MASTER SERVICES AGREEMENT
MSA- 724379

This Master Services Agreement ("**Agreement**") between **AETNA LIFE INSURANCE COMPANY**, located at 151 Farmington Avenue, Hartford, Connecticut ("**Aetna**"), and Hillsborough County Aviation Authority, located at Tampa Airport, Level 3 Blue SD, Tampa, FL, 33607("**Customer**") is effective as of August 1, 2022 ("**Effective Date**"). The following documents are a part of this Agreement and are hereby incorporated by reference: Attachment A, Supplemental Terms and Conditions, Business Associate Agreement, and Client Audit Request Form. Should any conflicting language be determined among these documents, Attachment A, Supplemental Terms and Conditions, will govern."

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.

This Agreement replaces and supersedes Services Agreement number MSA-724379, effective August 1, 2013. The parties therefore agree as follows:

1. TERM
The initial term of this Agreement will be one year beginning on the Effective Date. The initial term 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 first calendar day of the month in which the Services are provided (the "**Payment Due Date**"). The Customer shall provide with

their payment either a copy of the Aetna invoice, modified to reflect current eligibility, or a copy of a pre-approved invoice which meets Aetna's billing requirements. The Customer shall also reimburse Aetna for certain additional expenses, as stated in the Service and Fee Schedule(s).

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

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

5. BENEFIT FUNDING

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

Since funding is provided on a checks cleared basis, Aetna is not required to act on outstanding benefit checks (checks which have not been presented for payment) unless directed to do so by the Customer. The Customer may elect full escheat or stop pay services under a separate contract, to which additional fees may apply. In the absence of an escheat or stop pay contract, checks will be voided when they age five years, which does not eliminate the Customer's potential escheat liability.

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

(i) One year has elapsed since Aetna completed its runoff obligations; or

(ii) Aetna has exercised its right to suspend claim payments or terminate this Agreement as stated in section 17(B) (Termination).

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

For any calendar month, the maximum payment to be made to the banking facility to fund Plan benefit payments for those products mutually agreed upon is described below. Plan benefit payments and related charges in a calendar month which exceed the maximum payment for the month will be carried forward to be funded by the Customer in future calendar months of the current Agreement Period, except that for the last calendar month of the Agreement Period, the Customer is liable for any benefit payments which exceed the maximum payment for that month.

The maximum payment for any calendar month shall be equal to (i) less (ii) where:

i. shall be equal to the product of (A) and (B) where:

(A) equals the sum of the number of enrolled employees as indicated by Aetna records at

the beginning of each calendar month of the Agreement Period up to and including the current calendar month (provided the sum shall not be less than the number of calendar months up to and including the current calendar month times the number of employees as indicated by Aetna records as of the beginning of the first month of the Agreement Period), times

(B) the maximum benefit payment factor. This factor shall be determined by Aetna and shall be effective as of the first calendar month of an Agreement Period. The maximum benefit payment factor may be changed at such other times as the Aggregate Stop Loss Factor is adjusted under the Customer's then-current Stop Loss Insurance Policy with Aetna.

ii. shall equal the Plan benefit payments funded by the Customer during the preceding calendar months of the Agreement Period.

On the termination date, in addition to the liabilities described in section 17, the Customer is liable for and must provide funds to the banking facility equal to the difference between the total amount of claim benefit payments paid for the Agreement Period being terminated, and the amount of claim benefit payments that the Customer has already paid for the same Agreement Period.

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) **Third Party Consents** – The Customer shall obtain any consents, authorizations or other permissions from Employees or relevant third parties, which may be required under law or otherwise necessary in order for Aetna to access, use or disclose information and data for the purposes of providing Services under this Agreement.

(F) **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 – Unless required by applicable law and/or court order, 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. Unless required by applicable law and/or court order,

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/or court order 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 two years of the end of the time period being audited. Audits of any performance guarantees, if applicable, must be completed in the year following the period to which the performance guarantee results apply. Audits 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 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.

(C) 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 any person or entity acting on the Customer's behalf or at the Customer's direction. For purposes of (A) and (B) above, the standard of care to be applied in determining whether either party is "negligent" in

performing any duties or obligations under this Agreement shall be the standard of care set forth in section 3.

13. DEFENSE OF CLAIM LITIGATION

In the event of a legal, administrative or other action arising out of the administration, processing or determination of a claim for Plan benefits, the party designated in this document as the fiduciary which rendered the decision in the appeal last exercised by the Plan Participant which is being appealed to the court ("**appropriate named fiduciary**") shall undertake the defense of such action at its expense and settle such action when in its reasonable judgment it appears expedient to do so. If the other party is also named as a party to such action, the appropriate named fiduciary will defend the other party PROVIDED the action relates solely and directly to actions or failure to act by the appropriate named fiduciary and there is no conflict of interest between the parties. The Customer agrees to pay the amount of Plan benefits included in any judgment or settlement in such action. The other party shall not be liable for any other part of such judgment or settlement, including but not limited to legal expenses and punitive damages, except to the extent provided in section 12 (Indemnification).

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

14. REMEDIES

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

15. 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**").

16. 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 30 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 30 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, the Customer may request that Aetna continue processing runoff claims for Plan benefits that were incurred prior to the termination date, which are received by Aetna within 12months following the termination date. In such event, the parties shall mutually agree upon a fee for such runoff services, which shall be paid by the Customer prior to the commencement of the runoff services. 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.

17. GENERAL

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

(B) **Intellectual Property** - Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under this Agreement (the "**Aetna IP**"). Aetna has granted the Customer a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in this Agreement. Customer agrees not to modify,

create derivative product from, copy, duplicate, decompile, disassemble, reverse engineer or otherwise attempt to perceive the source code from which any software component of the Aetna IP is compiled or interpreted. Nothing in this Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent or otherwise transfer or convey, the Aetna IP to the Customer.

(C) **Notice** - Notices from Aetna to the Customer under this agreement are valid when delivered, in writing, to the Customer's email address provided at the time this contract was entered into (or such subsequent email address as the Customer has provided to Aetna by notice). Notices from the customer to Aetna are valid when delivered, in writing, to the Customer's Aetna account representative.

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

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

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

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

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

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

(J) **Entire Agreement; Order of Priority** - This Agreement, and the accompanying HIPAA business associate agreement, constitutes the entire understanding between the parties with respect to the subject

matter of this Agreement, and supersedes all other agreements, whether oral or written, between the Parties.

(K) **Amendment** – Except as provided for in the Customer's renewal package, no modification or amendment of this Agreement will be effective unless it is in writing and signed by both Parties, except that a change to a party's address of record as set forth in section 18(C) (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. Customer is a tax exempt agency.

(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.

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

HILLSBOROUGH COUNTY AVIATION AUTHORITY

BY:

Jane Castor, Secretary

Gary W Harrod, Chairman

Address: PO Box 22287
Tampa FL

Address: PO Box 22287
Tampa FL

WITNESS:

Signature

Printed Name

Approved as to form for legal sufficiency:

BY:

David Scott Knight, Assistant General Counsel

HILLSBOROUGH COUNTY AVIATION AUTHORITY

STATE OF FLORIDA

COUNTY OF HILLSBOROUGH

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online authorization, this ____ day of _____, 2022, by Gary Harrod, in the capacity of Chairman, and by Jane Castor in the capacity of Secretary, for Hillsborough County Aviation Authority, a public body corporate under the laws of the State of Florida, on its behalf.

Stamp or Seal of Notary

Signature of Notary

Print, Type, or Stamp Commissioned Name of Notary

Personally Known OR Produced Identification

Type of Identification Produced

Signed in the Presence of:

AETNA LIFE INSURANCE COMPANY

BY:

Witness

Daniel Finke

Printed Name

President

Printed Name

Witness

Printed Address

City/State/Zip

AETNA LIFE INSURANCE COMPANY

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notarization, this ____ day of _____, 2022, by _____ as

(Name of person)

_____, for _____.

(type of authority) (name of party on behalf of whom contract was executed)

Stamp or Seal of Notary

Signature of Notary

Print, Type, or Stamp Commissioned Name of Notary

Personally Known OR Produced Identification

Type of Identification Produced

GENERAL ADMINISTRATION SCHEDULE
TO THE MASTER SERVICES AGREEMENT- 724379
EFFECTIVE August 1, 2022

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) Aetna has value-based contracting ("**VBC**") arrangements with Network Providers. These arrangements reward providers based on indicators of value, such as, effective population health management, efficiency and quality care. Contracted rates with Network Providers may be based on fee-for-service rates, case rates, per diems, performance-based contract arrangements, risk-adjustment mechanisms, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. These mechanisms may include payments to physicians, physician groups, health systems and other provider organizations, including but not limited to organizations that may refer to themselves as accountable care organizations and patient-centered medical homes, in the form of periodic payments and incentive arrangements based on performance. Aetna will process any incentive payments attributable to the Plan

in accordance with the terms of each VBC arrangement. Each Customer's results will vary. It is possible that incentives paid to a particular provider or health system may be required even if the Customer's own population did not experience the same financial or qualitative improvements. It is also possible that incentives will not be paid to a provider even if the Customer's own population did experience financial and quality improvements. Upon request, Aetna will provide additional information regarding our VBC arrangements.

(C) Retroactive adjustments are occasionally made to Aetna's contract rates. Retroactive adjustments may occur, for example, when the federal government does not issue cost of living data in sufficient time for an adjustment to be made on a timely basis, or because contract negotiations were not completed by the end of the prior price period or due to contract dispute settlements. In all cases, Aetna shall adjust the Customer's payments accordingly. The Customer's liability for all such adjustments shall survive the termination of the Agreement.

(D) Aetna may contract with vendors who in turn are responsible for contracting with the providers who perform the health care services, and potentially for certain other services related to those providers such as claims processing, credentialing, and utilization management. Under some of these arrangements, the vendor bills Aetna directly for those services by its network of providers at the vendor's contracted rate with Aetna, and Aetna pays the vendor for those services. In certain cases, the amount billed by the vendor to Aetna, paid pursuant to the plan, includes an administrative fee for delegated services by the vendor. As a result, the amount the vendor pays to the health care provider through the vendor's contract with the provider may be different than the amount paid pursuant to the Plan because the allowed amount under the Plan will be Aetna's contracted rate with the vendor, and not the contracted amount between the vendor and the health care provider.

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

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

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

(H) Customer agrees to comply with all of the applicable terms of Aetna's network provider contracts.

5. NON-DIRECT NETWORKS

If Aetna is requested by the Customer, or otherwise arranges for network services to be provided for Plan Participants in a geographic area where Aetna does not have a directly contracted network of providers, (or additional access is requested or advisable), Aetna may contract with another network and or additional providers ("**non-Aetna network**") to provide the network services. With respect to the services provided by

providers in the non-Aetna network ("**non-Aetna network providers**"), the Customer acknowledges and agrees that, any other provisions of the agreement notwithstanding:

(A) Aetna may not credential, monitor or oversee the providers or the administrative procedures or practices of any non-Aetna network;

(B) No particular discounts may, in fact, be provided or made available by any particular providers;

(C) Performance guarantees appearing in the agreement may not apply to Services delivered by non-Aetna providers or networks; and

(D) Non-Aetna network providers are not employees or agents of Aetna and may not be contractors or subcontractors of Aetna.

The Customer further agrees that, if Aetna subsequently establishes or expands its own contracted provider network in a geographic area where services are being provided by a non-Aetna network, Aetna may terminate the non-Aetna network contract, and begin providing services through a network that is subject to the terms and provisions of the agreement. The Customer acknowledges that such conversion may cause disruption, including the possibility that a particular provider in a non-Aetna network may not be included in the replacement network.

MEDICAL
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT- 724379
EFFECTIVE August 1, 2022

The Service Fees and Services effective for the period beginning August 1, 2022 and ending July 31, 2023 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to “Member” shall mean a Plan Participant as defined in the Agreement.

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

Programs and Services – Self-Funded

Program Summary	OA-AS	CPII

Programs & Services Included in the Service Fee

Mature Base Service Fee	$23.04	$23.04
Implementation, Account Management & Plan Administration		
Designated Account Management Team	Included	Included
Designated Implementation Manager	Included	Included
Designated Service Center	Included	Included
Onsite Open Enrollment Meeting Preparation	Included	Included
Open Enrollment Marketing Material (Standard) Onsite Meeting Preparation	Included	Included
Digital ID Cards	Included	Included
Summary of Benefits and Coverage (SBC)	Included	Included
Claim Fiduciary Option 1	Included	Included
Non-ERISA	Included	Included
Network Services		
Institutes of Excellence™	Included	Included
Institutes of Quality® (IOQ) Benefit Differential	Included	Included
National Medical Excellence Program® - Transplant Coordination	Included	Included
Network access	Included	Included
Teladoc General Medical††	Included	Included
Teladoc Behavioral Health††	Included in General Medical	Included in General Medical
Teladoc Dermatology††	Included in General Medical	Included in General Medical
Care Management		
Aetna Compassionate Care Program	Included	Included
Aetna Maternity Program	Included	Included
Aetna One® Flex	Included	Included
Aetna Advice	Included	Included
Member Engagement Platform with Rewards Center (excludes cost of gift cards)	Included	Included
Utilization Management	Included	Included
Member Resources		
Aetna Concierge (includes First Impression Treatment)	Included	Included
Dedicated Toll Free Number	Included	Included
Member Website and Mobile Experience	Included	Included
MindCheck℠	Included	Included
Service Center Extended Hours (2 extra hours)	Included	Included
Wellness		
24-Hour Nurse Line: 1-800# Only	Included	Included
Aetna Get Active	$.60 PEPM	$.60 PEPM
Aetna Healthy Commitments℠ - Core	Included	Included
Biometric Screenings (Up to $33,300 with incentives)	Included	Included
Peerfit Program	Included	Included
Simple Steps to Healthier Life® Health Assessment	Included	Included
Allowances		
Wellness Allowance ($75,000)	Included	Included

Reporting and Integration		
Analytic Consultation from Plan Sponsor Insights	50 Hours	50 Hours
Clinical Consultation from Plan Sponsor Insights	50 Hours	50 Hours

Behavioral Health		
Managed Behavioral Health	Included	Included
Behavioral Health Condition Management Program - Standard	Included	Included
Applied Behavior Analysis (ABA)	Included	Included
AbleTo Network - subject to member cost share	Included	Included

†† There is a per consultation charge which will be shared by the member and plan sponsor based on type of service provided and member's benefit plan. Specific charges are available from your Account Manager.

Programs & Services Included in the Claim Wire

Network Services		
Subrogation‡	37.5% of recovered amount will be retained.	37.5% of recovered amount will be retained.
Coordination of Benefits and other contracted services‡	Up to 37.5% of recovered amounts will be retained.	Up to 37.5% of recovered amounts will be retained.
Third Party Claim and Code Review Program‡	Up to 37.5% of recovered amounts will be retained.	Up to 37.5% of recovered amounts will be retained.
National Advantage™ Program	We will retain 50% of savings	We will retain 50% of savings
Facility Charge Review (FCR) – Standard	Included	Included
Itemized Bill Review	Included	Included
Data iSight™	Included	Included

Care Management		
Enhanced Clinical Review Program – High Tech Imaging (PMPM)††	Included	Included
Enhanced Clinical Review Program – Diagnostic Cardiac (PMPM)††	Included	Included
Enhanced Clinical Review Program – Sleep Management (PMPM)††	Included	Included
Enhanced Clinical Review Program – Cardiac Implantable Devices (PMPM)††	Included	Included
Enhanced Clinical Review Program – Interventional Pain (PMPM)††	Included	Included
Enhanced Clinical Review Program – Hip and Knee Arthroplasties (PMPM)††	Included	Included

‡ Details can be found in our UW Disclosure document located at the following URL:
https://www.aetna.com/document-library/large-group-public-labor-self-funded-medical-underwriting-disclosures-12-01-2021.pdf

†† The cost is stated on a per member, per month (PMPM) basis. The fee is only charged to those members who fall into service areas where the program is available.

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 in the Service and 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 above and will not appear on the monthly billing statement for PEPM Administrative Fees, but will appear in other monthly reports provided to the Customer.

We are including allowance(s) for your Aetna plans applicable to each year of the Guarantee Period as outlined in the chart below.

Allowances - Self-Funded					Effective Date: August
Annual Allowance Type	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year5**
Plan Year Effective Date	**08/01/2022**	**01/01/2023**	**01/01/2024**	**01/01/2025**	**01/01/2026**
Wellness	$75,000	$75,000	$75,000	$75,000	$75,000
Total	**$75,000**	**$75,000**	**$75,000**	**$75,000**	**$75,000**

Our standard underwriting caveats apply for changes in membership of percent or greater.

Allowance

- Can be used for expenses applicable to the plan year for which they are offered.
- You can use the allowance(s) to offset expenses you incur as a result of implementing your contract with us, promoting products, programs or services, communicating with our members, and our system front-end charges.
- Should you terminate your contract with us, the allowance(s) cannot be used to fund implementation/communication expenses related to the new carrier's contract.

Wellness Allowance

- Can be used to pay for reasonable wellness-related programs or activities you received from third-party vendors incurred during the Guarantee Period year for which the allowance was applicable.
- Wellness allowance expenses must be for wellness-related programs or activities that are designed to promote the health and well-being of members, or to educate participants about healthy lifestyles and choices. Any wellness-related allowance amounts we pay you directly to offset or reimburse you for any expense or costs you reimbursed a vendor for directly, must comply with these conditions. Examples of reimbursable wellness related activities include programs or activities such as wellness fairs, biometric screenings and onsite flu vaccinations.

