other guarantees combined. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.

Medical Performance Guarantees

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by us in the event of one of the following occurrences:

i. A material change in the plan initiated by you or by legislative action that impacts the claim adjudication process, member service functions or network management

ii. Failure to meet your obligations to remit administrative service fees or fund claim payment wires under the Agreement

iii. Failure to meet your administrative responsibilities (for example, a submission of incorrect or incomplete eligibility information)

These guarantees will not apply if you terminate your Aetna medical plan in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the guarantee period (December 31, 2018).

Refund Process

We will provide you with final results for the performance guarantees when reporting is available after the end of the respective guarantee period. If necessary, we will provide a "lump sum" refund for any penalties we incurred.

Medical Performance Guarantees

Implementation

Overall Implementation Guarantee

Guarantee: We utilize the implementation team concept to carefully coordinate all aspects of the implementation. An Implementation Manager is assigned to assemble your implementation team and develop an Implementation Management Plan for the conversion to the new plan of benefits. The Implementation Management Plan will outline the tasks and target dates for their completion.

Working with your team, the Implementation Manager will help determine the implementation priorities. As new information becomes available and priorities change, the Implementation Management Plan is updated. However, for the implementation to progress in a timely manner, you will be responsible for providing key information to the Implementation Manager as close to the target dates as possible (e.g., finalized account structure, finalized plan of benefits, accurate eligibility files, signed legal agreements).

This guarantee is effective for the implementation period in the first guarantee period. The implementation period begins at the initial implementation meeting and runs through the implementation sign-off.

Penalty and Measurement Criteria: Via timely responses to the attached Implementation Evaluation Tool (provided at the end of this guarantee section), you agree to make us aware of possible sources of dissatisfaction throughout the implementation period. Each question is given a rating of 1 - 5 with 1 = lowest, 5 = highest. We will tally the results from the evaluation tool when received. Your responses to the attached evaluation tool are used to facilitate a discussion between you, your Implementation Manager and your Account Executive regarding the results achieved. If the Implementation Evaluation Tool is not completed and returned within 30 days of receipt, it is assumed that the service provided to you is satisfactory and the guarantee is deemed met. If, at the end of the implementation process, the score of the final evaluation falls below a 3, (meaning that service levels have not improved) we will make a mutually agreed upon reduction in compensation. The maximum reduction will be **2.5** percent of the guarantee period administrative service fees.

Medical Performance Guarantees

Open Enrollment ID Card Production and Distribution

Guarantee: We guarantee that 97 percent of Open Enrollment ID cards will be produced and mailed to your members within 15 business days following the receipt of ***complete, accurate, & viable*** electronic enrollment files

Penalty and Measurement Criteria: We will reduce our compensation by **2.0** percent of the guarantee period administrative service fees if we fail to produce and mail ID cards to your members within 15 business days of receiving the open enrollment eligibility file. Our records are used to determine whether ID cards were produced and mailed within the specified time frame.

Medical Performance Guarantees

Account Management

Overall Account Management Guarantee

Guarantee: We guarantee that the services (i.e., on-going financial, eligibility, drafting, benefit administration and continued customer support) provided by the Field Office Account Management Staff and/or the Employer Service Team during the guarantee period will be satisfactory to you.

Penalty and Measurement Criteria: Via semi-annual responses to the attached Account Management Evaluation Tool (provided at the end of this guarantee section) and this link **http://www.aetnasurveys.com/se.ashx?s=103ED34467D2D0E0**, you agree to make us aware of possible sources of dissatisfaction throughout the guarantee period. Your responses to the attached evaluation tool will evaluate account management services in the following categories:

- technical knowledge
- professionalism
- proactive management
- accessibility
- responsiveness of personnel

Each category will be given a rating of 1 - 5 with 1 = lowest, 5 = highest. We will tally the results from the report card(s) when received. The results of the survey(s) are used to facilitate a discussion between you and your Account Executive regarding the results achieved and opportunities for improvement.

If all report cards based on the frequency of the guarantee are not completed and returned within 15 days after the six month period, it is assumed that the service provided to you is satisfactory and the guarantee is deemed met. If the score on the first report card and the report card(s) for the subsequent survey(s) average a 3.0 or higher, no credit is due. Satisfactory service would equal a score of 3.0and would be based on the total average of 24 questions with a rating scale of 1 to 5. Should the score from the first report card and the average of the remaining report card(s) fall below a 3 (meaning that service levels have not improved), we will make a mutually agreed upon reduction in compensation. The maximum reduction will be **2.0** percent of the guarantee period administrative service fees.

Medical Performance Guarantees

Claim Administration

Turnaround Time (TAT)

Guarantee: We guarantee that the claim TAT during the guarantee period will not exceed 14 *calendar* days for 90.0 percent of the processed claims on a cumulative basis each year.

Definition: 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). **Weekends and holidays are included in turnaround time.** This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: If the cumulative year TAT exceeds the day guarantee as stated above, we will reduce our compensation by an amount equal to 0.3 percent of the guarantee period administrative service fees for each full day that the TAT exceeds 14 calendar days for 90.0 percent of all processed claims. The maximum reduction will be **1.5** percent of the guarantee period administrative service fees.

If you have more than 3,000 enrolled members, a computer generated TAT report for your specific claims will be provided on a quarterly basis. If you have less than 3,000 enrolled members, results will be reported at the site level.

Medical Performance Guarantees

Financial Accuracy

Guarantee: We guarantee that the financial accuracy will be 99.0 percent or higher.

Definition: 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) and then extrapolating the results based on the size of the population and combining 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.

$$\frac{\text{Dollars Paid Correctly}}{\text{Total Dollars Paid}}$$

We then extrapolate the results based on the size of the population and combine them with the extrapolated results of the other strata.

Penalty and Measurement Criteria: We will reduce our compensation by an amount equal to 0.3 percent of the guarantee period administrative service fees for each full 1.0 percent that financial accuracy drops below 99.0 percent. The maximum reduction will be **1.5** percent of the guarantee period administrative service fees.

Our audit results for the unit(s) processing your claims are used. Those results include our performance in processing ALL customers' claims handled by the unit(s) in question during the guarantee period, not just your plan's claims. The results for this guarantee are calculated using industry accepted stratified audit methodologies.

Medical Performance Guarantees

Total (Overall) Claim Accuracy

Guarantee: We guarantee that the total (overall) claim accuracy will be 95.0 percent or higher.