The above referenced fund(s) will be available as of the effective date of each plan year of the Guarantee Period. Only those expenses performed and billed by a third party are payable; reimbursement for time and materials incurred directly by the plan sponsor (e.g. hours worked by the plan sponsor's own employees) are not eligible. Our preferred method of payment is directly to the vendor. We will pay allowance related expenses directly to the vendor only after you send us proper documentation outlining the expenses you have incurred. On an exception basis, we can reimburse you directly. In the event the exception is granted, we'll require you to submit detailed paid receipts from the vendor. Documentation must be submitted within 60 days following the close of the plan year for which expenses were incurred. Acceptable documentation includes, but is not limited to:

- Vendor invoice(s) summarizing level of work completed, hourly rate and hours spent; and
- Invoices or other documentation summarizing any other miscellaneous expenses incurred (such as travel, and other business expenses related to service rendered)

The allowance amounts indicated above for the following Allowance Type(s) are available for the years indicated in the chart. These allowances are forfeited at the end of each plan year if not fully utilized (they do not get rolled over to the following plan year for a

cumulative amount).

- Wellness

We assume the funding of any allowance dollars is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. We will pay any allowances in accordance with applicable law. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and laws.

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

We are willing to guarantee the service fees as part of our commitment to containing costs. The increase to the service fees is provided below:

	Estimated Enrollment	Year 1	Year 2	Year 3
Guarantee Period Effective Date		August 01, 2022	August 01, 2023	August 01, 2024
Fee Basis		Mature	Mature	Mature

Medical Fees as Billed (PEPM)	Estimated Enrollment	Year 1	Year 2	Year 3
OA-AS	28	$23.04	$23.04	$23.04
CPII	562	$23.04	$23.04	$23.04
Plan Year Service Fees	**590**	**$163,123**	**$163,123**	**$163,123**

Service Fee Summary (Plan Year)	Year 1	Year 2	Year 3
Administrative Service Fees	$163,123	$163,123	$163,123
Service Fee Guarantee % Change†		**0.0%**	**0.0%**
Fee Credit††	($150,000)	$0	$0
Total Fees (incl Discounts, Credits, Broker Comp, Other Charges)	**$13,123**	**$163,123**	**$163,123**

Additional Service Fee Guarantee† (Excluding Other Charges)	Composite Fee	% Change
Year 4 of 5 (August 01, 2025) Mature	$23.73	3.0%
Year 5 of 5 (August 01, 2026) Mature	$24.44	3.0%

Clarifications

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

Prescription Drug Benefits

Prescription drug benefits are included and will be provided through Aetna Integrated Pharmacy Solutions.
If you terminate your Aetna prescription drug benefits, Aetna will increase the ASC Service Fees and medical trend, and the customer may also be subject to additional charges to integrate data with external Pharmacy vendors.

† Service Fee Guarantee

Our offer includes a service fee guarantee for the guarantee period August 01, 2022 to July 31, 2027
The guaranteed service fees excluding broker compensation are listed above. The service fee guarantee is subject to the terms and conditions as stated in the caveats and is contingent upon the customer maintaining all lines

of business with Aetna.

†† Fee Credit

We have included an administrative service fee credit. Refer to the fee credit letter for specific details. Should you decide to terminate your medical plan(s) you have with us prior to the end of the guarantee period, July 31, 2023 you agree to pay us a transition fee. Refer to your fee credit letter for specific details.

Caveats - Self-Funded — Effective Date: August 01, 2022

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

Underwriting Caveats

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

If any of the changes outlined below occur, we may adjust your Guaranteed Fees. If this happens, you'll have to pay any difference between the fees collected and the new fees calculated back to the start of the Guarantee Period. If fees are adjusted, the caveats below will be based on the new assumptions.

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

Enrollment

There is a 15 percent change in the total number of enrolled employees for all commercial medical products combined. Our 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.

Member-to-Employee Ratio

The member-to-employee ratio changes by more than 15 percent from the 2.5 ratio assumed in this quote.

Over Age 65 Enrollment

The number of over age 65 enrolled employees (excluding those enrolled on Medicare Direct plans) exceeds 6 percent of the total enrolled group or changes by more than 15 percent from the 35 enrollees assumed in this quote. Patient Management programs are excluded for Medicare primary members.

Maximum Account Structure

Maximum account structure exceeds the number of units illustrated in the table below. Account structure determines the reporting format. During the installation process, we'll 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.

Total Employees (Choice POS II, Open Access Aetna Select, PPO, EPO, Aetna HealthFund®, Indemnity)	Maximum Total Structure Per Product
Less than 1,000	60
1,000 to 2,999	80
3,000 to 4,999	150
5,000 to 9,999	300
10,000 to 19,999	350
20,000 to 49,999	500

50,000 and over	750

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

National Advantage™ Program
You change or terminate the National Advantage™ Program (NAP), Facility Charge Review (FCR), Itemized Bill Review (IBR), or Data iSight™ (DiS) programs.

Multi-Year Provision
You place the products, programs and services included in this multi-year fee guarantee out to bid with an effective date prior to July 31, 2027, then this guarantee is no longer valid.

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

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

Aetna relied on information from Hillsborough County Aviation Authority and its representatives in establishing the fees and terms of this proposal. If any of this information is inaccurate and has an impact on the cost of the programs, Aetna reserves the right to adjust the fees and terms upon receipt of corrected information

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

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

Plan Design
This proposal is based on the current benefit plan designs, plus any noted deviations.

Claim Fiduciary
Our proposal assumes we've been delegated claim fiduciary responsibilities. As claim fiduciary, we'll be responsible for final claim determination and the legal defense of disputed benefit payments. Our appeal administrative services are automatically included when we've been delegated claim fiduciary responsibilities.

External Review
External review has not been included in our proposal. External review uses outside vendors who coordinate medical review through their network of outside physician reviewers.

Non-ERISA
For non-ERISA plan, the risk 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 account for the additional liability risk as compared to known risks under an ERISA plan. An additional $0.35 PEPM is charged for non-ERISA plans and is included in our fees.

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

Wellness Incentives and Rewards
We offer several different wellness incentives and rewards programs that you may choose from to offer to your members. We, or our third-party vendors, will administer and distribute any wellness incentives or rewards earned to your members based on the program selected under the direction and control of your plan. The wellness incentives and rewards earned through these

programs may be taxable for your members. We will provide you reporting which will identify members who have each earned such wellness incentives or rewards. These reports will provide you the data needed for any tax information reporting requirements that you determine are necessary. However, you, as the plan sponsor, are responsible for complying with all tax information reporting requirements regarding any wellness incentives or rewards earned through these programs (cash, cash equivalent, or other tangible property) and provided by us or our third-party vendor to your members. You shall assume any, and all, liability for your noncompliance with any tax withholding or information reporting requirements. You may wish to consult with your legal counsel or other advisors as to the proper tax treatment of such wellness incentives or rewards.

Third-Party Audits

We don't 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.

Prescription Drug Benefits

Our quotation assumes that prescription drug benefits are included and will be provided through Aetna Integrated Pharmacy Solutions. If you terminate your Aetna prescription drug benefits, we will increase your Guaranteed Fees and medical trend assumption used for any applicable claim projections or claim target guarantee, and you may also be subject to additional charges to integrate data with external Pharmacy vendors.

Aetna Specialty Pharmacy℠ Program

The Aetna Specialty Pharmacy℠ program covers specialty prescription drugs when filled through a network retail or specialty pharmacy, including CVS Specialty© Pharmacy. CVS Specialty is an ideal specialty pharmacy for members needing injectables and specialty medications. Members receive the full support of CVS Specialty's clinical staff, including pharmacists, registered nurses, certified pharmacy technicians and regional clinical liaisons. In addition to providing convenient access to specialty medications, CVS Specialty provides educational support to help members, their family members and caregivers manage self-injectable medications. CVS Specialty also offers enhanced care coordination and access to health care providers, so care delivery is streamlined and effective.

Each prescription is limited to a maximum supply. Depending on plan design, members may be required to fill specialty drug prescriptions at a network specialty pharmacy, unless an emergency exists.

Additional Products, Programs and Services

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

Billing Information

Advanced Notification of Fee Change

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

Late Payment

We'll assess a late payment charge at a 12 percent interest rate if you fail to pay plan benefit payments or administrative service fees on a timely basis as outlined in the Agreement. We'll notify you of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to us under the Agreement or at law or in equity for failure to pay.

Extended Grace Period

As we agreed, we'll accept payment of service fees within 60 days. If you fail to pay service fees within 60 days, we'll assess a late payment charge. We reserve the right to change this extended period for paying Service Fees at any time. We'll provide you with 30 days written prior notice in the event we decide to change the arrangement. Any Service Fees due after the end of the 30 day notice period will be subject to the new arrangement. We reserve all rights to enforce Agreement remedies as to any Service Fees overdue.

Producer Compensation

The quoted fees don't include producer compensation.

Claim and Member Services

Runoff Claims Processing

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

Medical Service Center

We've assumed that claim administration and member services for the quoted plans will be managed centrally by the Tampa, FL Service Center. Members will be able to reach the Member Service representatives Monday through Friday,
from 8 a.m. to 8 p.m., local time (based on where the member resides).

Summary Plan Description (SPD) Modification

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

Reporting and Data Transfer

Aetna Intellectual Property

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

Claims History Transfer

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.

Data Integration (Historical)

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

Data Integration (Ongoing)

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

Data Transfer at Termination

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

Banking

We've assumed that you provide funds through a Fed drawdown by Aetna wire transfer for drafts issued under the self-funded arrangement assumed in this proposal.

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

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

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

Value-Based Contracting

A. Introduction to Value-Based Contracting

We have a variety of different value-based contracting (VBC) arrangements with many of our Network Providers. These arrangements compensate providers to improve indicators of value such as, effective population health management, efficiency and quality care.

B. Value-Based Contracting Models

We have VBC arrangements ranging from bundled payments and pay-for-performance approaches to more advanced forms of collaborative arrangements that include integrated technology and case management, aligned incentives and risk sharing. Our VBC models include:

Pay for Performance (P4P). Under P4P programs, we work together with providers (doctors and hospitals) to develop and agree to a set of quality and efficiency measures and their performance impacts their total compensation.

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

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

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

We will continue to evolve our value-based contracting arrangements over time. We employ a broad spectrum of different reimbursement arrangements with providers to advance the goals of improving the quality of patient care and health outcomes, while controlling costs.

C. Value-Based Contracting Example Calculations

A customers' financial responsibility under many VBC arrangement is determined based on provider performance, using an allocation method appropriate for each particular performance

program. These methods include: percentage of allowed claims dollars and percentage of paid capitation dollars; number of members; percentage of member months.

Examples

1. Pay for Performance. Percentage of allowed claims dollars and percentage of paid capitation dollars:
   Achieving agreed upon clinical and efficiency performance goals by comparing performance year end to performance year baseline or an industry standard.
   a. Provider earns $100,000 performance-based compensation for the 12-month period January to December;
   b. All plan sponsors, combined incurred $8,500,000 in claims with the provider for the 12-month period January to December;
   c. Plan sponsor incurred $150,000 in claims with the provider for the 12-month period January to December;
   d. Plan sponsor's share of claims costs is ($150,000/$8,500,000) = 1.7647 %. Formula: (Plan sponsor incurred claims/All plan sponsors incurred claims);
   e. Plan sponsor's share of the $100,000 performance-based compensation is 1.7647 % * $100,000) = $1,764.70, which would be processed as a claim through ordinary self-funded banking channels.

2. Patient Centered Medical Home and Accountable Care Organization. Percentage of member months:
   Achieving agreed upon clinical and efficiency goals as measured by performance year end to performance year baseline or an industry standard.
   a. Provider earns $100,000 performance-based compensation for the 12-month period January to December;
   b. All plan sponsors, combined had 100,500 member months with the provider for the 12-month period January to December;
   c. Plan sponsor had 9,500 member months(for 850 unique members) attributed to the provider for the 12-month period January to December;
   d. Plan sponsor's share of the member months is (9,500/100,500) = 9.4527 %. Formula: (Plan sponsor member months/All plan sponsors months);
   e. Plan sponsor's share of the $100,000 performance-based compensation is (9.4527 % * $100,000) = $9,452.73, which would be processed as a claim through ordinary self-funded banking channels.

3. Patient Centered Medical Home and Accountable Care Organization. Number of Members:
   In addition to Example 2 above, a quarterly Accountable Care Payment (ACP) may be made to the provider to fund activities necessary to meet the financial and clinical objectives. These are paid quarterly either during, or after the end of each quarter. The financial impact is considered in the total financial package negotiated with the provider.
   a. We determine the attributed patients for the provider for the quarter April through June;

b. Plan sponsor had 850 members attributed to the provider for the quarter April through June;
c. ACP and FFS payments are incorporated into the final analysis of provider performance against the medical claims target;
d. We apply the agreed upon rate to the attributed patients; i.e. $2.00 per-member, per-month (PMPM) = $6.00 per quarter per member, to determine funding to the provider;
e. Plan sponsor's calculated share is $5,100 ($6.00 * 850), which would be processed as a claim through ordinary self-funded banking channels.

A. General

We will process any payments in accordance with the terms of each VBC arrangement. In each of the VBC models, self-funded plan sponsors reimburse us for any payment attributable to their plan when the payments are made. Each customer's results will vary. It is possible that payments paid to a particular provider or health system may be required even if the plan sponsor's own population did not experience the same financial or qualitative improvements. It is also possible that payments will not be paid to a provider even if the customer's own population did experience financial and quality improvements. A report of VBC charges to a plan sponsor will be available on a quarterly basis.

Upon request, we will provide additional information regarding our VBC arrangements.

Late Payment Charges

We will assess a late payment charge if you do not provide funds on a timely basis to cover benefit payments and/or fail to pay service fees on a timely basis as outlined in the Agreement.

The current charges are outlined below:

1. Late funds to cover benefit payments (e.g., late wire transfers): 12 percent annual rate
2. Late payments of Service Fees: 12 percent annual rate

We reserve 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 the claim wire.

In addition, we'll charge to recover costs of collection including reasonable attorney's fees. We will notify you of any changes in late payment interest rates.

The late payment charges described in this section are without limitation to any other rights or remedies available to us under the Agreement or at law or in equity for failure to pay.

PRESCRIPTION DRUG
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT- 724379
EFFECTIVE August 1, 2022

The Service Fees and Services effective for the period beginning August 1, 2022 and ending July 31, 2023 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 Network
Employees	600

RETAIL			
	08/01/2022	**08/01/2023**	**08/01/2024**
Brand Discount	AWP - 19.50%	AWP - 19.60%	AWP - 19.70%
Generic Discount	AWP - 84.00%	AWP - 84.20%	AWP - 84.40%
Dispensing Fee	$0.70 per script	$0.70 per script	$0.70 per script

MAIL ORDER PHARMACY			
Mail Benefit Type	Mail Order Pharmacy		
	08/01/2022	**08/01/2023**	**08/01/2024**
Brand Discount	AWP - 25.00%	AWP - 25.10%	AWP - 25.20%
Generic Discount	AWP - 88.00%	AWP - 88.20%	AWP - 88.40%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

SPECIALTY PHARMACY			
Network	Specialty Network		
Product List	Aetna Specialty Product List		
	08/01/2022	**08/01/2023**	**08/01/2024**
Discount	AWP - 20.00%	AWP - 20.10%	AWP - 20.20%

Rebates

REBATES			
Formulary	Standard Opt Out Formulary		
Plan Design	3 Tier Qualifying *(In Force Today)		
Rebate Terms	Customer will receive the following guaranteed rebates:		
	08/01/2022	**08/01/2023**	**08/01/2024**
Retail	$195.51 Per Brand Script	$214.67 Per Brand Script	$234.95 Per Brand Script
Mail Order	$521.91 Per Brand Script	$578.16 Per Brand Script	$632.78 Per Brand Script
Specialty	$1,537.77 Per Brand Script	$1,691.54 Per Brand Script	$1,851.37 Per Brand Script

REBATES			
Formulary	Standard Opt Out Formulary		
Plan Design	3 Tier Non-Qualifying		
Rebate Terms	Customer will receive the following guaranteed rebates:		
	08/01/2022	**08/01/2023**	**08/01/2024**
Retail	$166.18 Per Brand Script	$182.47 Per Brand Script	$199.71 Per Brand Script
Mail Order	$443.62 Per Brand Script	$491.43 Per Brand Script	$537.87 Per Brand Script
Specialty	$1,537.77 Per Brand Script	$1,691.54 Per Brand Script	$1,851.37 Per Brand Script

REBATES			
Formulary	Standard Opt Out Formulary		
Plan Design	2 Tier *(In Force Today)		
Rebate Terms	Customer will receive the following guaranteed rebates:		
	08/01/2022	**08/01/2023**	**08/01/2024**
Retail	$166.18 Per Brand Script	$182.47 Per Brand Script	$199.71 Per Brand Script
Mail Order	$443.62 Per Brand Script	$491.43 Per Brand Script	$537.87 Per Brand Script
Specialty	$1,537.77 Per Brand Script	$1,691.54 Per Brand Script	$1,851.37 Per Brand Script

Capitalized terms in the pricing charts above are not intended to reflect defined terms except where specifically noted in the Master Services Agreement (MSA).