Definition: Overall accuracy is measured using industry accepted stratified audit methodology. Accuracy in each stratum (a subset of the claim population) is calculated by:

$$\frac{\text{Number of claims processed correctly}}{\text{Total number of claims audited}}$$

We then extrapolate the results based on the size of the population and combine them with the extrapolated results of the other strata.

Penalty and Measurement Criteria: We will reduce our compensation by 0.3 percent of the guarantee period administrative service fees for each full 1.0 percent that total claim accuracy drops below 95.0 percent. The maximum reduction will be **1.5** percent of the guarantee period administrative service fees.

Our audit results for the unit(s) processing your claims are used. Those results include our performance in processing ALL customers' claims handled by the unit(s) in question during the Guarantee period, not just your plan's claims. The results for this guarantee are calculated using industry accepted stratified audit methodologies.

Medical Performance Guarantees

Member Services

Average Speed of Answer

Guarantee: We guarantee that the ASA for the phone skill(s) providing your customer service will not exceed 30 seconds.

Definition: 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:

$$\frac{\text{Sum of all waiting times for all calls answered by the queue}}{\text{Number of incoming calls answered}}$$

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. 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 penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: We will reduce our compensation by 0.4 percent of the guarantee period administrative service fees for each full second that the ASA exceeds 30 seconds. The maximum reduction will be **2.0** percent of the guarantee period administrative service fees. The phone skill(s) providing your customer service are used.

Medical Performance Guarantees

Abandonment Rate

Guarantee: We guarantee that the average rate of telephone abandonment for the phone skill(s) providing your customer service will not exceed 2.0 percent.

Definition: The result is calculated as follows:

$$\frac{\text{Total number of calls abandoned}}{\text{Number of calls accepted into the skill}}$$

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 penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: We will reduce our compensation by 0.4 percent of the guarantee period administrative service fees for each 1.0 percent that the average abandonment rate exceeds 2.0 percent. The maximum reduction will be **2.0** percent of the guarantee period administrative service fees. The phone skill(s) providing your customer service are used.

Pharmacy Performance Guarantees

General Performance Guarantee Provisions

Aetna Life Insurance Company (ALIC) provides benefits administration and other services for the self-funded pharmacy plans. The services set forth in this document will be provided by ALIC (hereinafter "Aetna").

Performance Objectives

Aetna believes that measuring the activities described below are important indicators of how well we service Lancaster County. We are confident that pharmacy administration services provided to Lancaster County will meet their high standards of performance. To reinforce Lancaster County's confidence in Aetna's ability to administer their program, we are offering guarantees in the following areas:

Performance Guarantee Category	Minimum Standard	Proposed Penalty
Retail Claim Administration		
• Pharmacy System Availability	99.9%	$10,000
• Turnaround Time – Paper Claims	97.0% within a weighted average of 5 business days of receipt and 99.5% within a weighted average of 10 business days of receipt	$10,000
Mail Order Claim Administration		
• Turnaround Time – Clean Claims	98.0% within an average of 2 business days of receipt	$10,000
• Turnaround Time – Claims Requiring Intervention	95.0% within an average of 5 business days of receipt	$10,000
• Mail Order Dispensing Accuracy	99.98%	$10,000
Member Services		
• Average Speed of Answer	30 seconds or less	$10,000
• Abandonment Rate	3.0%	$10,000
• Pharmacy First Call Resolution	95.0% successfully resolved on the first call	$10,000
Total		**$80,000**

Pharmacy Performance Guarantees

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **January 1, 2018 through December 31, 2018** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the self-funded Aetna Pharmacy Management plans administered under the Administrative Services Only Agreement ("Services Agreement"). These guarantees do not apply to non-Aetna benefits or networks.

Aggregate Maximum

In total, Aetna agrees to place **$80,000** at risk through the Performance Guarantees outlined in this document. Our offer assumes 796 employee lives. Aetna reserves the right to revisit the guarantees if there is a change in enrollment of more than 15%.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

i. a material change in the plan initiated by Lancaster County or by legislative action that impacts the claim adjudication process, member service functions, pharmacy network management or rebates;
ii. failure of Lancaster County to meet its obligations to remit administrative service fees or fund Lancaster County bank account as stipulated in the General Conditions Addendum of the Services Agreement;
iii. failure of Lancaster County to meet their administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by Lancaster County or by Aetna.

Penalty Reconciliation and Refund Process

At the end of each guarantee period, Aetna will compile the Performance Guarantees results. If necessary, Aetna will provide a refund to Lancaster County for any penalties incurred.

Pharmacy Performance Guarantees

Retail Claim Administration

Pharmacy System Availability Guarantee

Guarantee: Aetna guarantees that the retail pharmacy claim processing system will be functional and available at least 99.9% of the time during regularly scheduled system availability. Claim processing system shall be available for Claim submission, integrated and standard processing 24 hours a day, 365 days a year, less scheduled maintenance downtime which shall be performed during non-peak hours.

Definition: System availability will be measured as the amount of time the claim processing system was functional and available to adjudicate claims during regularly scheduled operating times.

Penalty and Measurement Criteria: A penalty of $2,500 will apply for each 0.25% that the actual retail pharmacy claim processing system availability percentage falls below 99.9%. There will be a maximum penalty of **$10,000**. Guarantee results will be measured based on Aetna's book of business.

Turnaround Time – Paper Claims Guarantee

Guarantee: Aetna will guarantee that the claim payment processing turnaround time for all retail pharmacy claims submitted on paper will be 97.0% within a weighted average of 5 business days of receipt and 99.5% within a weighted average of 10 business days of receipt.

Definition: Total percentage of claims processed is measured as the number of claims processed within specified number of days divided by the total number of claims audited. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of $2,500 will apply for each 0.25% that the actual turnaround time for reimbursement of paper claims submitted falls below the guaranteed level of 97.0% within a weighted average of 5 business days of receipt and 99.5% within a weighted average of 10 business days of receipt. There will be a maximum penalty of **$10,000**. Guarantee results will be measured based on Aetna's book of business.

Pharmacy Performance Guarantees

Mail Order Claim Administration

Turnaround Time - Clean Claims Guarantee

Guarantee: Aetna guarantees that at least 98.0% of all mail order claims not requiring intervention will be dispensed and shipped within an average of 2 business days of receipt.

Definition: For the respective guarantee period, turnaround time for claims, not requiring intervention is determined by assessing the average time, in business days, that it takes prescriptions to be processed and shipped from the Aetna Rx Home Delivery pharmacy. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of $5,000 will apply for each full day that the average turnaround time of 98.0% of all mail order claims not requiring intervention exceeds an average of 2 business days. There will be a maximum penalty of **$10,000**. Guarantee results will be measured based on Aetna's book of business.

Turnaround Time – Claims Requiring Intervention Guarantee

Guarantee: Aetna guarantees that at least 95.0% of all mail order claims requiring intervention will be dispensed and shipped within an average of 5 business days of receipt.

Definition: For the respective guarantee period, turnaround time for claims, requiring intervention is determined by assessing the average time, in business days, that it takes prescriptions to be processed and shipped from the Aetna Rx Home Delivery pharmacy. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of $5,000 will apply for each full day that the average turnaround time of 95.0% of all mail order claims requiring intervention exceeds an average of 5 business days. There will be a maximum penalty of **$10,000**. Guarantee results will be measured based on Aetna's book of business.

Pharmacy Performance Guarantees

Mail Order Dispensing Accuracy Guarantee

- Correct drug dispensed to correct member
- Correct drug, strength, dosage form
- Correct instructions provided to the member for use

Guarantee: Aetna guarantees that at least 99.98% of all mail order prescriptions will be dispensed correctly for drug, strength, form, instructions, and patient.

Definition: For the respective guarantee period, total dispensing accuracy is measured as the number of prescriptions with no errors divided by the total number of prescriptions dispensed.

Penalty and Measurement Criteria: A penalty of $2,500 will apply for each 0.1% that the actual percentage of all mail order prescription dispensing accuracy falls below the target of 99.98%. There will be a maximum penalty of **$10,000**. Guarantee results will be measured based on Aetna's book of business.

Pharmacy Performance Guarantees

Member Services

Average Speed of Answer

Guarantee: Aetna will guarantee that the average speed of answer for the phone skill(s) providing Lancaster County's member services will not exceed 30 seconds.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average speed of answer. Average speed of answer is defined as the amount of time that elapses between the time a call is received into the telephone system and the time a representative responds to the call. The result expresses the sum of all waiting times for all calls answered by the queue divided by the number of incoming calls answered. ASA measures the average speed of answer for all callers answered. Interactive Voice Response (IVR) system calls are not included in the measurement of ASA. 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 penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of $2,500 will apply for each full second that the average speed of answer exceeds 30 seconds. There will be a maximum penalty of **$10,000**. Aetna's results for the unit(s) providing member services for Lancaster County will be used.

Abandonment Rate Guarantee

Guarantee: Aetna will guarantee that the average rate of telephone abandonment will not exceed 3.0%.

Definition: On an ongoing basis, Aetna measures telephone response time through monitoring equipment that produces a report on the average abandonment rate. The abandonment rate measures the total number of calls abandoned divided by the number of calls accepted into the unit. 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 penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of $2,500 will apply for each 0.25% that the average abandonment rate exceeds 3.0%. There will be a maximum penalty of **$10,000**. Aetna's results for the unit(s) providing member services for Lancaster County will be used.

Pharmacy Performance Guarantees

Pharmacy First Call Resolution Guarantee

Guarantee: Aetna will guarantee that 95.0% of member service calls with be successfully resolved on the first call. Resolution shall be deemed successfully resolved if there are no handoffs via resolution manager.

Definition: On an annual basis, Aetna will share with Lancaster County the First Call Resolution results. The rate will be calculated based upon first calls where the issue was within Aetna's control to resolve and there were no handoffs via resolution manager.

Penalty and Measurement Criteria: A penalty of $2,500 will apply for each 0.25% that the First Call Resolution rate falls below 95.0%. There will be a maximum penalty of **$10,000.** Aetna's results for the unit(s) providing member services for Lancaster County will be used.

Medical Discount Guarantee

We guarantee the discounts that result from our negotiated arrangements with providers that participate in our Choice Point of Service II (CPII) product. This discount guarantee applies to the claims incurred during the period January 1, 2018 through December 31, 2018. Three months of run out will be included in the reconciliation.

Attachment A shows our guaranteed discounts by network, for each of the following three service types:

- Hospital inpatient
- Hospital outpatient
- Physician/other

How we calculate our discounts

We determine the achieved discount on an aggregate basis, three months after close of the contract year. Here's how:

1. First, we apply the discounts in Attachment A to your billed eligible charges* by network, product and service type.

2. Next, we calculate the guaranteed discount percentage using the following equation:

$$\frac{\{\text{In-network provider discounts in dollars (hospital and physician)}\}}{\{\text{Total in-network billed eligible charges* (hospital and physician)}\}}$$

*Billed eligible charges are charges prior to application of plan design, discounts, and member cost sharing (copays and deductibles)

We calculate the discount using data from our Aetna Informatics data warehouse. The guarantee reconciliation excludes individual claims paid in excess of $100,000

Medical Discount Guarantee

Billed eligible charges exclusions

Billed eligible charges exclude the following:

- Duplicate or other ineligible/not covered/denied claims
- Claims paid by coordination of benefits where we are not primary (including Medicare)
- Claims on members aged 65 and over
- Claims incurred in passive or custom networks
- Behavioral health claims
- All non-medical claims (this includes pharmacy and specialty pharmacy claims, dental claims, and vision hardware claims)
- Non-facility billed eligible charges at a level equal to or within three percent of the negotiated rates
- Some charges where the contract allows us to pay the lesser of the billed amount or the contractual rates

Medical Discount Guarantee

Penalty reconciliation

We compare the guaranteed discount (based on the actual enrollment by product and network, and billed eligible charges by product and service type) against the total discount achieved. Based on that outcome, we make any fee adjustments using the table below.

Fee Adjustment	Maximum Guarantee Period Adjustment
3.0% fee reduction for each full 1.0% discount achieved falls below risk-free corridor	15%
No Adjustment	N/A

There is a risk-free corridor of 1.0 percentage points less than the guaranteed discount.

The maximum Medical Discount Guarantee adjustment is 15 percent of actual collected administrative service fees for the applicable guarantee period. Administrative service fees exclude program fees at risk in the Aetna Demonstrating Value Scorecard, Teladoc per-employee, per-month fees, WellMatch℠ per-employee, per-month fees, iTriage® per-employee, per-month fees, commissions, and any charges for services performed which are not included on the monthly administrative service fee bill.

Aggregate Maximum

In no event will total collected administrative service fees be adjusted by more than **25.0** percent due to the results of this guarantee and all other guarantees combined. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.

Medical Discount Guarantee

Conditions for the Guarantee

We rely on information from you and your representatives in creating and reconciling the terms of this guarantee. If any of this information is inaccurate, it may have an impact on the guaranteed network discounts. We reserve the right to revise or remove the guarantee if any of the following conditions are not met.