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

Terms & Conditions

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

- To the extent the pricing and services outlined in this document are part of a renewal to the Customer, the pricing set forth herein is valid for 90 days from the date of such offer.
- This pricing has an effective date of August 1, 2022. In order for Aetna to implement the pricing as set forth above by the effective date, a notification of award must be given 90 days prior to effective date.
- Our renewal assumes that Aetna administers both the medical and pharmacy benefits for Customer on an integrated basis. If Customer elects to use a different vendor to provide medical benefits, then Aetna reserves the right to adjust the pricing contained in this proposal.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Participating Pharmacy shall give the Plan Participant the benefit of the lesser of (i) the Participating Pharmacy's Usual and Customary Charge, (ii) MAC (where applicable) or (iii) discounted AWP cost. Participating Pharmacy shall collect and retain from the Plan Participant at the time of dispensing the lesser of (i) the Cost Share; (ii) the Participating Pharmacy's Usual and Customary Charge, (iii) MAC (where applicable) or (iv) discounted AWP cost.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
    - Discount and Dispensing Fee guarantees are measured individually and reconciled in the aggregate; surpluses in one or more component guarantees may be used to offset shortages in other component guarantees.
    - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within one

hundred eighty (180) days following the guarantee period.
  - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant 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, limited distribution drug (LDD) Claims, direct Plan Participant reimbursement / out-of- network claims, in-house pharmacy claims, vaccines (including for COVID) and other COVID testing-related Claims. 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 included in the Generic Discount guarantees.
  - Prescriptions dispensed by Participating Specialty Pharmacies are included in the Specialty Pharmacy Discount guarantee listed above. 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.
- Pricing and terms in this proposal assume the Customer has elected the Standard Opt Out formulary.
- The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members.
- Specialty Network means that Plan Participants are required to use the Aetna Specialty Pharmacy after One (1) Fill at a Participating Retail Pharmacy.
- The Overall Effective Discount (OED) offer is conditioned on Aetna being the exclusive provider of Specialty Services with the exception of the HIV class and Client implementing and maintaining a generics first plan design for specialty. Aetna may amend the individual Specialty Drug discounts from time to time to manage the financial guarantee. The financial guarantee is measured and reconciled annually across all Specialty Drugs dispensed by Aetna Specialty pharmacy, including through the Specialty Connect program, with the exception of the following exclusions (in addition to the standard exclusions).
  - New to market Brand Specialty Products
  - Limited distribution drugs
- For the items noted here, the following quoted rates shall apply:
  - New to market Specialty Products: AWP - 15% or MAC, if applicable (until a final price is determined and made available in the next published Specialty Pharmacy Addendum)
  - New to market limited distribution drugs: AWP - 10% (until a final price is determined and made available in the next published Specialty Pharmacy Addendum)
- MAC: Certain dosage forms and strengths may not be included on the MAC list and shall be priced at the specialty default rate.
- In the event retail leakage increases by a percentage change of 10%, or more, from the effective date of the agreement, Aetna reserves the right to amend pricing.
- Our financial offer does not assume any adoption of the Transform Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.
- Rebate guarantees may be subject to:
  - The adoption of Specialty Guideline Management (SGM) program
  - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
- The above rebate guarantees exclude:
  - Over the Counter (OTC) Claims
  - Limited distribution drug (LDD) Claims

  - 340B Claims
  - Compound Drug Claims
  - Paper or Member Submitted Claims
  - Coordination of Benefits (COB) or secondary payor Claims
  - Vaccine (including for COVID) and vaccine administration Claims
  - Other COVID testing-related Claims
  - Biosimilar Claims
  - Claims approved by Formulary Exception
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty rebate guarantees apply to Specialty Product claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:
  - Two-tier qualifying plan designs - will consist of an open plan design, with the first tier comprised of Generic Drugs and the second tier comprised of Brand Drugs. There are no requirements for a minimum Cost Share differential between these tiers. The plan design may need to implement formulary interventions recommended by Aetna.
  - Three-tier non-qualifying plan designs – maintain a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs.
  - Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a $15.00 co-payment differential between preferred and non-preferred Brand Drugs, at least a $15.00 differential in the minimum co- payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).

Additional Disclosures

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

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

1. Greater than 15% change in total membership or Claims volume as compared to the baseline
2. Customer-initiated change to the Benefit Plan Design, or Formulary alignment. To the extent applicable, Aetna will notify Customer in advance of any proposed Equitable Adjustment
3. Unexpected product offering decisions by drug manufacturers including an unexpected launch of a generic product; a brand product unexpectedly converted to OTC status; or the introduction of a lower cost alternative product that replaces an existing rebateable brand product

4. Other events triggering an Equitable Adjustment as detailed below:
    - Legal and/or regulatory changes specific to customers which negatively affects the economic value of the Agreement to a party or the parties under the Agreement, for example restrictions on preferred or limited network arrangements; policy changes impacting drug manufacturers which negatively affect the economic value of the Agreement including the ability to provide or maintain discounts or Rebates; and/or
    - An inability to access, or changes to, industry pricing information (e.g. AWP) required to support the current economic structure of the Agreement.

If one or more of such triggering events occurs, Aetna may initiate a review to determine if an Equitable Adjustment to any of the financial provisions is warranted as a direct result of the triggering event(s).

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

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

Rebate Payment Terms

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

Guaranteed earned Rebates are paid quarterly ninety (90) days after the quarter closes. Rebates are calculated and paid in accordance with the terms and conditions of this Agreement.

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 g b 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.

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

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

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 our Formulary options during the term of the Agreement solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. As such, Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the Plan. Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a result of factors, including but not limited to, market conditions, clinical information, cost, rebates and other factors.

Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

Other Payments

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

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with Customers.

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

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

Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation

for Aetna's efforts in administering the preferred Specialty Products program. Payments or rebates from drug manufacturers that compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder also will be retained by Aetna.

Early Termination

In the event Customer terminates the Agreement on or before July 31, 2023 (an "Early Termination") Aetna shall assess a penalty equal to $521,000. In the event Customer terminates the Agreement between August 1, 2023 and July 31, 2024 (an "Early Termination") Aetna shall assess a penalty equal to

$261,000. In the event Customer terminates the Agreement after August 1, 2024 but prior to July 31, 2025 (an "Early Termination") Aetna shall assess a penalty equal to $130,000. If there is a loss of enrollment greater than 15% after year 1, a partial early termination fee may apply. The partial fee will be calculated by taking the total termination fee divided by the total number of employees initially enrolled multiplied by the number of employees that have left Aetna. The calculation of the termination fee is applicable to subsequent losses of enrollment and not subject to a one-time event.

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

Late Payment Charges

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

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

ii. Late payments of Service Fees: 12.0%, annual rate

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

Pharmacy Audit Rights and Limitations

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the 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 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- 724379
EFFECTIVE August 1, 2022

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

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

I. CLAIM FIDUCIARY

The Customer and Aetna agree that with respect to Section 503 of the Employee Retirement Income Security Act of 1974, as amended, or applicable state law as appropriate, Aetna will be the "appropriate named fiduciary" of the Plan for the 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[SM]** - 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. **Aetna Maternity Program:**
   Through an intensive focus on prevention, early treatment and education, the Aetna 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. Aetna Informed Rewards

Aetna Informed Rewards is a program that rewards members who utilize lower cost providers to receive care for specific medical services. The rewards are provided in the form of an electronic gift card. To qualify for a reward, a member must search, by procedure type, for lower cost providers utilizing Aetna Health.com. The member must opt into the program for the selected procedure prior to receiving care. After the member receives services from one of the lower cost providers identified in Aetna Health, the claim is verified by our vendor, HealthSparq, the reward is paid. Member eligibility and claim data will be provided to HealthSparq to perform initial analysis and reporting for customers who elected the Aetna Informed Rewards program.

16. 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.

17. Aetna Oncology Solutions^{SM}:

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.

18. Lifestyle and Condition Coaching:

Lifestyle and Condition Coaching is part of a population health solution for Employees and their dependents which delivers a holistic, person-centric experience designed to promote healthier and more engaged employees, which in turn, drives improved organizational performance and cost savings.

The total health and well-being of each participant is monitored and analyzed using sophisticated and integrated clinical, consumer, behavioral and predictive analytics. A multi-disciplinary care team and digital toolset, helps participants to achieve their health and well-being goals with personalized support, and education.

The standard Lifestyle and Condition Coaching program offering includes lifestyle and condition management coaching. However, customers who choose to focus on lifestyle only or chronic conditions only may purchase standalone options including:

- Lifestyle and Condition Coaching: Lifestyle coaching
- Lifestyle and Condition Coaching: Condition coaching
- Lifestyle and Condition Coaching: Tobacco cessation

Lifestyle and Condition Coaching uses the Aetna Health Index to quantify the difference between the current and optimal health state for an individual or population. The difference between the current to the optimal health state is then scored and used to spot health improvement opportunities across an integrated health profile (e.g. unresolved Care Considerations, nonadherence to chronic medications, uncontrolled diabetes, at-risk for stroke, low-perception of health, etc.). With this approach, Plan Participants achieve a healthier lifestyle and better manage conditions like heart disease, type 2 diabetes, hypertension and obesity.

19. Member Engagement Platform:

Aetna's member engagement platform provides well-being related digital tools, programs and resources in a new comprehensive online experience designed to promote participant engagement, and includes visuals and graphics that prompt participants' interest and enthusiasm. The platform includes device integration and an online scheduling tool. Optional tools are also available, including the Rewards Center that coordinates incentive administration, and the ActiveChallenges that promote better nutrition, physical activity and weight management through team challenges.

The member engagement platform combines the following components:

- Comprehensive, proprietary health assessment
- Health Report and Health Actions
- Online digital coaching
- Personal Health Record
- Health Decision Support
- Health Trackers
- Health-related videos and online content
- Engaging tools and resources
- Social Communities
- Rewards Center
- ActiveChallenge program (buy-up option)

20. Aetna One® Advocate:

Aetna One® Advocate is a high-touch, high-tech customer service model that combines data driven processes with the expertise of highly-trained advocates. The data that Aetna has about each Plan Participant such as medical claims, lab values, pharmacy data, precertification requests and provider relationships is combined with information from Plan Participants regarding their preferred method of communication (i.e. phone calls, emails, text messages), and the Plan Participant is paired up with an

advocate team. Advocate teams may include concierge-level benefits specialists, nurses, wellbeing professionals, and provider network experts, and are all cross-trained to provide support from benefit questions to complex care management. Advocates also work directly with other internal resources or programs, external vendors and network providers to support Plan Participant and their families.

V. BEHAVIORAL HEALTH SERVICES

1. Managed Behavioral Health:

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

- Inpatient Care Management provides phone-based utilization review of inpatient behavioral health (mental health and chemical dependency) admissions intended to contain confinements to appropriate lengths, assure medical necessity and appropriateness of care, and control costs. Inpatient Care Management provides precertification, concurrent review and discharge planning of inpatient behavioral health admissions. These services also include identification of Plan Participants for referral to a Behavioral Health Condition Management program.

- Outpatient Care Management includes precertification on a limited number of selected services. Where precertification is required, the request for services is reviewed against a set of criteria established by clinical experts and administered by trained staff, in order to determine coverage of the proposed treatment. Where precertification is not required, cases are identified for Outpatient Case Management through the application of clinical algorithms.

2. Behavioral Health Condition Management

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

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

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

3. AbleTo

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

consists of therapists and behavioral health coaches. Each web-based videoconferencing session, online interface or telephone support session, is subject to Plan terms applicable to a behavioral health office visit, including cost share, deductible, etc.

VI. TECHNOLOGY/WEB TOOLS

1. Online Provider Directory:

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

2. Secure Member Portal:

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

3. 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 secure member portal 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^{SM} incentive tracking is available for program completion in the premium option.

4. Metabolic Health in Small Bytes:

Metabolic Health in Small Bytes is a program promoting metabolic syndrome risk reduction and reversal. This program targets the root cause of obesity by using a holistic approach (mental, emotional, and physiological) to help Employees identify underlying reasons for their weight and what barriers may exist which impede weight loss. Classes are taught live in an online virtual classroom. The program is available in multiple formats for convenience and engagement.

5. Aetna Second Opinion:

Aetna Second Opinion, powered by 2nd.MD is a virtual program that provides access to skilled medical specialists who are under contract with our vendor 2nd.MD, to provide advice and second opinions. 2nd.MD has a dedicated 1-800 telephone number, online portal and integrated app. The medical specialists made available through the 2nd.MD program are independent contractors and are neither employees nor agents of 2nd.MD or Aetna. 2nd.MD supports a Plan Participant by onboarding the Plan Participant and assigning them a nurse coordinator, vetting the appropriateness of their second opinion request, connecting the Plan Participant with a 2nd.MD medical specialist based on the Plan Participant’s condition, obtaining all relevant medical records and digitizing, and coordinating the consultation and follow-up. On average, 2nd.MD can provide a plan participant with a second opinion within three days.

VII. OTHER SERVICES

1. Teladoc:

Teladoc is a vendor that provides access to providers who are under contract with Teladoc, to provide consultations for non-urgent care needs by telephone. The providers 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**") begins the session by learning about the employee so that he can tailor his approach and content to the needs of the individual. ALEX uses plain language to ask questions about topics such as family status, dependents, health care needs, lifestyle, financial status and risk tolerance – all the while avoiding insurance jargon often associated with choosing a benefits plan. The online and mobile-friendly experience includes audio, on-screen text and animations to ensure an engaging, personalized interaction.

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's secure member portal.

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:

Aetna's Mindfulness at Work program is an evidence-based mind-body solution that targets Employees with stress. The program teaches evidence-based stress management skills, including mindfulness awareness, breathing techniques and emotions management. Classes are taught live in an online virtual classroom. The program is available in multiple formats for convenience and engagement.

6. **eM Life:**
   The eM Life platform offers daily, live short-form classes, an on-demand library of audio and video content, working memory game, well-being articles, meditation timer, and an annual engagement campaign. Available via web browser and mobile devices.

7. **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.

8. **Peerfit®:**
   Aetna has contracted with a vendor, Peerfit®, to provide a fitness program. Customers buy access to the platform for their employees by sponsoring the program. The program would give each employee a designated amount of standard fitness classes per month in the form of a credit allowance. These credits would be distributed to Employees via the Peerfit site. These Employees would sign in to the site and look for classes or fitness activities within a network of boutique fitness studios in their area, which would be paid for with the program credit allowance. Employees can try fitness classes without the burden of a long term commitment or contract. Any unused credits are forfeited at the end of the month, but are replenished to the designated number of credits for use in the next month.

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

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

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

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

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

Subrogation/reimbursement recoveries will be credited to the Customer net of fees charged by Aetna.

Aetna does not credit individual Plan Participant claims for subrogation/reimbursement recoveries.

The Customer must notify Aetna should the Customer pursue, recover by settlement or otherwise waive any subrogation/ reimbursement claim, or instruct Aetna to cease pursuit of a potential subrogation claim.

Aetna will be entitled to the subrogation/reimbursement fee, which will be calculated based on the full amount of claims paid at the time the Customer settles the file or instructs Aetna to cease pursuit.

The Customer must notify Aetna of its election to terminate the subrogation/reimbursement services provided by Aetna. All claims identified for potential subrogation/reimbursement recovery prior to the date notification of such election is received, including both open subrogation files and matters under investigation, shall be handled to conclusion by Aetna and shall be governed by the terms of this provision.

Aetna does not handle new subrogation/reimbursement cases on matters identified after the Customer's termination date.

11. National Advantage Program (NAP):

There are three components to NAP: Contracted Rates (with or without Professional Claims Repricing), Facility Charge Review and Itemized Bill Review. Plans enrolled in NAP automatically have access to NAP's Contracted Rates component. The Contracted Rates component also includes Professional Claims Repricing, if warranted, based on the plan's out-of-network rate structure. Plans enrolled in the Contracted Rates component have two optional components that are available: Facility Charge Review and Itemized Bill Review. Unless otherwise agreed in writing, only the NAP components selected by the Customer in the Service and Fee Schedule will be provided by Aetna.

A. Contracted Rates Component

Through the Contracted Rates component of NAP, Aetna either contracts with third-party vendors to access their contracted rates with providers (a "**Vendor Accessed Rate**"), or directly contracts with providers (a "**Directly Contracted Rate**") (collectively, a "**Pre-Negotiated Contracted Rate**") 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**"). An Aetna Directly Contracted Rate is applied to a claim first, if available (for example, a Directly Contracted Rates is typically applicable for indemnity plans and narrow-network arrangements). If a Directly Contracted Rate is not available, an external vendor looks for a Vendor Accessed Rate based on a preset hierarchy of vendor contracted networks. Providers with Pre-Negotiated Rates are collectively referred to as "**NAP Providers**."

When a Pre-Negotiated Contracted Rate is applied to a claim, the provider is contractually bound not to balance bill Plan Participants. To limit balance billing for Plan Participants, the Pre-Negotiated Contracted Rate will apply even if that 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**").

For Voluntary Out-of-Network Claims, allowed amounts will be based upon the Contracted Rates component, as available, or a percentage of Medicare rates. If a Medicare or analogous rate is not available, the claim will be referred for an Ad Hoc Rate or Facility Charge Review (as described below), as applicable. For Involuntary Out-of-Network Claims, all aspects of the Contracted Rates component will apply.

B. Facility Charge Review ("FCR") Component

FCR applies to inpatient and outpatient facility claims for which a Pre-Negotiated Contracted Rate is not available and for which the claim amount exceeds a certain threshold as determined by Aetna. Through the FCR component, Aetna establishes a charge for a Plan benefit in the geographic area where such benefit was provided to the Plan Participant ("**Recognized Charge**"). The Recognized Charge is based on the provider's estimated cost, including an anticipated profit margin. The claim will be priced based on the Recognized Charge. Even with FCR, if a provider refuses to agree to a negotiated rate, claims may be priced at billed charges in certain circumstances.

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) NAP Fees

(a) The Customer's fees for the NAP program are charged as a percentage of the Savings achieved for a claim paid under NAP ("**NAP Fee**"), as described in the Service and Fee Schedule. For purposes of calculating the NAP Fee, the following definitions shall apply:

- "**Savings**" means the difference between (i) the Reference Price, and (ii) the NAP priced amount.