- Minimum Enrollment: You enroll a minimum of 500 employees in the quoted Aetna self-funded medical products.
- Group Composition: You do not have any acquisitions or divestitures.
- In-Network Claims: This guarantee applies only to the in-network medical claims that fall into the participating networks shown on Attachment A.
- Pharmacy Claims: You exclude all Pharmacy and Specialty Pharmacy claims.
- Provider Practice: 2018 provider billing and reimbursement practices remain consistent with current practices.
- Coverage Termination: The Medical Discount Guarantee is considered met if Aetna medical coverage is terminated by you prior to December 31, 2018.

Medical Choice POS II Discount Guarantee

Illustrative Inpatient Hospital Discount [1]	Illustrative Outpatient Hospital Discount [1]	Illustrative Physician/Other Discount [1][3]	Illustrative Composite Target Discount [2]
39.8%	44.6%	37.7%	40.0%

[1] These discounts are illustrative only as they have been weighted by the distribution of employees by network from the current census file.

[2] This composite target is illustrative only. The final guaranteed target will depend on the actual enrollment by network and claim service mix known at the end of the guarantee period. For purposes of this illustration, the service mix of network billed eligible claims prior to discount is based on network level assumed utilization of hospital inpatient, hospital outpatient, and physician/other.

[3] Our non-facility discounts exclude the impact of claims where the provider bills at a level within 3% the contracted rates, along with some situations where the contract allows us to pay the lesser of the billed amount or the contracted rate.

Network ID	State	Network Name	Rating Area ID	Rating Area	Employees Within	Hospital Inpatient	Hospital Outpatient	Physician/ Other [3]
8704	NE	MHMO Nebraska HMO	3085	Lincoln (NB01)	708	40.10%	45.70%	38.00%
8704	NE	MHMO Nebraska HMO	3084	Rural Lincoln (NB01)	50	34.30%	30.00%	35.10%
8704	NE	MHMO Nebraska HMO	3083	Omaha (NB01)	17	48.80%	59.30%	34.00%
8704	NE	MHMO Nebraska HMO	3086	Rural Omaha (NB01)	11	34.30%	30.00%	35.10%
8704	NE	MHMO Nebraska HMO	3088	Rural Nebraska (NB01)	8	34.30%	30.00%	35.10%
8704	NE	MHMO Nebraska HMO	3082	TriCity (NB01)	1	31.00%	28.30%	33.70%
8761	IA	MHMO Council Bluffs IA	3080	Pottawattamie (IA02)	1	36.90%	34.70%	40.70%

Aetna In Touch Care℠ Demonstrating Value Scorecard

General Performance Guarantee Provisions

Aetna Life Insurance Company, on behalf of itself and its affiliates ("Aetna", "our" or "we") provides health benefits administration and other services (set forth in this document) for the self-funded Aetna medical plans operated on behalf of County of Lancaster (also "you" or "your").

Performance Objectives

We believe that measuring the activities described below is an important indicator of how well we service your account. To reinforce your confidence in our ability to administer our Aetna In Touch Care program, we are offering guarantees for our Care Management Programs, which include:

- Financial Performance
- Member Satisfaction Surveys
- Operational Performance – Custom Care Management: AITC Premier - Designated
- Clinical Performance

You may receive reporting throughout the year relative to utilization or operational data. The data contained in those reports may differ from the actual performance guarantee results due to the timing of the report and/or auditing of performance guarantee results.

Aetna In Touch Care℠ Demonstrating Value Scorecard

	Minimum Standard	PEPM @ risk		Total @ risk
Financial Performance				
• Care Management Return on Investment	2:1	$ 8.48	pepm	$ 81,001
Member Satisfaction Surveys				
• IHL, AITC	90%	$ 0.20	pepm	$ 1,910
Operational Performance - Aetna In Touch Care - Care Advocate Team				
• Engaged of Reach Rate - Urgent Members	90%	$ 0.05	pepm	$ 478
• Engaged of Reach Rate - Moderate Members	60%	$ 0.05	pepm	$ 478
• Sustained Engagement Rate	50%	$ 0.10	pepm	$ 955
• Retention Rate	45%	$ 0.10	pepm	$ 955
• Depression Screening	90%	$ 0.10	pepm	$ 955
• Discharge Planning	95%	$ 0.10	pepm	$ 955
• Case Management Plan	98%	$ 0.10	pepm	$ 955
• Preadmission Outbound Call	95%	$ 0.10	pepm	$ 955
• Post Discharge Outbound Call	95%	$ 0.10	pepm	$ 955
• Case Management High Cost Claimant Screening	95%	$ 0.10	pepm	$ 955
• Utilization Management Touch Rate	93%	$ 0.10	pepm	$ 955
Clinical Outcome Improvement Rates				
• CAD members using statins	55%	$ 0.05	pepm	$ 478
• Diabetic members using statins	50%	$ 0.05	pepm	$ 478
• Diabetic HbA1c less than 8%	80%	$ 0.05	pepm	$ 478
• Diabetic HbA1c improvement	70%	$ 0.05	pepm	$ 478
• Diabetic neuropathy	80%	$ 0.05	pepm	$ 478
• Asthma-controller medications	80%	$ 0.05	pepm	$ 478
• Diabetic Hba1c greater than 9%	23%	$ 0.05	pepm	$ 478
Total		**$ 10.03**		**$ 95,807**
	Employees in above programs:	796		

Aetna In Touch Care℠ Demonstrating Value Scorecard

Guarantee Period

The guarantee period shall be represented as a one-year guarantee for the implementation of the programs and the year immediately following the implementation such as January 1, 2018 through December 31, 2018 and then shall be on an annual basis thereafter, upon the mutual agreement of the parties (hereinafter "guarantee period").

The performance guarantees shown below will apply to the incremental costs for each of the programs administered under the Administrative Services Only arrangement (through a 'Services Agreement' or 'Master Services Agreement', as the case may be, but each hereinafter referred to as 'Agreement'). The incremental costs for each of the programs are represented in the "amount at risk" column on the scorecard on page 2. These guarantees do not apply to non-Aetna benefits or networks.

Performance guarantees described herein will not apply if Agreement termination occurs prior to the end of the guarantee period. Performance guarantees are subject to enrollment requirements outlined in the financial conditions.

Changes in Clinical Practice Guidelines

Medical knowledge is dynamic and as research progresses the recommendations for evidence-based clinical guidelines change. Such changes may involve:

- A test, service or medication is no longer recommended
- A change in the frequency or intensity of a test or service, or dosage of a medication
- A change in the clinical goal or target
- A change in the specifications for the denominator population

When a recognized national organization changes clinical practice guidelines that impact performance guarantees, we reserve the right to amend or eliminate the performance guarantees. This is necessary because physicians will start to manage their patients in accordance with the revised guidelines. If a test, service or medication is no longer recommended, then the performance guarantee must be eliminated since we cannot recommend to physicians and patients to have a test done or take a medication that is no longer recommended. When the service continues to be recommended but at a different frequency or with a new target, Aetna will modify the associated metric accordingly.

We will notify you when such changes are being made. It may be necessary to recalculate performance for the baseline year to reflect changes in clinical target or specifications for denominator population. This is required to accurately calculate improvement from baseline.

Aetna In Touch Care℠ Demonstrating Value Scorecard

Demonstrating Value Scorecard Guarantee Maximum

We will place at risk up to $10.03 PEPM of the collected Care Management programs guarantee period administrative service fees. The Care Management guarantee period administrative service fees will be calculated at the end of the respective guarantee period and will be based on the total number of your employees enrolled in the underlying medical plans that also offer the services of the programs for each guarantee period.

Aggregate Guarantee Maximum

In no event will the total collected administrative service fees be adjusted by more than 30.0% of actual collected fees due to the results of this guarantee and all other guarantees combined. "Collected fees" means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee.

Financial Conditions

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

- Actual Aetna medical enrollment increases or decreases by 10% or more.
- MedQuery® is an essential component of the Aetna In Touch Care℠ program and must be included.
- This guarantee assumes both medical and pharmacy programs are administered by Aetna.
- If you utilize an external vendor for onsite biometric screenings or other wellness programs, this guarantee assumes we will receive those external feeds, when data being collected by the external vendor has a material impact on the results of the performance guarantees outlined in this agreement.
- Under age 65 population is structured separately from the over age 65 population for accounting/reporting purposes with us. This guarantee excludes populations that are over age 65 with Medicare primary.
- The average member age of your enrolled Aetna medical plan participants is greater than 34.
- Your member/employee ratio is at least 2:1.
- Member eligibility (complete, accurate and viable enrollment data; including member phone numbers) is fully loaded in our eligibility system 35 days prior to effective date.
- We currently have or will receive a minimum of 24 months of prior carrier medical and pharmacy experience.
- The prior carrier medical and pharmacy data must be received by us in our stated acceptable format for data feeds within 45 days of the program effective date.

Aetna In Touch Care℠ Demonstrating Value Scorecard

Refund Process

We will provide you with final results for the scorecard when reporting is available after the end of the respective guarantee period. Reporting that outlines associated savings for the contract period is estimated to be available at the end of the third quarter following the close of the respective guarantee period. If the guarantees have not been met, at your sole discretion, Aetna shall (1) provide a cash payment to County of Lancaster for the amount due as a result of Aetna's non-compliance within thirty (30) days of your receipt of such results or (2) reduce the following month(s)'s administrative fee payment by the amount due by County of Lancaster. In no event will more than 100% of collected Care Management program fees be refunded.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by us in the event of the one of the following occurrences:

i. A material change in the plan initiated by you or by legislative action that impacts the claims adjudication process, member services functions, medical management or network management

ii. Failure to meet your obligations to pay administrative services fees or fund claim payment wires under the Agreement

iii. Failure to meet your administrative responsibilities (for example, a submission of incorrect or incomplete eligibility information).

These guarantees will not apply if you:

- Terminate your Aetna Custom Care Management Solutions: Aetna In Touch Care℠ Premier – Designated program prior to the end of the guarantee period.
- Terminate your Aetna medical plan in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the guarantee period, December 31, 2018.

Aetna In Touch Care℠ Demonstrating Value Scorecard

Financial Performance

Care Management ROI

Guarantee: We will guarantee that the savings associated with the Care Management Program will be equal to two times the guarantee period administrative service fee of $10.03 per-employee, per-month (PEPM). The guarantee fee includes:

- concurrent review
- precertification
- Aetna Custom Care Management Solutions: Aetna In Touch Care℠ Premier - Designated
- MedQuery
- Personal Health Record (PHR)

The guarantee will be reconciled annually using the Aetna In Touch Care CC and HEM Report and the Program Savings Report. Book of Business results will be used.

Penalty and Measurement Criteria: We will place $8.48 per employee, per month of the guarantee period administrative service fees at risk for this metric.

If the guarantee period administrative fees for the Care Management program are $150,000 we will guarantee that the guarantee period Care Management program savings will be two times the fees paid. If actual guarantee period Care Management program savings are $200,000, the guarantee period administrative fee reduction would be $50,000. This $50,000 reduction would lower the service fees paid to $100,000 resulting in a 2:1 ratio of program savings to program costs.

Member Satisfaction Surveys

We will guarantee an overall positive response rate of 90 percent or better on medical management program surveys administered during the plan year. The survey assumes a 5 point scale with the top 3 responses viewed as positive. Member satisfaction surveys will be administered for each individual program and then averaged equally across the surveys to derive one overall member satisfaction survey result for 2018 (for instance, for a customer offering 3 surveys, each result would be blended equally 33.3%). The surveys will be administered on a book-of-business basis. Results are available on a calendar year basis only.

Aetna In Touch Care℠ Demonstrating Value Scorecard

A minimum of 2 member satisfaction surveys must be administered. The survey results must be blended together to derive one member satisfaction rate that will apply to all surveys administered. For example: The In Touch Care survey generates a 92 percent satisfaction level and the Informed Health Line survey generates an 88 percent satisfaction level. The guarantee would be considered "met," as the blended average is 90 percent.

Penalty and Measurement Criteria (for all member satisfaction surveys combined): Member satisfaction surveys will be administered for each individual program and then averaged equally across the surveys to derive one overall member satisfaction survey result for 2018. If the combined result is less than 90%, We will pay $0.20 per employee, per month of the guarantee period administrative service fees back to you.

In Touch Care Program Participant Satisfaction

Guarantee: We will guarantee a positive response rate of 90 percent or better on the Aetna In Touch Care program surveys administered during the guarantee period. The survey assumes a 5 point scale with the top 3 responses viewed as positive. The surveys will be administered on a book-of-business basis. Results are available on a calendar year basis only. The survey is based on a statistically valid, randomly selected sample size of participants ages 18 to 64.