- "**Reference Price**" means (i) for Involuntary Out-of-Network Claims, the amount billed by the provider for the covered service; (ii) for Voluntary Out-of-Network Claims, the benefit level set forth under the Plan; and (iii) 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.

(b) The Customer will not owe any NAP Fees with respect to amounts that are the financial responsibility of Aetna, such as when Aetna writes stop loss insurance and the individual or aggregate limit, as applicable, is reached.

(c) If Aetna pays more than the Reference Price, the Savings will be defined as zero.

(d) NAP Fees will be credited back to the Customer for any Savings subsequently reduced or eliminated for which the Customer has already paid a NAP Fee.

(e) Aetna will provide a quarterly report of Savings and NAP Fees. NAP Fees may be included with claims in other reports.

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

(iii) Customer Acknowledgements
Customer acknowledges that:
(a) Aetna does not credential, monitor or oversee those providers who participate through Vendor Accessed Rates. NAP Providers participating in the Contracted Rates component may not necessarily be available or convenient.

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

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

(iv) General Provisions
(a) Aetna's only liability to the Customer for any loss of access to a discount arising under or related to NAP, regardless of the form of action, shall be limited to the NAP Fee actually paid to Aetna by the Customer for services rendered. Any performance standards agreed

to by Aetna and set forth in the Agreement are not affected by this provision and shall remain in effect.

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

PRESCRIPTION DRUG SERVICES SCHEDULE
TO THE MASTER SERVICES AGREEMENT- 724379
EFFECTIVE August 1, 2022 ("Schedule Effective Date")

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 Prescription Drug Service and Fee Schedule (as modified by Aetna from time to time pursuant to section 4, Service Fees, of the Agreement) will be provided or arranged by Aetna through its affiliate, CVS Caremark. 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 Other 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 Customer has chosen to support the external review process through the use of their own vendors. If Aetna makes the final level internal review decision, Aetna will direct the Plan Participant to the Customer for external review requests. If the Customer makes the final level internal appeal decision, the Customer will direct the Plan Participant as to how and when to file an external review request.

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:

"AWP" means the "average wholesale price" for a standard package size of a Prescription Drug from the most current pricing information provided to us by Medi-Span Master Drug Database (MDDB) (with supplements) or any other nationally available reporting service of pharmaceutical prices as selected by us. We use a single data reporting source for determining a Customer's AWP pricing. The standard

package size applicable to a Mail Order Pharmacy shall mean the actual package size dispensed. The standard package size applicable to a Participating Retail Pharmacy shall be the actual package size dispensed as reported by the Participating Retail Pharmacy to CVS Caremark.

"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.

"Biosimilar Drug" means a type of biological product that is approved by the FDA, that is highly similar to a biological product already approved by the FDA notwithstanding minor differences in clinically inactive components, and that there are no clinically meaningful differences between the biologic product and the reference product in terms of the safety, purity, and potency of the product.

"Brand Drug" shall mean, consistent with the drug classification under the Agreement, drugs or devices for which the Medi-Span Multisource Code field contains "M" (co-branded product), or "N" (single source brand), or "O" (originator). In limited circumstances, we may preserve the generic status of a product and override the M, N, or O indicators and deem the drug to be a Generic Drug through review of additional information such as: (a) Multisource code; (b) FDA Application Data (NDA/ANDA); (c) Medispan Brand Name Code; (d) Medispan Labeler Code; (e) Medispan FDA Reference Listed (Orange Book) and (f) price, and may alter the classification so as to classify the drug as a Generic Drug based on the above criteria.

"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" shall mean, consistent with the drug classification under the Agreement, drugs or devices for which the Medi-Span Multisource Code field contains a "Y" (generic). In limited circumstances, we may preserve the generic status of a product and override the M, N, or O indicators and deem the drug to be a Generic Drug through review of additional information such as: (a) Multisource code; (b) FDA Application Data (NDA/ANDA); (c) Medispan Brand Name Code; (d) Medispan Labeler Code; (e) Medispan FDA Reference Listed (Orange Book) and (f) price, and may alter the classification so as to classify the drug as a Generic Drug based on the above criteria

"House or Authorized Generic Drug" means a Brand Drug submitted with a Dispense As Written (DAW) code 5 in place of its generic equivalent and where the pharmacy is reimbursed at a Generic Drug rate, including MAC, as applicable. For reconciliation of the mail Generic Drug discount guarantees, the AWP of house generics shall be the average per unit AWP of the generic equivalents, and not the AWP of the Brand Drug.

"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 Pharmacy Fee Schedule

Limited distribution drugs (LDDs) and exclusive distribution drugs
Limited distribution and exclusive distribution Specialty Products are only available through a limited number of pharmacy providers due to exclusive or preferred vendor arrangements with drug manufacturers.

"Mail Order Pharmacy" or "Specialty Pharmacy" means a licensed mail order and specialty pharmacy designated by Aetna to provide or arrange for Covered Services to Plan Participants.

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

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

"National 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, Mail Order Pharmacy or Specialty Pharmacy.

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

"Prescription Drug 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.

"Precertification" means a process under which certain drugs require precertification (prior approval) before Plan Participants can obtain them as a covered benefit. The Aetna's Precertification Unit must

receive prior notification from physicians or their authorized agents requesting coverage for medications on the Precertification List.

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

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

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

"Rebates" means all payments, rebates and other consideration paid, credited or owing to and/or collected by Aetna from CVS Caremark and/or any of their respective affiliates, from any pharmaceutical manufacturer (i) arising from or as a result of the inclusion or exclusion on any Formulary of Covered Services manufactured, sold or distributed by such manufacturer. Rebates shall not include any fees or other compensation paid, credited, or owing by a pharmaceutical manufacturer to Aetna or CVS Caremark or any of their respective affiliates, as applicable, in exchange for the performance or provision of front-end pharmacy or clinical services or activities, including any of the following services and activities: (i) Plan Participant adherence or compliance services, (ii) nursing or other Plan Participant support, (iii) physician or member communication services, (iv) Plan Participant assistance and referrals, (v) product launch and similar support, (vi) equipment replacement services, (vii) clinical and other research or studies, (viii) data and analytics, and (ix) services to ensure the appropriate distribution of high risk biopharmaceuticals.

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

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

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

"Specialty Products" means those injectable and non-injectable Prescription Drugs, other medicines, agents, substances and other therapeutic products that are designated in the Prescription Drug 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 Prescription Drug 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 Prescription Drug 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) Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Mail Order Pharmacy on its internet website and via its member services call center. The Mail Order Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Mail Order Pharmacy generally will require that medications and supplies be dispensed in quantities not to exceed a 90-day supply, unless otherwise specified in the description of Plan benefits. If the

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

(iii) Specialty Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Specialty Pharmacy on its internet website and via its member services call center. The Specialty Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Specialty Pharmacy generally will require that Specialty Products 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 Specialty Pharmacy obtains consent of the Prescriber, the Specialty Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. The Specialty Pharmacy shall make refill reminder services available to Plan Participants. Aetna and/or the Specialty Pharmacy may promote the use of the Specialty Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Specialty Pharmacy's cost, unless otherwise agreed upon by Aetna and the 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") for the Customer to consider and adopt as its Formulary. The Formulary options made available to the Customer will be determined and communicated by Aetna prior to the implementation date. The Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted the 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 members. As such, the 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. The

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. The Customer agrees that any proposed additions and/or deletions to the Formulary will be adopted by the plan sponsor as a matter of the plan sponsor's plan design, and that the Customer has the right to elect to not implement any such addition or deletion, which such election shall be considered a Customer change to the Formulary **subject to Aetna's ability to operationally administer such election and, if so, Aetna's reservation of right to make appropriate and equitable financial changes resulting therefrom**. The 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.

(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) Drug Savings Review. If purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule, Aetna shall administer the Drug Savings Review. Drug Savings Review programs use a rapid Retrospective DUR approach. Claims are systematically analyzed, within 72 hours of adjudication, for possible physician outreach based on program algorithms. The specific outreach programs are designed to promote quality, cost-effective care in accordance with accepted clinical guidelines through mailings or telephone calls to physicians.

Drug Savings Review will analyze Claims on a daily basis, identify potential opportunities for quality and cost improvements, and will notify physicians of those opportunities. The physician based programs will identify:

- Certain medications that may duplicate each other's effect;
- Certain drug to drug interactions; and
- Prescriptions for a multiple daily dose when symptoms might be controlled with a once-daily dosing

(vi) Pharmacy Advisor Program. Aetna shall implement and administer as specified in the description of Plan benefits the Pharmacy Advisor Program which focuses on improving adherence, reducing costs and closing gaps in care in targeted conditions where adherence is critical, such as diabetes, asthma and heart failure. Identifying members with such targeted conditions will enable the Pharmacy Advisor Program to alert and provide pharmacists at local Participating Retail Pharmacies with information that will be helpful in their treatment. Effective January 1, 2022, the Pharmacy Advisor Program will be available only if purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule.

(vii) Aetna Healthy Actions℠ Rx Savings. If purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule, the Aetna Healthy Actions Rx Savings program helps to reduce a Plan Participant's cost share for certain prescription drugs and can include outreach to Plan Participants and prescribing

doctor to help promote adherence. It targets drugs for which compliance has been found to be most critical to realize cost savings for Plan Participants and plan sponsors. The targeted drugs treat certain chronic conditions such as diabetes, hypertension, and asthma.

(viii) Choose Generics Program. If purchased by the Customer as indicated on the Fee Schedule, the Choose Generics Program is an option that encourages Plan Participants to receive Brand Drugs rather than their generic equivalent. Under this program, Plan Participants can choose to obtain the Brand Drug at a higher than normal cost (subject to the exceptions described in the paragraph immediately below). Such higher cost will be equal to the Cost Share for the Brand Drug plus the difference in the cost between the Brand Drug and its generic equivalent. The cost differential is not applied to the Plan Participant's deductible.

If no generic equivalent medication or corresponding MAC amount is available or the prescriber has written "dispense as written" on the prescription order, the cost differential described above is not applied to the higher cost. In some instances, a Brand Drug is not eligible for a corresponding MAC amount due to Formulary and/or Rebate contract requirements that prohibit application of "member pay the difference" logic or mandate minimum copay steerage levels. In other instances, a Brand Drug may not be eligible for a corresponding MAC amount due to supply and/or pricing considerations.

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 the Secure Member Portal and Aetna Website.

Through the Secure Member Portal, Plan Participants have access to the Aetna website and Aetna Health mobile app. Plan Participants have access to the following:

- Estimating the cost of Prescription Drugs (Price a Drug^{SM}).
- Prescription Comparison Tool – Compares the estimated cost of filling prescriptions at a Participating Retail Pharmacy to the Mail Order Pharmacy mail-order prescription service.
- Aetna Formulary – Available for Plan Participants who wish to review prescribed medications to verify if any additional coverage requirements apply.
- View drug alternatives for medications not on the Preferred Drug List.

- Claim information and EOBs.

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 CVS Caremark 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. CVS Caremark may share these Rebates with Aetna. 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 Prescription Drug 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 CVS Caremark 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 vary based on several factors, including the volume of utilization, benefit plan design, and Formulary or preferred coverage terms. CVS Caremark may share these rebates with Aetna. 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 receives Rebates from CVS Caremark. The amount of Rebates will be determined in accordance with the terms set forth in the Customer's Prescription Drug 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 Prescription Drug 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 CVS Caremark are terminated or modified in whole or in part; or (c) the Rebates actually received by Aetna from CVS Caremark 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 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 Rebates. These payments are generally for one of three purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data, (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and Plan Participants about clinical guidelines, disease management and other effective therapies, or (iii) to compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder. These payments are not considered as Rebates and are not included in rebate sharing arrangements with plan sponsors, including without limitation, Customer

CVS Caremark may also receive network transmission fees from its network pharmacies for services it provides for them. These amounts are not considered rebates and are not shared with plan sponsors. These amounts are also not considered part of the calculation of claims expense for purposes of discount guarantees.

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

These other payments are unrelated to the Prescription Drug Formulary Rebate arrangements, and serve educational as well as other functions. Consequently, these payments are not considered Rebates, and are not included in the Rebates provided to 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 CVS Caremark and Prescription Drug manufacturers. Consequently, a Prescription Drug may be included on the Formulary that is more expensive than a non-Formulary alternative before any Rebates Aetna may receive from CVS Caremark are taken into account. In addition, certain Prescription Drugs may be chosen for Formulary status because of their clinical or therapeutic advantages or level of acceptance among physicians even though they cost more than non-Formulary alternatives. The net cost to the Customer for Covered Services will vary based on: (i) the terms of CVS Caremark's arrangements with Participating Pharmacies; (ii) the amount of the Cost Share obligation under the terms of the Plan; and (iii) the amount, if any, of Rebates to which the Customer is entitled under this Schedule and Prescription Drug 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 charged to Aetna by CVS Caremark may be more than the negotiated Participating Pharmacy payment rate charged to Aetna by CVS Caremark for the non-Formulary Prescription Drug; and (ii) Rebates received by Aetna from CVS Caremark are not reflected in the cost of a Prescription Drug obtained by a Plan Participant.

4. The Customer acknowledges that Aetna contracts with Participating Retail Pharmacies through CVS Caremark to provide the Customer and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna or CVS Caremark for Covered Services dispensed by Participating Retail Pharmacies can vary from one pharmacy product, plan or network to another.

Under this Schedule and Prescription Drug 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 CVS Caremark for Covered Services dispensed by the Participating Retail Pharmacy. Where the uniform price exceeds the actual price negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by the Participating Retail Pharmacy, Aetna realizes a positive margin. In cases where the uniform price is lower than the actual price negotiated and paid by Aetna to CVS Caremark for Covered Services dispensed by the Participating Retail Pharmacy, 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 CVS Caremark, Aetna retains the benefit of the use of the funds between these payments.

5. The Customer acknowledges that Aetna generally pays CVS Caremark for Brand Drugs dispensed by Participating Pharmacies whose patents have expired and their Generic Drug equivalents at a single, fixed price established by Aetna (Maximum Allowable Cost or MAC). MAC pricing is designed to help promote appropriate, cost-effective dispensing by encouraging Participating Pharmacies to dispense equivalent Generic Drugs where clinically appropriate. When a Brand Drug patent expires and one or more generic alternatives first become available, the price for the Generic Drug(s) may not be significantly less than the price for the Brand Drug. Aetna reviews the drugs to determine whether to pay CVS Caremark based on MAC or on a discounted fee-for-service basis, typically a percentage discount off of the listed Average Wholesale Price of the drug (AWP Discount). This determination is based in part on a comparison under both the MAC and AWP Discount methodologies of the relative pricing of the Brand and Generic Drugs, taking into account any Rebates Aetna may receive from CVS Caremark in connection with the Brand Drug. If Aetna determines that under AWP Discount pricing the Brand Drug is less expensive (after taking into account manufacturer Rebates Aetna receives) than the generic alternative(s), Aetna may elect not to establish a MAC price for such Prescription Drugs and continue to pay CVS Caremark according to an AWP Discount.

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

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 Prescription Drug 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 CVS Caremark for Covered Services dispensed by Participating Pharmacies, (b) paid Rebates in accordance with this Schedule and the

Prescription Drug 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 Prescription Drug 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 Prescription Drug 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 Prescription Drug 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- 724379
EFFECTIVE August 1, 2022

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.

Attachment A

Supplemental Terms and Conditions

The Awarded Respondent (hereinafter "Supplier") agree as set forth below:

A. Indemnification and Hold Harmless

To the maximum extent permitted by Florida law, in addition to Supplier's obligation to provide pay for and maintain insurance as set forth elsewhere in this Term of Award, Supplier will indemnify and hold harmless the Authority, its members, officers, agents, employees, and volunteers from any and all liabilities, suits, claims, procedures, liens, expenses, losses, costs, fines and damages (including but not limited to claims for attorney's fees and court costs) caused in whole or in part by the:

1. presence on, use or occupancy of Authority property;
2. acts, omissions, negligence (including professional negligence and malpractice), errors, recklessness, intentional wrongful conduct, activities, or operations;
3. any breach of the terms of this Term of Award;
4. performance, non-performance or purported performance of this Term of Award;
5. violation of any law, regulation, rule, Advisory Circular or ordinance;
6. infringement of any patent, copyright, trademark, trade dress or trade secret rights; and/or
7. contamination of the soil, groundwater, surface water, storm water, air or the environment by fuel, gas, chemicals or any other substance deemed by the Environmental Protection Agency or other regulatory agency to be an environmental contaminant

by the Supplier or the Supplier's officers, employees, agents, volunteers, subcontractors, invitees, or any other person directly or indirectly employed or utilized by the Supplier, regardless of whether the liability, suit, claim, lien, expense, loss, cost, fine or damages is caused in part by an indemnified party. This indemnity obligation expressly applies, and shall be construed to include, any and all claims caused in part by negligence, acts or omissions of the Authority, its members, officers, agents, employees, and volunteers, however, Supplier is only responsible to Authority for the portion of such claims that are directly attributable to Supplier's acts or omissions.