Informed Health® Line Program Participant Satisfaction

Guarantee: We will guarantee a blended positive response rate of 90 percent or better on the program surveys administered during the guarantee period. 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 size of Informed Health Line participants ages 18 to 64.

Aetna In Touch Care℠ Demonstrating Value Scorecard

Operational Performance - Aetna Custom Care Management Solutions: Aetna In Touch Care℠ Premier – Designated

Engaged of Reached Rate – Urgent (High Risk) Members

Guarantee: We will guarantee an engagement rate of 90 percent or better of those members identified as urgent (high risk) that we are successful in reaching in our Aetna In Touch Care program. Engagement is defined as:

$$\frac{\text{Cumulative nurse-engaged year-to-date*}}{\text{All members with outreach minus the unable-to-reach**}}$$

* The numerator is calculated as nurse engaged (member or provider) participation level
** The denominator is calculated as all members targeted for nurse engagement and reached; excludes unable to reach

Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: We will place $0.05 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 80 percent - We return 100 percent of the fee allocated to this component
- 90 percent, but < 90 percent - We return 50 percent of the fee allocated to this component

Engaged of Reached Rate – Moderate High Risk Members

Guarantee: We will guarantee an engagement rate of 60 percent or better of those members identified as moderate high risk that we are successful in reaching in our Aetna In Touch Care program. Engagement is defined as:

$$\frac{\text{Cumulative nurse-engaged year-to-date*}}{\text{All members with outreach minus the unable-to-reach**}}$$

* The numerator is calculated as nurse engaged (member or provider) participation level
** The denominator is calculated as all members targeted for nurse engagement and reached; excludes unable to reach

Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Aetna In Touch Care℠ Demonstrating Value Scorecard

Penalty and Measurement Criteria: We will place $0.05per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 50 percent - We return 100 percent of the fee allocated to this component
- 50 percent, but < 60 percent - We return 50 percent of the fee allocated to this component

Sustained Engagement Rate

Guarantee: We will guarantee that 50 percent of high-risk members who become nurse engaged will complete 2 successful clinical calls with a nurse, excluding members identified in last quarter of year or members who transition to another program. Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 40 percent - We return 100 percent of the fee allocated to this component
- 40 percent, but < 50 percent - We return 50 percent of the fee allocated to this component

Retention Rate

Guarantee: We will guarantee that less than 45 percent of high-risk members initially engaged will become unable-to-reach or will opt out of engagement, excluding members identified in last quarter of the year or members who transition to another program. Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- >55 percent - We return 100 percent of the fee allocated to this component
- 55 percent, but >45 percent - We return 50 percent of the fee allocated to this component

Aetna In Touch Care℠ Demonstrating Value Scorecard

Depression Screening

Guarantee: We will guarantee that 90 percent or more of members 18 years or older that agree to engage in the Care Management program will be screened for depression. Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for this metric as follows:

- < 85 percent - We return 100 percent of the fee allocated to this component
- 85 percent, but < 90 percent - We return 50 percent of the fee allocated to this component

Discharge Planning

Guarantee: We will guarantee that 95 percent of cases targeted for discharge planning will have activity documented in Aetna Total Clinical View (ATV), for instance where an inpatient length of stay is greater than 3 days. Members managed by other clinical areas (for example, Beginning Right Maternity) would be managed separately are not included in this guarantee. Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for our Discharge Planning guarantee as follows:

- < 80 percent – We return 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - We return 50 percent of the fee allocated to this component
- 90 percent, but < 95 percent - We return 20 percent of the fee allocated to this component

Case Management Plan

Guarantee: We will guarantee that 98 percent of cases accepted for case management will have a documented case management plan within 7 business days of the start of the event. Members managed by other clinical areas (for example, Beginning Right maternity) would be managed separately and not included in this guarantee. Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Aetna In Touch Care℠ Demonstrating Value Scorecard

Penalty and Measurement Criteria: We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for our Case Management Plan guarantee as follows:

- < 83 percent - We return 100 percent of the fee allocated to this component
- 83 percent, but < 93 percent - We return 50 percent of the fee allocated to this component
- 93 percent, but < 98 percent - We return 20 percent of the fee allocated to this component

Preadmission Outbound Call

Guarantee: We will guarantee 2 outreach attempts and an unable to reach letter to 95 percent of members targeted for a preadmission call. This applies to all elective admissions when notified 5 days prior to a scheduled elective inpatient event. This guarantee excludes maternity, newborns, behavioral health, coordination of benefits (COB), Medicare, skilled nursing facility (SNF), rehabilitation admissions and transplants (members managed through the National Medical Excellence Program®). Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for our Preadmission Outbound Call Rate guarantee as follows:

- < 80 percent - We return 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - We return 50 percent of the fee allocated to this component
- 90 percent, but < 95 percent – We return 20 percent of the fee allocated to this component

Post Discharge Outbound Call

Guarantee: After an inpatient hospitalization, we will guarantee 2 outreach call attempts and an unable to reach letter to 95 percent of members discharged to home. We will update our records within 5 business days following the member's documented discharge date to home. This guarantee excludes maternity, newborns, behavioral health, coordination of benefits (COB), Medicare, skilled nursing facility (SNF), rehabilitation admissions and transplants (members managed through the National Medical Excellence Program®). This assumes timeliness of notification of a discharge by a facility provider (defined as notification of discharge within 48 hours or first business day, whichever is sooner). Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Aetna In Touch Care℠ Demonstrating Value Scorecard

Penalty and Measurement Criteria: We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for our Post Discharge Outbound Call Rate guarantee as follows:

- < 80 percent - We return 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - We return 50 percent of the fee allocated to this component
- 90 percent, but < 95 percent – We return 20 percent of the fee allocated to this component

Case Management High Cost Claimant Screening

Guarantee: We will guarantee that 95 percent of membership with claims in excess of $50,000 will be screened for case management. Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Penalty and Measurement Criteria: We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for our Case Management High Cost Claimant Screening Rate guarantee as follows:

- < 80 percent - We return 100 percent of the fee allocated to this component
- 80 percent, but < 90 percent - We return 50 percent of the fee allocated to this component
- 90 percent, but < 95 percent - We return 20 percent of the fee allocated to this component

Utilization Management Touch Rate

Guarantee: Aetna will guarantee that 93 percent of all inpatient, excluding non-high-risk maternity stays, will be touched by at least one Utilization Manager (UM) program. Designated Care Advocate Team with Aetna In Touch Care Premier book of business results will be used to reconcile the guarantee annually using the appropriate performance guarantee report.