In addition to the duty to indemnify and hold harmless, Supplier will have the separate and independent duty to defend the Authority, its members, officers, agents, employees, and volunteers from all suits, claims, proceedings or actions of any nature seeking damages, equitable or injunctive relief, liens, expenses, losses, costs, royalties, fines, attorney's fees or any other relief in the event the suit, claim, or action of any nature arises in whole or in part from the:

1. presence on, use or occupancy of Authority property;
2. acts, omissions, negligence (including professional negligence and malpractice), errors, recklessness, intentional wrongful conduct, activities, or operations;
3. any breach of the terms of this Term of Award;
4. performance, non-performance or purported performance of this Term of Award;
5. violation of any law, regulation, rule, Advisory Circular or ordinance;
6. infringement of any patent, copyright, trademark, trade dress or trade secret rights; and/or
7. contamination of the soil, groundwater, surface water, storm water, air or the environment by fuel, gas, chemicals or any other substance deemed by the Environmental Protection Agency or other regulatory agency to be an environmental contaminant

by the Supplier or the Supplier's officers, employees, agents, volunteers, subcontractors, invitees, or any other person directly or indirectly employed or utilized by the Supplier regardless of whether it is caused in part by the Authority, its members, officers, agents, employees, or volunteers. This duty to defend exists immediately upon presentation of written notice of a suit, claim or action of any nature to the Supplier by a party entitled to a defense hereunder. This defense obligation expressly applies, and shall be construed to include, any and all claims caused by the negligence, acts or omissions, of the Authority, it's members, officers, agents, employees and volunteers.

If the above indemnity or defense provisions or any part of the above indemnity or defense provisions are limited by Fla. Stat. § 725.06(2)-(3) or Fla. Stat. § 725.08, then Supplier agrees to the following:

To the maximum extent permitted by Florida law, Supplier will indemnify and hold harmless the Authority, its members, officers, agents, employees, and volunteers from any and all liabilities, damages, losses, and costs, including, but not limited to, reasonable attorneys' fee, to the extent caused by the negligence, recklessness, or intentional wrongful conduct of the Supplier and persons employed or utilized by the Supplier in the performance of this Term of Award.

If the above indemnity or defense provisions or any part of the above indemnity or defense provisions are limited by Fla. Stat. § 725.06(1) or any other applicable law, the monetary limitation on the extent of the indemnification shall be the greater of the (i) monetary value of this Term of Award, (ii) coverage amount of Commercial General Liability Insurance required under this Term of Award, or (iii) $1,000,000.00. Otherwise, the obligations of this Article will not be limited by the amount of any insurance required to be obtained or maintained under this Term of Award.

In addition to the requirements stated above, to the extent required by FDOT Public Transportation Grant Agreement and to the fullest extent permitted by law, the Supplier shall indemnify and hold harmless the State of Florida, FDOT, including the FDOT's officers and employees, from liabilities, damages, losses and costs, including, but not limited to, reasonable attorney's fees, to the extent caused by the negligence, recklessness or intentional wrongful misconduct of the Supplier and persons employed or utilized by the Supplier in the performance of this Term of Award. This indemnification in this paragraph shall survive the termination of this Purchase Order. Nothing contained in this paragraph is intended to nor shall it constitute a waiver of the State of Florida's and FDOT's sovereign immunity.

Supplier's obligations to defend and indemnify as described in this Article will survive the expiration or earlier termination of the Term of Award until it is determined by final judgment that any suit, claim or other action against the Authority, its members, officers, agents, employees, and volunteers is fully and finally barred by the applicable statute of limitations or repose.

Nothing in this Article will be construed as a waiver of any immunity from or limitation of liability the Authority, or its members, officers, agents, employees, and volunteers may have under the doctrine of sovereign immunity under common law or statute.

The Authority and its members, officers, agents, employees, and volunteers reserve the right, at their option, to participate in the defense of any suit, without relieving Supplier of any of its obligations under this Article however, Supplier shall provide and control the defense and settlement with respect to claims to which its indemnification obligation applies.

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If this Article or any part of this Article is deemed to conflict in any way with any law, the Article or part of the Article will be considered modified by such law to remedy the conflict.

B. Warranty of Services

Supplier warrants that the services performed under this Term of Award will be in accordance with the highest applicable professional or industry standards, first quality workmanship, and on-time as specified in the project schedule.

C. Non-Discrimination

During the performance of these services, the Supplier, for itself, its assignees and successors in interest, agrees as follows:

1. The Supplier will comply with the regulations relative to non-discrimination in federally assisted programs of the Department of Transportation (DOT) Title 49, Code of Federal Regulations, Part 21, as amended from time to time (hereinafter referred to as the Regulations), which are incorporated herein by reference and made a part of this Term of Award.

2. Civil Rights. The Supplier, with regard to the work performed by it under this Term of Award, will not discriminate on the grounds of race, color, or national origin in the selection and retention of subcontractors, including procurements of materials and leases of equipment. The Supplier will not participate directly or indirectly in the discrimination prohibited by the Acts and the Regulations, including employment practices when the Term of Award covers any activity, project, or program set forth in Appendix B of 49 CFR Part 21. During the performance of this Purchase Order, the Supplier, for itself, its assignees, and successors in interest agrees to comply with the following non-discrimination statutes and authorities, including but not limited to:
    a. Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq., 78 stat. 252), (prohibits discrimination on the basis of race, color, national origin);
    b. 49 CFR part 21 (Non-discrimination In Federally-Assisted Programs of The Department of Transportation—Effectuation of Title VI of The Civil Rights Act of 1964);
    c. The Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, (42 U.S.C. § 4601), (prohibits unfair treatment of persons displaced or whose property has been acquired because of Federal or Federal-aid programs and projects);
    d. Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794 et seq.), as amended, (prohibits discrimination on the basis of disability); and 49 CFR Part 27;
    e. The Age Discrimination Act of 1975, as amended, (42 U.S.C. § 6101 et seq.), (prohibits discrimination on the basis of age);
    f. Airport and Airway Improvement Act of 1982, (49 USC § 471, Section 47123), as amended, (prohibits discrimination based on race, creed, color, national origin, or sex);
    g. The Civil Rights Restoration Act of 1987, (PL 100-209), (Broadened the scope, coverage and applicability of Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973, by expanding the definition of the terms “programs or activities” to include all of the programs or activities of the Federal-aid recipients, sub-recipients and contractors, whether such programs or activities are Federally funded or not);
    h. Titles II and III of the Americans with Disabilities Act of 1990, which prohibit discrimination on the basis of disability in the operation of public entities, public and private transportation systems, places of public accommodation, and certain testing entities (42 U.S.C. §§ 12131 – 12189) as implemented by Department of Transportation regulations at 49 CFR parts 37 and 38;
    i. The Federal Aviation Administration’s Non-discrimination statute (49 U.S.C. § 47123) (prohibits discrimination on the basis of race, color, national origin, and sex);
    j. Executive Order 12898, Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations, which ensures nondiscrimination against minority populations by discouraging programs, policies, and activities with disproportionately high and adverse human health or environmental effects on minority and low-income populations;
    k. Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency, and resulting agency guidance, national origin discrimination includes discrimination because of limited English proficiency (LEP). To ensure compliance with Title VI, the Supplier must take reasonable steps to ensure that LEP persons have meaningful access to the Supplier’s programs (70 Fed. Reg. at 74087 to 74100); and
    l. Title IX of the Education Amendments of 1972, as amended, which prohibits the Supplier from discriminating because of sex in education programs or activities (20 U.S.C. 1681 et seq).
3. In all solicitations either by competitive bidding or negotiation made by the Supplier for work to be performed under a subcontract, including procurement of materials or leases of equipment, each potential subcontractor or supplier must be notified by the Supplier of Supplier’s obligations under this Term of Award and the Regulations relative to nondiscrimination on the grounds of race, color or national origin.
4. The Supplier will provide all information and reports required by the Regulations or directives issued pursuant thereto and must permit access to its books, records, accounts, other sources of information and its facilities as may be determined by the Authority or the Federal Aviation Administration (FAA) to be pertinent to ascertain compliance with such Regulations, orders and instructions. Where any information required of the Supplier is in the exclusive possession of another who fails or refuses to furnish this information, the Supplier will so certify to the Authority or the FAA, as appropriate, and will set forth what efforts it has made to obtain the information.

5. In the event of the Supplier's non-compliance with the non-discrimination provisions of this Term of Award, the Authority will impose such contractual sanctions as it or the FAA may determine to be appropriate, including, but not limited to, withholding of payments to the Supplier under this Term of Award until the Supplier complies, and/or cancellation, termination or suspension of this Term of Award, in whole or in part.
6. The Supplier will include the provisions of Paragraph C, Non-Discrimination, Items 1 through 5 above in every subcontract and subconsultant contract, including procurement of materials and leases of equipment, unless exempt by the Regulations or directives issued pursuant thereto. The Supplier will take such action with respect to any subcontract or procurement as the Authority or the FAA may direct as a means of enforcing such provisions, including sanctions for non-compliance. Provided, however, that in the event the Supplier becomes involved in or is threatened with litigation with a subcontractor or supplier as a result of such direction, the Supplier may request the Authority to enter into such litigation to protect the interests of the Authority and, in addition, the Supplier may request the United States to enter into such litigation to protect the interests of the United States.
7. The Supplier assures that, in the performance of its obligations under this Term of Award, it will fully comply with the requirements of 14 CFR Part 152, Subpart E (Non-Discrimination in Airport Aid Program), as amended from time to time, to the extent applicable to the Supplier, to ensure, among other things, that no person will be excluded from participating in any activities covered by such requirements on the grounds of race, creed, color, national origin, or sex. The Supplier, if required by such requirements, will provide assurances to the Authority that the Supplier will undertake an affirmative action program and will require the same of its subconsultants.

D. Compliance
1. Supplier shall be subject to and in compliance with all Rules and Regulations, Policies, Standard Procedures and Operating Directives of the Authority.
2. Supplier shall have in its possession all applicable permits or licenses that may be required by federal, state, or local law to furnish goods, materials, machinery, apparatus or services required under the scope of this Term of Award.
3. Supplier shall be subject to and in compliance with all federal, state, or local law in the performance of this Term of Award.

E. Accounting Records and Audit Requirements
1. Books and Records
In connection with payments to Supplier under this Term of Award, it is agreed Supplier will maintain full and accurate books of account and records customarily used in this type of business operation, in conformity with Generally Accepted Accounting Principles (GAAP). Supplier will maintain such books and records for five years after the end of the term of this Term of Award. Supplier will not destroy any records related to this Term of Award without the express written permission of the Authority.
2. Financial Reports
Supplier will submit all financial reports required by Authority, in the form and within the time period required by Authority.
3. Overpayment Recovery and the Authority's Right to Perform Claim Audits, Inspections, or Attestation Engagements
(i) Overpayment Recovery. Supplier shall reprocess any identified errors in Plan benefit payments (other than errors Aetna reasonably determines to be *de minimis*, such amount is currently $15, but may be subject to future adjustments) and seek to recover any resulting overpayment by attempting to contact the party receiving the overpayment twice by letter, phone, or email. The Authority may direct Supplier not to seek recovery of overpayments from Plan Participants, in which event Supplier will have no further responsibility with respect to those overpayments. The Authority shall reasonably cooperate with Supplier in recovering all overpayments of Plan benefits. If a third-party recovery vendor, collection agency, or attorney is used to pursue the recovery, the overpayment recoveries will be credited to the Authority net of fees charged by Supplier or those entities (unless such overpayment was caused solely by Supplier as a result of Supplier's breach of its standard of care).

Any requested payment from Supplier relating to an overpayment must be based upon documented findings or direct proof of specific Claims, reasonably agreed to by both parties, and must be due to Supplier'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.

When seeking recovery of overpayments from a provider, Supplier has established the following process: if it is unable to recover the overpayment through other means, Supplier shall use its reasonable best efforts to offset one or more future payments to that provider for services rendered to Plan Participants by an amount equal to the prior overpayment. Supplier may also 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 Supplier) by the amount of the overpayment, and Supplier will credit the recovered amount to the plan that overpaid the provider. The Authority's right to recover overpayments shall be governed by this process and it has no right to recover any specific overpayment from a network provider, unless otherwise provided for in this Term of Award.

(ii) Claim Audits. The Authority, or its duly authorized representative, will be permitted, at its own expense, to initiate and perform Plan claim transaction audits upon reasonable advance notice to Supplier (a complete listing of the claims chosen for audit must be provided at least four weeks prior to the on-site portion of the audit). The Authority may conduct one audit per year and the audit must be completed within two years of the end of the time period being audited provided, however, Supplier will run impact reports to address systemic issues identified during such audit. Audits of any performance guarantees, if applicable, must be completed in the year following the period to which the performance guarantee results apply. The Authority will pay Supplier a fee for audits of a sample size in excess of 250 claim transactions or that cannot be completed within a five-day period onsite. Audits must be performed at the Florida location where the Authority's claims are processed or remotely by electronic means if available.

The Authority 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 Supplier, (ii) has terminated from Supplier or any of its affiliates within the past 12 months, or (iii) is affiliated with a vendor subcontracted by Supplier to adjudicate claims. If the audit firm or Authority's Internal Audit staff 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 Supplier's standards for professionalism by signing Supplier'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 Authority shall provide reasonable advance notice of its intent to audit and shall complete an Audit Request Form providing information reasonably requested by Supplier. No audit may commence until the Audit Request Form is completed and executed by the Customer, the auditor and Supplier. Further, the Authority or its representative shall provide Supplier with a complete listing of the claims chosen for audit at least four weeks prior to the on-site portion of the audit.

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

(iii) Compliance Inspections/Attestation Engagements. The Authority, or its duly authorized representative, will have the right to inspection (at the Authority's expense) Supplier's records directly pertaining to Supplier's performance under this Award (the "Records") for the sole purpose of determining compliance with this Term of Award, and to request annual attestations of compliance with any or all terms of the Award. When conducting an inspection, Supplier will grant Authority reasonable access to examine the Records and Supplier's processes, facilities and systems for compliance with the terms of this Award. Except as otherwise permitted by law, the parties agree that: (a) such inspection may only occur during normal business hours at the locations where Supplier's personnel provide Services or retain such Records, and only after 20 business days' advance notice; (b) inspections will be conducted in a manner that is designed to minimize any adverse impact on normal business operations; and (c) any Records accessed by Authority in the performance of any such inspection will be deemed to be the Confidential Information of Supplier except as otherwise determined by applicable law or court order.

If as a result of any onsite claim audit or inspection engagement, it is determined that Supplier has overcharged Authority, Supplier will re-pay Authority for such overcharge discovered during such audit. .

For purposes of determining Supplier's obligations under the section entitled "Overpayment Recovery and the Authority's Right to Perform Claim Audits, Inspections, or Attestation Engagements," the "standard of care" to be applied is the level of reasonable care that a similarly situated services provider would exercise under similar circumstances.

Supplier agrees to deliver or provide access to all records requested by Authority auditors within fourteen (14) calendar days of the request. The parties recognize that Authority will incur additional costs if records requested by Authority auditors are not provided in a timely manner and that the amount of those costs is difficult to determine with certainty. Consequently, the parties agree that Authority may assess liquidated damages in the amount of one hundred dollars ($100) per day for each record requested that is not received. Such damages may be assessed beginning on the fourteenth (15th) day. Accrual of such damages will continue until specific performance is accomplished. If as a result of any engagement, it is determined that Supplier has overcharged Authority in Premium Payments, Supplier will re-pay Authority for such overcharge and the Authority may assess interest of up to twelve percent (12%) on the overcharge from the date the overcharge occurred. If it is determined that Supplier has overcharged Authority by more than three percent of the reimbursable amount, excluding any lump sum amount, contained in this Term of Award, Supplier will also pay for the entire cost of the engagement.

Supplier agrees to comply with Section 20.055(5), Florida Statutes, and to incorporate in all subcontracts the obligation to comply with Section 20.055(5), Florida Statutes. Supplier will include a provision providing Authority the same access to business records at the subconsultant and subcontractor level in all of its subconsultant and subcontractor agreements executed related to this Term of Award. The requirements of this paragraph are applicable to subcontractors by engaged by Supplier to provide dedicated services to the Authority under this Term of Award.

F. Applicable Law and Venue

This Term of Award will be construed in accordance with the laws of the State of Florida. Venue for any action brought pursuant to this Term of Award will be in the Circuit Court of Hillsborough County, Florida, or in the Tampa Division of the U.S. District Court for the Middle District of Florida. Supplier hereby waives any claim against Authority, and its officers, Board members, agents, or employees, for loss of anticipated profits caused by any suit or proceedings directly or indirectly attacking the validity of this Term of Award or any part hereof, or by any judgment or award in any suit or proceeding declaring this Term of Award null, void, or voidable, or delaying the same, or any part hereof, from being carried out.

G. Dispute Resolution

1. Dispute Resolution
   a. A claim is a written demand or assertion by one of the parties seeking, as a matter of right, an adjustment or interpretation of this Term of Award, payment of money, extension of time or other relief with respect to the terms of this Term of Award. The term claim also includes other matters in question between Authority and Supplier arising out of or relating to this Term of Award. The responsibility to substantiate claims will rest with the party making the claim.
   b. If for any reason Supplier deems that additional cost or time is due to Supplier for work not clearly provided for in this Term of Award, or previously authorized changes in the work, Supplier will notify Authority in writing of its intention to claim such additional cost or time. Supplier will give Authority the opportunity to keep strict account of actual cost and/or time associated with the claim. The failure to give proper notice as required herein will constitute a waiver of said claim.
   c. Written notice of intention to claim must be made within ten (10) days after the claimant first recognizes the condition giving rise to the claim or before the work begins on which Supplier bases the claim, whichever is earlier.
   d. When the work on which the claim for additional cost or time is based has been completed, Supplier will, within ten (10) days, submit Supplier's written claim to Authority. Such claim by Supplier, and the fact that Authority has kept strict account of the actual cost and/or time associated with the claim, will not in any way be construed as proving or substantiating the validity of the claim.
   e. Pending final resolution of a claim, unless otherwise agreed in writing, Supplier will proceed diligently with performance of this Term of Award and maintain effective progress to complete the work within the time(s) set forth in this Term of Award.
   f. The making of final payment for this Term of Award may constitute a waiver of all claims by Authority except those arising from:
      (1) Claims, security interests or encumbrances arising out of this Term of Award and unsettled;
      (2) Failure of the work to comply with the requirements of this Term of Award;
      (3) Terms of special warranties required by this Term of Award;
      (4) Latent defects.
2. Resolution of Claims and Disputes
   a. Authority will review claims and may (1) request additional information from Supplier which will be immediately provided to Authority, or (2) render a decision on all or part of the claim. Authority will notify Supplier in writing of the disposition of the claim within 21 days following the receipt of such claim or receipt of the required additional information.
   b. If Authority decides that the work relating to such claim should proceed regardless of Authority disposition of such claim, Authority will issue to Supplier a written directive to proceed. Supplier will proceed as instructed.

H. Conflict of Interest

Prior to doing business with the Authority and throughout the term of this Term of Award, the Supplier shall notify the Authority if any Supplier's corporate officer or member is related to an Authority employee or member of the Authority Board of Directors.

I. Compliance with Public Records Law

IF THE SUPPLIER HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE SUPPLIER'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS PURCHASE ORDER, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT (813) 870-8721, ADMCENTRALRECORDS@TAMPAAIRPORT.COM, HILLSBOROUGH COUNTY AVIATION AUTHORITY, P.O.BOX 22287, TAMPA FL 33622.

Supplier agrees in accordance with Florida Statute Section 119.0701 to comply with public records laws including the following:

1. Keep and maintain public records required by Authority in order to perform the services contemplated by this Term of Award.
2. Upon request from Authority custodian of public records, provide Authority with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119 Fla. Stat. or as otherwise provided by law.
3. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of this Term of Award Term and following completion of this Term of Award.
4. Upon completion of this Term of Award, keep and maintain public records required by Authority to perform the services. Supplier shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to Authority, upon request from Authority custodian of public records, in a format that is compatible with the information technology systems of Authority.

The Supplier specifically waives any claims against the Authority related to the disclosure of any materials if made under a public records request.

End of Document

aetna™	Customer Audit Request Form (03/2006 version) Approved for Data Release

The following information is furnished in support of your request for an on-site audit of the claim transactions established, held or administered by Aetna Life Insurance Company, or one of its affiliated companies ("Aetna"), in connection with the payment of claims for an employee benefits plan for which Aetna provides certain claim and other services pursuant to Group policy or Administrative Service Contract Number(s):

1. Customer Name

2. Audit Purpose

3. Method of Selection for Audit Sample

Is the audit sample random statistically based? (If so, state the confidence and precision level used.)

Is the audit sample stratified, targeted or focused? (If so, state which method.)

State the location of the office where the audit will take place.

4. Number of Claim Transactions to be Audited and Time Period Being Reviewed

5. Auditors

How many individuals will conduct the proposed audit?	Will Customer personnel alone be involved? ☐ No ☐ Yes	If "No" identify the firm or organization that will be used as Customer's Agent: & list names of auditors who will conduct audit & company employed by. Auditor 1)_____ 2)_____ Employed by: 1)_____ 2)_____

Agent is identified as the firm, individual, or organization responsible for performance of an audit on behalf of Customer. Customer and Agent represent that they are aware of no conflict of interest between Agent(s) designated to perform the work and Aetna that would impair the objectivity of the audit or compromise Aetna's proprietary information. Additionally, Agent or Agent's Auditors may not be compensated on the basis of a contingency fee or a percentage of overpayments identified or recovered. Effective with customer audit requests received April 1, 2002 or later, a customer's request to perform an audit will be declined if the payment for their Agent's (s') services is based on contingency fee payment.

In making this request to perform an audit, Customer and Agent acknowledge that the claim transactions and other information which are the subject of the proposed audit contain Aetna proprietary information and personal and confidential health information (collectively "Confidential Information"), and agree that such information shall not be used or disclosed for any purpose other than that specified in item (2) of this audit request, without the express, written consent of Aetna and any individuals to whom the information pertains or unless required by applicable law and/or court order. Customer represents that Customer has informed its enrollees that Confidential Information may be used in connection with audits through enrollment forms executed by Customer's subscribers. Customer and Agent further represent that the individuals who will conduct the proposed audit on Customer's behalf (i) are qualified by appropriate training and experience for such work, (ii) will perform the audit in accordance with published administrative safeguards, procedures, and applicable law against unauthorized use and disclosure, in the audit report or otherwise, of Confidential

Information, and (iii) will not make or retain any record of or concerning genetic markers or treatment of drug or alcohol abuse, mental/nervous conditions, or AIDS/HIV in connection with the proposed audit. In any event, Customer and Agent shall take any and all other steps reasonably necessary to safeguard Confidential Information against unlawful and unauthorized access, use, and disclosure.

Agent agrees to indemnify, defend, and hold Customer harmless from any actual or threatened legal or administrative action, claim, liability, penalty, fine, assessment, lawsuit, litigation, or other loss, expense or damage, including without limitation reasonable attorneys' fees and costs (together "Liability"), that Customer may incur arising out of or relating to Aetna's release of Confidential Information in connection with the proposed audit, including without limitation any Liability incurred as a result of any breach by Agent of any applicable law, regulation, or other legal mandate or the terms and conditions of this request. Customer and Agent agree that Aetna will have the right to: (a) review a draft of the audit findings and to comment on those findings before they are finalized and presented to the Customer; (b) review the final audit findings and summary; (c) have an exit interview; (d) receive a copy of the final Audit Report; and (e) include with the final Audit Report a supplementary statement containing facts that Aetna considers pertinent to the audit.

The signatures below are the signatures of Customer's and Agent's (s') authorized representatives. It is agreed by signature below that: (a) the audit results/error rates will not be extrapolated for potential financial payment pursuant to the contract, (b) the Agent may perform a stratified statistical audit and as part of the process of completing the calculation for the audit may extrapolate the error rates for each strata in order to present results, (c) the audit will not extend beyond the approved volume unless agreed to in advance by Aetna, (d) if it is agreed by Aetna and Customer that any payment has been made by Aetna to or on behalf of an ineligible person or that more than the appropriate amount has been paid, Aetna shall undertake good faith efforts (defined as 2 written or verbal attempts, and/or Aetna's submittal of the collection effort to its third party collection vendor) to recover the erroneous payment, (e)Customer may not seek collection , or use a third party to seek collection, of overpayments pursuant to the contract.

Customer: Completed by:	Title:	Date:
Agent: Completed by:	Title:	Date:
Aetna: Completed by:	Title:	Date:

Aetna Audit Policy, except as agreed to by Customer and Aetna:

All claims audits must be commenced within two (2) years following the period being audited. Customer's right to audit claims is waived if the audit is not commenced within two (2) years following the period being audited; provided, however, that Aetna does not significantly delay action on the customer's request to commence the audit during that period. In the event of a significant delay, the time for auditing shall be extended for a reasonable period agreed to by Customer and Aetna.

All performance guarantee audits must be commenced within one (1) year following the period being audited. Customer's right to conduct a performance guarantee audit is waived if the audit is not commenced within one (1) year following the period being audited; provided, however, that Aetna does not significantly delay reporting performance guarantee results. In the event of a significant delay, the time for auditing shall be extended for a reasonable period agreed to by Customer and Aetna.

The scope and extent of any cycle audits to review general or operation controls outside of the claim transaction audits covered above must be mutually agreed upon in advance by Customer and Aetna and commence within three (3) years following the period to be audited. Customer's right to conduct a cycle audit is waived if the audit is not commenced within three (3) years following the period being audited.

Where a Customer's internal auditors wish to perform cycle audits to review general or operation controls outside of claim transaction reviews covered above, the scope and extent of the review must be mutually agreed upon in advance by both parties and commence within three (3) years following the period being audited. Customer's right to audit any service covered under this paragraph is waived if the audit is not commenced within three (3) years following the period being audited.

Audit requests by governmental agencies with jurisdiction (other than governmental agencies acting in their role as customers) are not subject to the above timing requirements or any other limitations, except as required by law.

All audits must be performed at the location where Customer's claims are processed. Aetna is not responsible for paying Customer's audit fees or the costs associated with any audit. Aetna reserves the right to charge the Customer administrative costs for any audit which: (i) cannot be completed onsite within a five (5) day period; (ii) contains a sample size in excess of 250 claim transactions: or (iii) otherwise creates exceptional administrative demands upon Aetna (i.e. audit questionnaires in excess of 150 questions). To the extent practicable, Aetna will endeavor to communicate the basis of any charges to Customer prior to the audit.

Aetna maintains the confidentiality of its negotiations and contracts with providers. Therefore, Aetna does not provide provider contracts for review as part of the audit process. Depending on proposed audit findings, Aetna will allow limited review of relevant portions of provider contracts if related to a specific audited claim.

Any payment by Aetna resulting from the audit must be based upon documented findings, agreed to by both parties, and must be solely due to Aetna's actions or inaction.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)
BUSINESS ASSOCIATE AGREEMENT

THIS Business Associate Agreement ("BA Agreement"), effective as of August 1st, 2022("Effective Date"), is entered into between Aetna Life Insurance Company, on behalf of itself and those of its affiliates providing services in connection with this BA Agreement ("Business Associate") and Hillsborough County Aviation Authority on behalf of the Aetna Life Insurance Company ("Covered Entity"). Hillsborough County Aviation Administration represents that it has the authority to agree to the terms and conditions of this BA Agreement for and on behalf of Covered Entity for which Business Associate provides plan administration services under current or future agreements between the parties ("Services Agreement"). For purposes of this BA Agreement, "Business Associate" includes only those subsidiaries and affiliates of Aetna Life Insurance Company that create, receive, transmit or otherwise maintain Protected Health Information, as defined below, in connection with this Agreement.

In conformity with the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996, as amended, including but not limited to the requirements under the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the implementing regulations at 45 CFR Parts 160-64 (the "Privacy and Security Rules"), and related public guidance issued by the Department of Health and Human Services (all of the foregoing, collectively, "HIPAA"), Business Associate will under the following terms and conditions have access to, maintain, transmit, create and/or receive certain Protected Health Information:

1. Definitions. Capitalized terms used and not otherwise defined in this BA Agreement shall have the meanings assigned to such terms by HIPAA.
   (a) Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g), but shall be limited to persons who are participants enrolled in, are seeking to become enrolled in, or were previously enrolled in the plan administered under the Services Agreement.
   (b) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "Protected Health Information", as defined by 45 CFR 160.103, limited to the information created, maintained, transmitted, or received by Business Associate from or on behalf of Covered Entity.
   (c) Standard Transactions. "Standard Transactions" means the electronic health care transactions for which HIPAA standards have been established, as set forth in 45 CFR, Parts 160-162.

2. Obligations and Activities of Business Associate
   (a) Business Associate agrees to not use or disclose Protected Health Information other than (i) for purposes of performing its obligations under the Services Agreement, (ii) as otherwise permitted or required by this BA Agreement, or (iii) as Required By Law.
   (b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this BA Agreement.
   (c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this BA Agreement.
   (d) Business Associate agrees to report to Covered Entity any use or disclosure of Protected Health Information not provided for by this BA Agreement of which it becomes aware, including a Breach of Unsecured Protected Health Information or a Security Incident.
   (e) Business Associate agrees to report to Covered Entity any Security Incident without unreasonable delay, and in no event later than ten (10) calendar days , after becoming aware that such Security

Incident affects Covered Entity's information, except that, for purposes of this Security Incident reporting requirement, the term "Security Incident" shall not include inconsequential incidents that occur on a daily basis, such as scans, "pings" or other unsuccessful attempts to penetrate computer networks or servers containing electronic PHI maintained by Business Associate.

(f) Business Associate agrees to report to Covered Entity any Breach of Unsecured Protected Health Information without unreasonable delay and in no case later than thirty (30) calendar days after becoming aware that such Breach affects Covered Entity's Protected Health Information. Such notice shall include the identification of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate, to have been, accessed, acquired, or disclosed in connection with such Breach. In addition, Business Associate shall provide any information reasonably requested by Covered Entity for purposes of making the notifications required by 45 CFR 164.404(c) as soon as such information is available to Business Associate. Business Associate's notification of a Breach under this section shall comply in all respects with each applicable provision of 45 CFR Part 164, Subpart D and related guidance issued by the Secretary from time to time.

In addition, if delegated in writing by Covered Entity, Business Associate shall provide such notices to the media and to Individuals affected by the Breach as required by 45 CFR 164.404 and 45 CFR 164.406. Business Associate shall provide Covered Entity with advance copies of such notices prior to distribution. In all cases, Covered Entity shall be responsible for submitting reports of Breaches directly to the Secretary.

(g) Business Associate shall require any Subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of Business Associate to agree in writing to restrictions and conditions that are no less protective than those that apply through this BA Agreement to Business Associate with respect to such information, in accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable.

(h) Business Associate shall provide access directly to an Individual, at the request of Covered Entity or an Individual and in a prompt and reasonable manner, including in the electronic form or format requested by the Individual, to Protected Health Information in a Designated Record Set, subject to and consistent with the timing and other provisions of 45 CFR 164.524.

(i) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set at the request of Covered Entity or an Individual, subject to and consistent with the timing and other provisions of 45 CFR 164.526.

(j) Business Associate agrees to make (i) internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, and (ii) policies, procedures, and documentation relating to the safeguarding of Electronic Protected Health Information available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Covered Entity's or Business Associate's compliance with the Privacy and Security Rules.

(k) Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information, subject to and consistent with 45 CFR 164.528.

(l) Business Associate agrees to provide to an Individual, at the request of Covered Entity or an Individual, an accounting of disclosures of Protected Health Information subject to and consistent with the timing and other provisions of 45 CFR 164.528.

(m) With respect to Electronic Protected Health Information, Business Associate shall implement and comply with the administrative safeguards set forth at 45 CFR 164.308, the physical safeguards set forth at 45 CFR 310, the technical safeguards set forth at 45 CFR 164.312, and the policies and procedures set forth at 45 CFR 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives,

maintains, or transmits on behalf of Covered Entity. Business Associate acknowledges that (i) the foregoing safeguards, policies and procedures requirements shall apply to Business Associate in the same manner that such requirements apply to Covered Entity, and (ii) Business Associate shall be subject to HIPAA enforcement provisions, as amended from time to time, for failure to comply with the Security Rule safeguards, policies and procedures requirements and any guidance issued by the Secretary from time to time with respect to such requirements.

(n) If Business Associate conducts any Standard Transactions on behalf of Covered Entity, Business Associate shall comply with, and require any Subcontractor to comply with, the applicable requirements of 45 CFR Parts 160-162.

(o) Business Associate acknowledges that it shall be subject to the HIPAA enforcement provisions, as amended from time to time, for (i) impermissible uses and disclosures, (ii) failure to provide breach notification to Covered Entity, (iii) failure to provide access to a copy of Electronic Protected Health Information to either Covered Entity or the Individual, or the Individual's designee, (iv) failure to disclose Protected Health Information where required by the Secretary to investigate or determine Covered Entity's compliance with HIPAA, and (v) failure to provide the accounting of disclosures required in this BA Agreement.

(p) To the extent under the Services Agreement or this BA Agreement Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).

3. Permitted Uses and Disclosures by Business Associate

3.1 General Use and Disclosure

Except as otherwise provided in this BA Agreement, Business Associate may use or disclose Protected Health Information to perform its obligations under the Services Agreement, provided that such use or disclosure would not violate the Privacy and Security Rules if done by Covered Entity.

3.2 Specific Use and Disclosure Provisions

(a) Except as otherwise provided in this BA Agreement, Business Associate may use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

(b) Except as otherwise provided in this BA Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached in accordance with the Breach and Security Incident notifications requirements of this BA Agreement.

(c) Business Associate shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an Individual without Covered Entity's prior written approval and notice from Covered Entity that it has obtained from the Individual, in accordance with 45 CFR 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by Business Associate.

(d) Business Associate may use or disclose Protected Health Information to communicate about a product or service, provided that such communication is made in a manner that does not constitute marketing as defined in 45 CFR 164.501 or otherwise constitute a use or disclosure that Covered Entity is prohibited from performing itself.

(e) Business Associate may use Protected Health Information to perform Data Aggregation services.

(f) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j).

(g) The provisions of this BA Agreement notwithstanding, Business Associate is permitted to de-identify Protected Health Information, provided that it does so in accordance with HIPAA de-identification rules. De-identified information does not constitute Protected Health Information, and may be used and disclosed by Business Associate for its own purposes, including, without limitation, for purposes of developing comparative databases, performing statistical analysis and research, and improving the quality of Business Associate's products and services.

4. Obligations of Covered Entity

4.1 Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

(a) Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity's notice of privacy practices agreed to in accordance with 45 CFR § 164.520(b)(2), to the extent that such limitation(s) may affect Business Associate's use or disclosure of Protected Health Information.

(b) Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, to the extent that such changes affect Business Associate's uses or disclosures of Protected Health Information.

(c) Covered Entity agrees that it will not impose special limits or restrictions on the uses and disclosures of its Protected Health Information that may impact in any manner the use and disclosure of Protected Health Information by Business Associate under the Services Agreement and this BA Agreement, including, but not limited to, restrictions on the use and/or disclosure of Protected Health Information as provided for in 45 C.F.R. 164.522(a), unless such restrictions are required by 45 CFR 164.522(a). The foregoing notwithstanding, Business Associate agrees to accommodate reasonable requests for alternative means of communications pursuant to 45 C.F.R. 164.522(b).

4.2 Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy and Security Rules if done by Covered Entity except that Business Associate may use Protected Health Information in its possession (i) for Business Associate's proper management and administrative services, or (ii) to provide Data Aggregation services to the Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).

5. Term and Termination

(a) Term. The provisions of this BA Agreement shall take effect on the Effective Date, and shall terminate upon expiration or termination of the Services Agreement, except as otherwise provided herein.