Note: Aetna offers several utilization management programs for members who have been (or will be) admitted to a hospital. A patient may have any, all or none of the programs extended based on a variety of criteria. Despite the possibility of having more than one program administered for a single inpatient stay, the utilization management touch rate only reflects a single program or "touch" by our nurses. For example, if member 1 had concurrent review, member 2 had concurrent review and discharge planning, and member 3 had no programs, then the touch rate would be 2 touched members divided by 3 inpatient stays, or 66.7 percent.

Aetna In Touch Care℠ Demonstrating Value Scorecard

Penalty and Measurement Criteria: We will place $0.10 per employee, per month of the guarantee period administrative service fees at risk for our UM Touch Rate guarantee as follows:

- < 78 percent - We return 100 percent of the fee allocated to this component
- 78 percent, but < 88 percent - We return 50 percent of the fee allocated to this component
- 88 percent, but < 93 percent - We return 20 percent of the fee allocated to this component

Clinical Performance

Guarantee: The clinical guarantees offer a year over year improvement. Since this is the first year of your Aetna In Touch Care program, this year is a reporting-only guarantee. For each of the measures itemized in the table below:

(1) If the measure in the prior year is at the target or higher, we guarantee the target.
(2) If the measure in the prior year is below the target, we guarantee a minimum 5 percent improvement in the difference between the prior year result and the target. The minimum improvement calculation is:

(Target - prior year) x 5 percent

To be included in the guarantee measures, members measured during each measurement period must be:

- Participating in the In Touch Care program
- Enrolled for at least 11 months in the guarantee period
- Identified as having the chronic condition for at least 6 months

Guarantee measure	Minimum Target
• CAD members using statins	55%
• Diabetic members using statins	50%
• Diabetic members receiving an HbA1c Test in the past 12 months	80%
• Diabetic members with HbA1c less than 8 percent	70%
• Diabetic members screened for or having evidence of nephropathy in the past 12 months.	80%
• Persistent asthmatic members using appropriate controller medications in the past 12 months.	80%

Aetna In Touch Care℠ Demonstrating Value Scorecard

Guarantee measure	Maximum Target
• Diabetic members with HbA1c more than 9 percent	23%

Penalty and Measurement Criteria: We will place $0.05 per employee, per month of the guarantee period administrative service fees at risk for *each* guarantee measure listed above as follows:

- If we achieve the target compliance level, we return none of the fee.
- If we do not achieve the target compliance level but do achieve a minimum five percent improvement between the prior year and the target, we return none of the fee.
- If neither of these conditions is met, we will return $0.05 per employee, per month.

Reconciliation example for minimum targets
If the prior year rate is 50 percent and the target compliance rate for the metric is 70 percent, the guarantee will be to improve the rate from the current 50 percent to 51 percent in the following year [50 percent + (70 percent-50 percent) x 5 percent].

Reconciliation example for maximum targets
If the prior year rate is 33 percent and the target compliance rate for the metric is 23 percent, the guarantee will be to improve (reduce) the rate from the current 33 percent to 32.5 percent in the following year [33 percent – (33 percent – 23 percent) x 5 percent].

Because you implemented the Aetna In Touch Care program this year, this is a reporting-only guarantee. Book of business results will be reported. If this guarantee is offered next year, Aetna In Touch Care book of business results will be used to reconcile the guarantee.

PHARMACY
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT

EFFECTIVE 01/01/2018

Lancaster County

aetna

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Pharmacy Discounts & Fees

Pricing Arrangement	Traditional
Network	Aetna National with Extended Day Supply (Retail 90) Network
Employees	796

RETAIL 30			
	01/01/2018	01/01/2019	01/01/2020
Brand Discount	AWP - 17.00%	AWP - 17.10%	AWP - 17.20%
Generic Discount	AWP - 77.00%	AWP - 77.20%	AWP - 77.40%
Dispensing Fee	$1.00 per script	$1.00 per script	$1.00 per script

RETAIL 90			
	01/01/2018	01/01/2019	01/01/2020
Brand Discount	AWP - 20.00%	AWP - 20.10%	AWP - 20.20%
Generic Discount	*Included in Retail 30 pricing above*		
Dispensing Fee	$0.90 per script	$0.90 per script	$0.90 per script

MAIL ORDER PHARMACY			
Mail Benefit Type	Mail Order Pharmacy		
	01/01/2018	01/01/2019	01/01/2020
Brand Discount	AWP - 24.00%	AWP - 24.10%	AWP - 24.20%
Generic Discount	AWP - 80.00%	AWP - 80.20%	AWP - 80.40%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

AETNA SPECIALTY PHARMACY	
Network	Exclusive Specialty Network
Price List	Preferred

CLINICAL PROGRAM FEES	
Expanded Rx Check	Included at No Additional Cost

Rebates

REBATES			
Formulary	Aetna Premier Plus		
Rebate Terms	Plan sponsor will receive the following minimum rebates:		
	01/01/2018	**01/01/2019**	**01/01/2020**
Retail (30 or 90 Day)	Greater of 100% or $88.75 Per Brand Script	Greater of 100% or $97.75 Per Brand Script	Greater of 100% or $108.25 Per Brand Script
Mail Order	Greater of 100% or $228.25 Per Brand Script	Greater of 100% or $251.50 Per Brand Script	Greater of 100% or $278.75 Per Brand Script

Terms & Conditions

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

- To the extent the pricing and services outlined in this document are part of a proposal to the Customer, the pricing set forth herein is valid for 90 days from the date of such proposal.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Prescriptions dispensed by a Participating Retail Pharmacy shall be processed at the lower of the pharmacy's submitted Usual & Customary Retail Price, MAC (where applicable) plus a Dispensing Fee, or discounted AWP cost plus a Dispensing Fee.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
    - Discount and Dispensing Fee guarantees are measured individually and reconciled in the aggregate; surpluses in one or more component guarantees may be used to offset shortages in other component guarantees.
    - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within one hundred eighty (180) days following the guarantee period.
    - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant copay and include zero balance due claims.
    - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein: compound drug claims, direct Plan Participant reimbursement / out-of-network claims, over-the-counter products, and vaccines. In addition, we do not identify or administer any claims for 340B.
    - Retail pricing guarantees include claims that reflect the Usual & Customary Retail Price.
    - Single Source Generic Drugs are excluded from the Generic Discount guarantees.
    - Brand Drug Discount guarantees include Single Source Generic Drugs.
    - Specialty Products dispensed by Participating Retail Pharmacies are included in the Retail Brand Discount guarantee listed above.
    - Aetna has assumed 0% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.
- Limited Distribution Specialty Products are excluded from the pricing terms contained herein.
- Exclusive Specialty Products network means that Plan Participants are required to use the Aetna Specialty Pharmacy after one (1) fill at a Participating Retail Pharmacy.
- Pricing and terms in this proposal assume the Customer has elected the Aetna Premier Plus formulary.
- Rebate guarantees are measured individually by component and reconciled in the aggregate on an annual basis within one hundred eighty (180) days following the end of the Plan year; a

surplus in one or more component Rebate guarantees may be used to offset shortages in other component Rebate guarantees.