(b) Termination for Cause. Without limiting the termination rights of the parties pursuant to the Services Agreement and upon either party's knowledge of a material breach by the other party, the non-breaching party shall either:

i. Provide an opportunity for the breaching party to cure the breach or end the violation, or terminate the Services Agreement, if the breaching party does not cure the breach or end the violation within the time specified by the non-breaching party, or

ii. Immediately terminate the Services Agreement, if cure of such breach is not possible.

(c) Effect of Termination.

The parties mutually agree that it is essential for Protected Health Information to be maintained after the expiration of the Services Agreement for regulatory and other business reasons. Notwithstanding the expiration of the Services Agreement, Business Associate shall extend the protections of this BA Agreement to such Protected Health Information, and limit further use or

disclosure of the Protected Health Information to those purposes that make the return or destruction of the Protected Health Information infeasible.

6. Miscellaneous

(a) Regulatory References. A reference in this BA Agreement to a section in the Privacy and Security Rules means the section as in effect or as amended, and for which compliance is required.

(b) Amendment. The Parties agree to take such action to amend this BA Agreement from time to time **as is necessary** for Covered Entity and Business Associate to comply with the requirements of HIPAA.

(c) Survival. The respective rights and obligations of Business Associate under Section 5(c) of this BA Agreement shall survive the termination of this BA Agreement.

(d) Interpretation. Any ambiguity in this BA Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy and Security Rules. In the event of any inconsistency between this BA Agreement and the Services Agreement, including any other appendices, schedules, exhibits and attachments, the terms and conditions of this BA Agreement shall control.

(e) No third party beneficiary. Nothing express or implied in this BA Agreement or in the Services Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

(f) Governing Law. This BA Agreement shall be governed by and construed in accordance with the governing law provisions of the Services Agreement, subject to applicable federal law.

(g) Countersignature: This BA Agreement may be executed in several counterparts, each of which shall be deemed an original but all of which shall constitute one and the same instrument. In addition, this BA Agreement may contain more than one counterpart of the signature page and this BA Agreement may be executed by the affixing of the signatures of Business Associate and Covered Entity, or [*Insert name of plan sponsor*] on behalf of Covered Entity, to one of such counterpart signature pages. All of those counterpart signature pages shall be read as though one, and they shall have the same force and effect as though all of the signers had signed a single signature page.

(h) Notices: Any notices or communications to be given under this Agreement shall be made to the address and/or fax numbers given below:

To Covered Entity:
Hillsborough County Aviation Authority

Attention: Joe Lopano
Phone: _____
Fax:_____

E-mail: jlopano@tampaairport.com

To Business Associate:
Aetna
HIPAA Member Rights Team
151 Farmington Avenue, AN33
Hartford, CT 06156
Fax: (859) 280-1272

Email: HIPAAFulfillment@aetna.com

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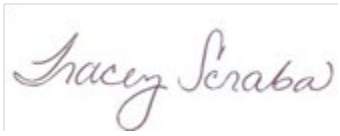
AETNA LIFE INSURANCE COMPANY	**COVERED ENTITY**
	
Authorized Signature	Authorized Signature
Tracey Scraba Print Name	Print Name
VP and Chief Privacy Officer Title	Title
Date	Date

EMPLOYEE ASSISTANCE PROGRAM (EAP)
SERVICE SCHEDULE
HILLSBOROUGH COUNTY AVIATION AUTHORITY (hereinafter "Customer")
EFFECTIVE AUGUST 1, 2022
MASTER SERVICES AGREEMENT No. MSA-724379

Subject to the terms and conditions of the Master Services 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 will be provided by Aetna Behavioral Health, LLC, an affiliate of Aetna Life Insurance Company. Additional Services may be provided at the Customer's written request and Aetna's written approval. This schedule shall supersede any previous document(s) describing the Services.

I. Excluded and/or Superseded Provisions of the Agreement:

- Section 1 ("Term") is excluded and replaced by Section III.E. of this schedule.
- Section 4 ("Service Fees") is excluded and replaced by Section IV. of this schedule.
- Section 5 ("Benefit Funding") does not apply with respect to the Services pursuant to this schedule.
- Section 6 ("Fiduciary Duty") does not apply with respect to the Services pursuant to this schedule, unless Customer determines its EAP is part of the Plan.
- Section 7 ("Customer's Responsibilities") is excluded and replaced by Section III.A of this schedule.
- Section 8 ("Records") is excluded and replaced by Section III.B. of this schedule.
- Section 10 ("Audit Rights") is excluded and replaced by Section III.C. of this schedule.
- Section 11 ("Recovery of Overpayments") does not apply with respect to the Services pursuant to this schedule.
- Section 12 (D) ("Indemnification") is excluded and replaced by Section III.D. of this schedule.
- Section 16 (D) ("Responsibilities On Termination") does not apply with respect to the Services pursuant to this schedule.
- Section 17 (L) ("Taxes") does not apply with respect to the Services pursuant to this schedule.

II. Definitions - When used in this schedule and/or the Service and Fee Schedule, all capitalized terms shall have the following meanings:

(A) "**Employee**" means any person eligible to receive Services under this schedule by virtue of being a current employee of the Customer, and not designated a temporary employee, and employees of subsidiaries and affiliates of the Customer who are reported by the Customer, in writing, to Aetna for inclusion under this schedule. For purposes of the telephonic access services, counseling sessions and provider network, "Employee" does not include employees of the Customer whose work location is in California.

(B) "**Dependent**" means the eligible family members, including household members, and dependents (including adult children up to age 26), of an Employee to receive Services under this schedule as a dependent of an Employee.

(C) If applicable, the term "**EAP Behavioral Health Professional**" may mean EAP Network Provider or EAP Staff Clinician.

(D) If applicable, the term "**EAP Network Providers**" shall mean licensed behavioral health professionals, who meet all Aetna credentialing standards, and who are contracted by Aetna, as independent contractors, to provide counseling to Members.

(E) The term "**EAP Staff Clinicians**" shall mean behavioral health professionals who are licensed in the State in which they practice and who are employed by Aetna to provide clinical services to Members. EAP Staff

clinicians may be part of Aetna's EAP call center and may provide telephonic clinical services. If applicable, EAP Staff Clinicians may be located at the Customer site and provide counseling at the Customer's location.

(F) "**Member(s)**" means Employees and Dependents eligible for Services.

(G) "**Payment Due Date**" shall mean the date that payment is required as set forth on the Customer's invoice. Payment Due Date will be 30 days from the invoice generation date for the invoice month(s). Payment is to be made in a form and manner as reasonably determined by Aetna.

III. Administration Services:

A. Customer Responsibilities.

(1) Employee Count - If needed and where applicable, on or before the Effective Date, the Customer may be requested to furnish to Aetna a listing of Employees (by zip code of each Employee's place of residence). Thereafter, the Customer shall supply to Aetna, on a monthly basis by the Payment Due Date, current Employee counts in a form and manner as reasonably determined by Aetna. Aetna shall not be responsible in any manner for any delay or error in the provision of Services caused by the Customer's failure to furnish accurate Employee counts in a timely fashion. If the Customer fails to provide current Employee counts with payment by the Payment Due Date, all Employee counts will be updated and reflected in the next billing and payment cycle. Aetna will not process Employee counts retroactively nor will Aetna perform any retroactive fee adjustments due to the Customer submitting inaccurate employee counts.

(2) Summary Plan Description ("**SPD**") – If the Customer's EAP is part of the Plan, the Customer shall provide Aetna with all Plan documents at least 30 days prior to the Effective Date or such other date mutually agreed upon by the parties. Absent the Customer providing Aetna with an SPD, Aetna shall automatically apply its internal policies and procedures to all EAP plans, including but not limited to internal appeals and external review, as applicable. Aetna does not review the Customer's SPD for compliance with applicable law.

B. Records. Aetna, its affiliates and authorized agents shall use all documents, records and reports received or created by Aetna in the course of delivering Services ("Documentation") in compliance with applicable privacy laws and regulations, including without limitation regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. Aetna may de-identify and use them for quality improvement, statistical analyses, product development and other lawful purposes -other than administration of EAP Services.

C. Audit Rights. The Customer may perform audits of Employee Assistance Program processes only, during normal business hours upon reasonable written notice. A process audit may not be conducted more than once annually and will not include access to individually identifiable Member information. Any requested payment from Aetna resulting from the audit must be based upon documented findings, agreed to by both parties, and must be solely due to Aetna's actions or inactions.

D. Indemnification. The Customer and Aetna agree that, except for counseling services provided by EAP Staff Clinicians: (i) Aetna does not render medical services or treatments to Members; (ii) neither the Customer nor Aetna is responsible for the health care that is delivered by EAP Network Providers; (iii) EAP Network Providers are solely responsible for the health care they deliver to Members; (iv) EAP Network Providers are not the agents or employees of the Customer or Aetna; and (v) the indemnification obligations of Section 12 (A) and (B) of the Agreement do not apply to any portion of any loss, liability, damage, expense, settlement, cost or obligation caused by the acts or omissions of EAP Network Providers with respect to Members.

E. Term.

Unless one party informs the other of its intent to allow this schedule to terminate in accordance with the Agreement, the initial term of this schedule shall be three (3) years beginning on the Effective Date as first written above (referred to as an "Agreement Period").

IV. Fees.

All Service Fees for Services under this schedule are summarized in the Employee Assistance Program Service and Fee Schedule. No Services other than those identified in the Employee Assistance Program Service and Fee Schedule are included in the Service Fees. Aetna will provide the Customer with a monthly statement indicating the Service Fees owed for that month.

V. Subcontractors.

The work to be performed by Aetna under this schedule may, at its discretion, be performed directly by it or wholly or in part through a subsidiary, an affiliate, or under a contract with an organization of its choosing. Aetna will remain liable for Services under this schedule.

VI. EAP Services.

All Services described in this schedule are available within the 50 U.S. states only. International EAP Services are only available if specifically described and priced separately.

A. UNLIMITED TELEPHONIC ACCESS: Unlimited telephonic access to the Aetna EAP call center staff, available 24 hours per day, 7 days per week, 365 days per year for purposes of assessing Member need and referring to appropriate EAP Services.

B. COUNSELING SESSIONS: A clinical session with an EAP Network Provider or EAP Staff Clinician. Sessions are intended to assist with emotional, family, personal, or work related behavioral health issues.

- COUNSELING SESSIONS WITH EAP NETWORK PROVIDERS AND CONTRACTED TELEVIDEO PROVIDERS: Counseling sessions can be provided face-to-face, telephonically, or via televideo (when appropriate), or online chat (when appropriate). Online chat counseling sessions are provided by one of our contracted providers. Face-to-face or telephonic sessions are provided by an EAP Network Provider. Televideo sessions are provided by one of Aetna's telemedicine contracted providers. Each Member is entitled, on a contract year, up to the number of counseling sessions per problem as set forth in the Service and Fee Schedule (e.g., up to three counseling sessions per Member per problem under the 3-Session EAP Model), unless a State regulation requires otherwise. All counseling sessions require prior authorization. The Member must contact Aetna to receive referrals and authorizations for all counseling sessions whether face-to-face, telephonic, or televideo. Marital and/or family sessions are considered one problem for the couple or family and sessions are not authorized individually for each attendee. Face-to-face, telephonic, and televideo counseling sessions count toward the number of counseling sessions per Member per problem. One week of online chat counseling messages are equal to one EAP session.

C. EAP PROVIDER NETWORK: A nationwide network of licensed behavioral health professionals, who meet all Aetna credentialing standards, and who are contracted by Aetna, as independent contractors, to provide counseling to Members. EAP Network Providers include, but are not limited to: social workers, licensed professional counselors, marriage and family therapists, master's level psychiatric nurses and psychologists.

D. TRAINING AND EDUCATION: The term "Training and Education" refers to training, provided by Aetna, or an Aetna Contracted educator to the Customer, concerning general behavioral health and work/life issues. This includes Employee Orientation Meetings and Supervisor Orientation Trainings. This training may be provided in different ways, in person, telephonically, or web-based. Additional fees apply to web-based training over 50 participants (Participants is defined as unique phone lines calling into the webinar). Department of Transportation (DOT) services are excluded from standard Training and Education services. For specialized DOT training, see separate definition under Drug Free Workplace Services. Mental Health First Aid trainings are excluded from standard Training and Education services. For specialized Mental Health First Aid training, see separate definition under Mental Health First Aid.

E. MANAGEMENT SERVICES:

- MANAGEMENT CONSULTATION: A telephonic resource for managers, supervisors, and human resources professionals to assist in identifying and resolving workplace issues and promoting a productive workforce. Issues may include but are not limited to employee personal and family issues, behavioral health concerns, workplace conflict, workplace crisis and other disruptions, substance abuse, threats of violence and employee performance concerns. This includes the provisions of guidance to the Customer in making voluntary referrals for Employees to the EAP. The EAP will coordinate with specialty providers as needed (SAP, DOT, FFD).

- MANDATORY REFERRALS: Case management to assist the Customer and Employees in addressing significant workplace performance issues. Mandatory referrals are used to monitor compliance with the EAP Behavioral Health Professional's recommendations, wherein the EAP, with appropriate executed release of information forms, confirms the Employee's participation in and compliance with the program.

- DRUG FREE WORKPLACE SERVICES: Suite of services to assist the Customer in managing workplace related employee substance misuse and/or disclosure of substance abuse in the workplace. Services for general employer industries include Aetna EAP case management of mandatory referrals related to workplace impacted substance abuse, as well as management consultation services as described above. Services for transportation related industries, such as employers who are regulated by DOT, FMCSA, FAA, FRA, FTA, PHMSA, etc., include substance abuse case management by a Substance Abuse Professional (SAP) for Department of Transportation regulation compliance. Additional service for transportation regulated Employees includes DOT training to meet Drug-Free Workplace regulations regarding drug and alcohol awareness available through American Substance Abuse Professionals (ASAP) or comparable SAP provider. A variety of training formats are available, including on-site, on-line or video.

- FITNESS FOR DUTY (FFD) CONSULTATION AND COORDINATION: A Fitness for Duty Evaluation is a forensic evaluation completed by a specially trained psychologist or psychiatrist, outside the EAP, for the purpose of evaluating an employee's ability to safely perform the functions of their job, assess organizational and behavioral risk, and provide a report recommending steps needed to be taken to minimize the Customer risk in returning the employee to work. Fitness for Duty Evaluations are outside the scope of EAP, and as such the EAP does not conduct Fitness for Duty Evaluations. Upon specific request, the EAP may assist the Customer with locating companies or providers external to the EAP who are capable of performing FFD Evaluations. At all times the Customer is responsible for working directly with the identified FFD provider as well as directly making payment arrangements with that provider for the FFD Evaluation. All decisions, regarding returning to work, retaining or dismissing employees remain with the Customer.

- SUBSTANCE ABUSE PROFESSIONAL (SAP) CONSULTATION AND CONTACT INFORMATION: Upon request of the Customer, for drug and alcohol cases that fall under the Department of

Transportation (DOT) guidelines, Aetna shall provide initial and ongoing management consultation on DOT issues. Aetna will further provide contact information of local providers in our specialized network of qualified Substance Abuse Professionals. The Customer is responsible for choosing and working directly with the SAP, as well as performing follow-up, compliance and aftercare attendance monitoring. The Customer is responsible for payment of the SAP and determines whether the employee or employer pays SAP fees as well as recommended treatment costs.

- MENTAL HEALTH FIRST AID: An educational program offered to customers to help managers and employees recognize and respond to mental health issues in the workplace. The curriculum includes an overview of mental health and provides education about anxiety, depression, suicide, trauma, psychosis, and substance use disorders, along with videos, interactive exercises and practice scenarios. Courses must be taught onsite. The eight hour course provides all participants with Mental Health First Aid Certification for three years. A four-hour option is available for a general overview of the topic. The four-hour class does NOT provide participants with a Mental Health First Aid Certification. Courses are limited to 30 participants per course.

F. CRITICAL INCIDENT SUPPORT (Crisis Support/Management Services/Critical Incident Stress De-Briefing (CISD) Services): An array of services offered by the EAP that helps an organization to prepare for, prevent, or respond to traumatic events. Acts of war are excluded from on-site CISD Services.

- ONSITE STANDARD CRITICAL INCIDENT SUPPORT: On-site attendance response time in greater than two hours for hourly onsite crisis support and Critical Incident Stress De-Briefing (CISD) Services at Customer sites to help an organization prepare for, prevent, or respond to traumatic events.

- ONSITE IMMEDIATE CRITICAL INCIDENT SUPPORT: On-site attendance response time in less than two hours for hourly onsite crisis support and Critical Incident Stress De-Briefing (CISD) Services at Customer sites to help an organization prepare for, prevent, or respond to traumatic events.

G. REDUCTION IN FORCE: A service in which the EAP provides a counselor or counselors on-site at the employers' facility to assist managers, employees being eliminated, and employees remaining after the reduction in work force.

H. COMMUNICATION AND PROMOTIONAL MATERIALS: Information provided to Employees and management about EAP Services, including, in part, how EAP Services can be accessed for consultation and assistance. The communications and promotional resources may include template e-mails, letters, flyers, wallet cards, and posters for Employees and management. Aetna will provide reasonable quantities of printed materials in support of implementation and/or on an annual basis at the Customer's request at no cost. Reasonable quantities are defined as up to 120% of the number of eligible Employees for items such as flyers or brochures; a quantity up to 5% of the number of eligible Employees for items such as posters; and a quantity of up to 20% of anticipated attendees at health fairs for other promotional items. Requests exceeding these quantities may incur an additional fee.