- Specialty rebates are included under the Retail rebates.

Additional Disclosures

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

Aetna reserves the right to make appropriate changes to these price points if any event materially impacts Aetna's net income derived under this Agreement. Such events include (i) the termination or material modification of any material manufacturer Rebate contract, (ii) any significant changes in the composition of Aetna's pharmacy network or in Aetna's pharmacy network contract compensation rates with its pharmacy network subcontractor, CVS Health, (iii) a change in government laws or regulations, (iv) a change in the Plan that is initiated by Customer, (v) AWP is discontinued or modified in whole or in part, or (vi) a greater than 15% change in enrollment or a material change, as defined by Aetna, in the drug utilization, plan design, geographic mix or demographic mix of the covered population from what was assumed at the time of underwriting. Aetna shall provide the Customer with at least sixty (60) days written notice of such changes together with a sufficiently detailed explanation supporting these price point changes. If sixty (60) days written notice is not practicable under the circumstances, Aetna shall provide written notice as soon as practicable.

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

Rebate Payment Terms

Rebates will be distributed on a quarterly basis by claim wire credit. Rebate allocations will be made within 180 days from the end of each calendar quarter, with payments issued to customers in the month following allocation. Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

The rebate schedule will be as follows:

- Rebate calculations related to the first quarter will be paid in September of the same year
- Rebate calculations related to the second quarter will be paid in December of the same year
- Rebate calculations related to the third quarter will be paid in March of the following year
- Rebate calculations related to the fourth quarter will be paid in June of the following year

Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates and which are paid separately to Aetna or designated third parties (e.g., mailing vendors, printers). These payments are to reimburse Aetna for the cost of various educational programs. These programs are designed to reinforce Aetna's goals of maintaining access to quality, affordable health care for Plan Participants and the Customer. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates as compensation for (i) bona fide services it performs, such as the analysis or provision of aggregated information regarding utilization of health care services and the administration of therapy or disease management programs and (ii) drug therapies that underperform pursuant to value-based contracting arrangements. Consequently, these other payments are not considered Rebates, and are not included in the Rebates provided to the Customer, if any, under this agreement.

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

Formulary Management

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

Other Payments

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with plan sponsors, including without limitation, Customer.

Aetna's PBM subcontractor may also receive network transmission fees from its network pharmacies for services it provides for them. These amounts are not considered Rebates and are not shared with plan sponsors. These amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees.

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

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

Early Termination

In the event Customer terminates the Agreement prior to December 31, 2020 (an "Early Termination") Aetna shall retain any earned but unpaid rebates as of the Early Termination date subject to any exception thereto provided herein. If there is a loss of enrollment greater than 15% after year 1, Aetna may retain the earned but unpaid rebates on this enrollment loss by taking the total rebates divided by the total number of employees multiplied by the number of employees that have left Aetna. This calculation of Rebate retention is applicable to subsequent losses of enrollment and not subject to a one-time event. Termination for purposes of this condition is defined as 50 percent or greater membership reduction from the membership we assumed in this Service and Fee Schedule.

The pharmacy guarantees agreed to between the Customer and Aetna, if any, shall be considered null and void for the Plan year prior to an early termination subject to any exception thereto provided herein. In addition, there will not be any partial-year reconciliation of guarantees with loss of enrollment as outlined above.

Late Payment Charges

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

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

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

Pharmacy Audit Rights and Limitations

Customer is entitled to one annual Rebate audit, subject to the audit terms and conditions outlined in the pharmacy services schedule.

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the pharmacy services schedule.

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

Aetna Specialty Pharmacy

Discounts and Dispensing Fees for Specialty Products that are covered under the pharmacy plan and dispensed to Plan Participants through Aetna Specialty Pharmacy (ASRx) are indicated on the Specialty Pharmacy Addendum. A copy of the Customer's Specialty Pharmacy Addendum will be provided at renewal and upon request and may be modified by Aetna from time to time.

Limited Distribution Specialty Products

Certain Specialty Products may not be available at Aetna Specialty Pharmacy (ASRx) due to restricted or limited distribution requirements. These Specialty Products are referred to as Limited Distribution Specialty Products. Aetna has contracted with other network pharmacies to dispense Limited Distribution Specialty Products which are excluded from the pricing and terms contained in this Agreement. A copy of the current list of Limited Distribution Specialty Products may be obtained from Aetna upon request.

Firm Stop Loss Quote

	Option 1
Stop Loss Coverage Effective Date:	1/1/2018
Policy Period Length (months):	12
Number of Employees Covered Under Stop Loss:	796
Number of Single Covered Under Stop Loss:	358
Number of Family Covered Under Stop Loss:	438
Aetna Choice POS II:	796
Producer Compensation:	0%
Terminal Liability Option:	N/A
Claims Paid Basis for Medical Coverages:	Issued
Claims Paid Basis for Rx coverage is on an issued basis	
INDIVIDUAL STOP LOSS COVERAGE SPECIFICATIONS	
Individual Stop Loss Level:	$200,000
Contract Type:	24/12
Coinsurance %:	100%
M/N Claims Apply to ISL (Aetna Administered only):	Yes
Rx Claims Applied to ISL (Aetna Administered only):	Yes
Individual Specific Stop Loss Limits (Lasering):	No Lasers
Individual Lifetime Stop Loss Payment Amount:	Unlimited
Reimbursement Method:	See below
Prior Carrier Runoff Cap (per participant):	$600,000
Total Stop Loss Premium:	$791,746
PEPM Single Rate:	$45.40
PEPM Family Rate:	$113.52
Premium (PEPM) Composite Rate:	**$82.89**

Stop Loss premium is billed on a composite basis.
*Individual Stop Loss reimbursements resulting from including run-in claims administered by the prior TPA will be handled on a delayed year-end basis. Aetna claims that exceed the Individual Stop Loss Amount during the first twelve months of the policy period will be handled on an immediate reimbursement basis.