I. MANAGEMENT REPORTS: A specific collection of data and narrative information designed to inform the Customer about the overall utilization of the program. Customer may receive reports on a quarterly electronic basis. If for any 2 consecutive reporting periods there is less than 1% utilization, reporting frequency will default to annual reporting.

J. INTAKE MODEL:
    - STANDARD MODEL: Initial intake calls answered by a care service associate/customer service representative.

K. EAP EXCLUSIONS: The following services are outside the scope of the EAP:

- Counseling services beyond the allowed number of sessions covered by the EAP benefit.

- Court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody, or visitation evaluations, or paid for by Workers' Compensation.
- Formal psychological evaluations which normally involve psychological testing and result in a written report.
- Diagnostic testing and/or treatment.
- Visits with psychiatrist, including medication management.
- Prescription medications.
- Services for remedial education.
- Inpatient, residential treatment, partial hospitalizations, intensive outpatient.
- Ongoing counseling for a chronic diagnosis that requires long term care.
- Biofeedback.
- Hypnotherapy.
- Aversion therapy.
- Examination and diagnostic services required to meet employment, licensing, insurance coverage, travel needs.
- Services with a non-contracted EAP provider.
- Fitness for duty evaluations.
- Legal representation in court, preparation of legal documents, or advice in the areas of taxes, patents, or immigration, except as otherwise described in this document.
- Investment advice (nor does plan loan money or pay bills).

VII. Worklife Services

A. UNLIMITED TELEPHONIC ACCESS: Unlimited telephonic access to the call center staff, available 24 hours per day, seven days per week, 365 days per year.

B. CAREGIVING SERVICES: Services that include consultation, information, education and referral services in connection with, in part, adoption, childcare, parenting, temporary back-up care, summer care, special needs, high-risk adolescents, academic services, education loans, grandparents as parent, adult care, elder care, and disaster resources. Carekits may be included with this service.

C. PERSONAL SERVICES: Free educational materials, personalized referrals, and interactive web tools to assist with:

1. Health & Wellness--children's health; women's health; men's health; seniors' health; weight loss and nutrition; fitness and exercise programs; general health; safety; stress management; information on diseases and conditions; and more.
2. Daily Life--home improvement; pet care; consumer information; automotive services; relocation; travel; time management; cleaning services; and more.

D. LEGAL SERVICES: Services provided through the EAP that include:

1. LEGAL SERVICES:
    a. ½ hour initial consultation with selected participating attorney on an unlimited number of new legal topics (each Plan year). Certain topic areas are excluded, including employment law. Also excluded are matters that, in the attorney's opinion, lack merit. Court costs, filing fees and fines are the responsibility of the Member. If Members choose to continue with the participating attorney and hire that attorney on their own, they will receive 25% off of the fees for services beyond the initial consultation (excluding flat legal fees, contingency fees, and plan mediator services).
    b. Mediation Services – Each Member is entitled to one initial thirty minute office or telephone consultation per separate legal matter at no cost with a participating mediator. In the event that the Member wishes to retain a participating mediator after the initial consultation, they will be provided with a preferred rate reduction of 25% from the mediator's normal hourly rate. Typical matters may include divorce and child custody, contractual and consumer disputes, real estate and landlord tenant, car accidents and insurance disputes.
    c. Simple Will Preparation - Members receive resources to complete one simple will.
    d. All initial consultation (and discounted consultations) must be for legal matters related to the Employee and eligible household members.

E. FINANCIAL SERVICES: Services provided through the EAP that include:

1. FINANCIAL SERVICES:
    a. ½ hour initial consultation with the selected participating financial counselor on an unlimited number of new financial counseling topics each Plan year.
    b. Financial counseling topics include budgeting, credit, debt, retirement, college planning, buying vs. leasing, mortgages/refinancing, financial planning, tax questions, tax preparation, IRS matters, tax levies and garnishments, consumer credit counseling, and community services.
    c. A discount of 25% off the tax preparation services.
    d. Employees may have the option to purchase additional services for a monthly nominal fee.

F. IDENTITY THEFT SERVICES: Services provided through the EAP that include:

1. IDENTITY THEFT SERVICES**:**
    a. 1-hour telephonic fraud resolution consultation for identity theft.
    b. Coaching and direction on prevention and restoring credit for victims of identity theft.
    c. Free Identity Theft Emergency Response Kit for victims of identity theft.
    d. Individual Employees may have the option to purchase additional services for a monthly nominal fee.

G. MEMBER WEBSITE:

1. CORE MEMBER WEBSITE: Access to customizable member website for free webinars, online worklife searches, concierge database, discount program, thousands of articles, videos, and tools on worklife and behavioral health topics.

EMPLOYEE ASSISTANCE PROGRAM (EAP)
HILLSBOROUGH COUNTY AVIATION AUTHORITY (hereinafter "Customer")
EFFECTIVE AUGUST 1, 2022 THROUGH JULY 31, 2025
MASTER SERVICES AGREEMENT No. MSA-724379

DOMESTIC EAP SERVICE AND FEE SCHEDULE ("SFS")

The Service Fees and Services effective for the period beginning August 1, 2022 and ending July 31, 2025 are specified below. All Services described are available within the 50 U.S. states only.

PEPM = Per employee per month

Services	Service Fees
EAP Session Model Unlimited Telephonic Access with Up to eight (8) counseling sessions with an EAP Network Provider or televideo provider, delivered via face-to-face, telephonically, televideo, or online chat* per problem per contract year *One week of online chat counseling messages are equal to one EAP session.	$ 1.57 PEPM
Worklife Services, including Caregiving Services, Personal Services, Legal and Financial Services, Identity Theft Services, Core Member Website	Included in the EAP Session Model PE/PM.

Services	Service Fees
Critical Incident Support/Critical Incident Stress De-Briefing (CISD) Services—Standard Services (On-site attendance response time in greater than two hours)	**Unlimited Standard CISD Services**: Unlimited Standard CISD sessions are included in the EAP Session Model PEPM Rate. CISD Services are limited to 10 hours per incident. Immediate CISD's are subject to the fees described below. Issues concerning downsizing, mergers, acquisition activities (i.e. Reductions in Force or RIF's), or services beyond the 10 hour cap, are subject to the hourly rate of $250.00 per hour plus travel and preparation expenses reimbursed at a flat rate of $150.00 per counselor. CISD hours used, whether fee for service and/or within the bank of standard hours, are calculated based upon the combined total number of hours all clinicians are on-site.
Critical Incident Support/Critical Incident Stress De-Briefing (CISD) Services—Immediate Services (On-site attendance response time in two hours or less)	**Fee for Service Immediate CISD Pricing**: $350.00 per hour plus travel and preparation expenses reimbursed at a flat rate of $150.00 per counselor. CISD hours used, whether fee for service and/or within the bank of standard hours, are calculated based upon the combined total number of hours all clinicians are on-site. the hourly fees.
Critical Incident Support/Critical Incident Stress De-Briefing (CISD) Cancellation Fee	Whenever possible, the Customer agrees to provide Aetna with 24 hours' advance notice of cancellation of any requested Workplace Crisis Response Services. Failure to provide Aetna with 24 hours' notice of cancellation of any services will result in the following: • **Unlimited Standard CISD Services Cancellation Fee**: Services which are excluded from the unlimited provision listed above, i.e. above the 10 hours per incident cap, immediate CISD services, downsizings, mergers, acquisition activities (i.e. Reductions in Force or RIF's), which are subject to the hourly rate will result in a charge of $375.00 per incident.
Reduction in Force	**Fee for Service Reduction in Force Pricing**: $250.00 per hour plus travel and preparation expenses reimbursed at a flat rate of $150.00 per counselor.

Services	Service Fees
Reduction in Force Cancellation Fee	**Reduction in Force Cancellation Fee:** $375.00 per incident charge for failure to provide Aetna with 24 hours' notice of cancellation of Reduction in Force service.
Training and Education	**Fee for Service On-Site Training Pricing**: $250.00 per hour for the total amount of time that the educator is on site, plus a $150.00 per hour charge for travel and preparation time. If training is not scheduled consecutively or multiple topics are scheduled, additional travel and preparation costs may apply. **Fee for Service Webinar Training Pricing:** $250.00 per hour, plus a $150.00 charge for preparation for each web-based training for up to 50 Members. For webinars with more than 50 Members, an additional charge of $25.00 applies for each additional 25 Members up to a maximum of 200 Members. Sessions less than one hour in duration will count as one hour of Training and Education. If the Customer requests a specific educator, or an educator with specific qualities, including but not limited to specialized certifications, experiences or language, the Customer will be billed any additional incurred fees beyond the hourly fee above or have hours deducted from bank. In addition, if the Customer cannot accommodate the schedule/availability of a local Aetna contracted educator, requiring that the services of an educator 50 miles away or greater from the Customer's location is necessary, then the Customer will be billed any additional incurred fees beyond the hourly fee above or have hours deducted from bank.
Training and Education Cancellation Fee	Failure to provide Aetna six (6) business days' notice of cancellation of a previously scheduled training program may result in a of the following: • **Fee for Service Training Cancellation Fee**: $375.00 per hour for services which are provided on a fee for service basis and which are subject to the hourly rate.
Mental Health First Aid Training	Please contact your Account Executive for Mental Health First Aid pricing should you require these services.

Services	Service Fees
	Community Version ONLY *8-Hour Course* - This option provides eight (8) hours of standard Mental Health First Aid curriculum. Fee includes all instructor fees, travel (if applicable). Check with your Account Executive for more information **Corporate Level ONLY** *8-Hour Course In-Person (30 participant maximum)* - This option provides eight (8) hours of standard Mental Health First Aid curriculum. Fee includes all instructor fees, travel, and customization for delivery locations within continental United States. Additional travel and expenses may apply for delivery locations in Alaska and Hawaii. *4-Hour Course In-Person (30 participant maximum)* - This option provides four (4) hours of standard Mental Health First Aid curriculum. Fee includes all instructor fees, travel, and customization for delivery locations within continental United States. Additional travel and expenses may apply for delivery locations in Alaska and Hawaii. *6-Hour Course – two hours self directed preparation + four hours instructor led training Virtual (15 participant minimum and maximum)* - This option provides six (6) hours (2 hours self-directed pre-work + 4 hours of instructor led training) of standard Mental Health First Aid curriculum. Fee includes all instructor fees and customization. *4-Hour Course Virtual (Minimum of 15 participants and Maximum of 25 participants)* - This option provides four (4) hours of standard Mental Health First Aid curriculum. Fee includes all instructor fees and customization. **Mental Health First Aid Cancellation Fee Schedule** If the Customer cancels for any reason within 30 days from the training date, the Customer will be responsible for cancellation fees as follows: • 50% of the total fee 15-30 days prior to the scheduled date of training. • 100% of the total fee 0-14 days prior to the scheduled date of training.

Services	Service Fees
Drug Free Workplace Services	
Substance Abuse Case Management by a Substance Abuse Professional (SAP) and/or for Department of Transportation regulation compliance	$750.00 per case
DOT training to meet Drug-Free Workplace regulations regarding drug and alcohol awareness	DOT Alcohol and Drug-Free Workplace for Supervisors Training to meet Drug-Free Workplace regulations regarding drug and alcohol use. Additional fees may be added on to the base rate for DOT training. These fees will be assessed on a case-by-case basis and are dependent upon travel expenses and for classes that exceed 50 Members. • DOT Supervisor Training - Two hours at $800 DOT Alcohol and Drug-Free Workplace for Employees Awareness Training (Note: this training does not meet Drug-Free Workplace regulations regarding drug and alcohol use.) Additional fees may be added on to the base rate for DOT training. These fees will be assessed on a case-by-case basis and are dependent upon travel expenses and for classes that exceed 50 Members. • DOT Employee Training - One hour at $400

Aetna also may adjust Service Fees effective as of the date on which any of the following occurs.

1) If, for any Service, there is a (+/-) 20% change in the number of Employees from the number of Employees assumed in Aetna's quotation as of the Effective Date of this SFS.
2) Change in Services—A material change in Services is requested or initiated by the Customer or by legislative action.
3) Premium Taxes or Assessments—If legislative or regulatory action results in the assessment of premium taxes or other like charges as it concerns those Services provided under the terms of this SFS.

Account Team Information	
SAE Name:	
SAE Phone:	
SAE Email:	
AM Name:	
AM Phone:	
AM Email:	
Customer Information	
Customer Name ("**Customer**"):	
Eligible Carrier, Account, & Group(s) (CAG)	(Please list hierarchy or use "*" to signify that entire population under given carrier or account is eligible).
Coalition/TPA/Health Plan name if different from Customer name:	
Customer Type	
☐ Employer ☐ Coalition/TPA ☐ Health Plan	

This Vendor Election Form ("**VEF**"), once executed, is an exhibit to the Point Solutions Management Amendment ("**Amendment**") between Aetna Life Insurance Company, and Customer. All capitalized terms used in this VEF and not otherwise defined shall have the meanings set forth in the Amendment or Agreement. In the event of a conflict between the terms of this VEF and the terms of this Amendment, the terms of this VEF shall control.

PrudentRx, LLC ("**Vendor**" or "**PrudentRx**") provides co-pay program related services to plan sponsors that include guidance on plan benefit design for specialty products and assistance to members to secure available copay assistance for specialty drugs through the various programs funded by pharmaceutical companies ("**PrudentRx Solution**").

Customer agrees to implement the PrudentRx Solution pursuant to the Point Solutions Management Amendment effective with the following parameters:

PRUDENTRX SOLUTION:

Additional Defined Terms:

"**Benefit Cap**" means the maximum dollar benefit available during a calendar year under a Pharma Copayment Assistance Program for a Specialty Drug. If a Specialty Drug does not have a Pharma Copayment Assistance Program, the Benefit Cap will be zero for such Specialty Drug for purposes of the PrudentRx Solution.

"**Covered Class**" means a therapeutic class that is included in the PrudentRx Solution implemented for Customer, as specified on Attachment 1. Updates to the Covered Classes will be communicated to Customer from time to time.

"**Essential Health Benefits**" shall have the meaning given to such term at 42 U.S.C. § 18022(b), which currently includes items and services in the following ten benefit categories: (1) ambulatory patient

services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

"**Participating Member**" means a Member who elects to participate in the PrudentRx Solution.

"Pharma Copayment Assistance Program" means a program sponsored by a pharmaceutical company that provides financial assistance for payment of the patient's cost-share for those patients who meet the program eligibility criteria, as established by the pharmaceutical company, but excluding any program that conditions assistance on financial need.

"Program Drug List" means the "*PrudentRx Program Drug List*," which is a listing of Specialty Drugs that will be included in the PrudentRx Solution for Customer.

"Program Product" means a Specialty Drug that is listed on the Program Drug List.

"**Specialty Tier**" means the adjudication tier for branded, single source prescription Specialty Drugs and other very high cost products.

Program Description: The PrudentRx Solution shall consist of the following elements:

- Scope: Pharma Copayment Assistance Programs. The Program is available only to Members.
- Plan Design: For the Plans participating in the PrudentRx Solution, as designated by Customer in the "Customer Information" in the table above, Customer shall adopt a plan design for Specialty Drugs in a Covered Class that consists of the following elements:
  - Specialty Tier: Customer will implement a Specialty Tier. Products on the Specialty Tier shall be subject to a thirty percent (30%) Cost Share. All Specialty Drugs in a Covered Class shall be adjudicated at the Specialty Tier.
  - Non-Essential Health Benefits: Certain products in a Covered Class shall be deemed non-Essential Health Benefits.
  - Exception Process: When an amount equal to the Benefit Cap has been received from a Pharma Copayment Assistance Program for a Participating Member for a calendar year for a Program Product, the Plan shall implement an exception process whereby the Plan shall assume responsibility for the Cost Share for the Program Product for the remainder of the calendar year. This shall include any amounts not paid by a Pharma Copayment Assistance Program, such as when there is a residual leftover after applying the maximum copay assistance to the claim.
  - Deductible and OOP Max: Amounts paid for the benefit of a Member by a Pharma Copayment Assistance Program shall not be counted towards the Member deductible or the Member annual out of pocket maximum obligation.
  - Summary Plan Description. The Customer shall adopt language in its Summary Plan Description that aligns with the above requirements. A template for such language is

provided on Attachment 2. Although PrudentRx will assist with the language in the Summary Plan Description, the Customer and the Plan administrator remain responsible for fulfilling their fiduciary duties under ERISA with respect to the content of the Summary Plan Description.

- Program Drug List: PrudentRx shall develop a Program Drug List for Customer, which Program Drug List shall be subject to review and approval by CVS Caremark to verify plan design alignment with the Formulary (i.e., no cost share disadvantage of preferred formulary products).

- Member Notification & Enrollment: PrudentRx will work in conjunction with Customer to develop a communication and enrollment process regarding the PrudentRx Solution, to include the following:

  - Enrollment in the PrudentRx program is a two-step process:
    - Step One: Member information is on file with PrudentRx.
    - Step Two: Member needs to call PrudentRx at 1-800-578-4403 after receipt of the welcome letter to register for any copay assistance available from drug manufacturers. Step two of the enrollment process must be completed to be fully enrolled

  - Send a standardized and non-editable notice to Members utilizing a Specialty Drug in a Covered Class identified via historic claim files.

  - Implement the PrudentRx high touch comprehensive communication process for Members who are projected to participate in the PrudentRx Solution at the customers launch date.

  Within one (1) business day of receipt of a claim for a Specialty Drug in a Covered Class, PrudentRx shall conduct outreach to the Member if the Member is not currently enrolled in an available Pharma Copayment Assistance Program. PrudentRx shall coordinate with the Member and seek to complete Member enrollment in the applicable Pharma Copayment Assistance Program within three (3) business days of receipt of such claim, subject to Member satisfaction of the eligibility requirements of such Pharma Copayment Assistance Program. Within ten (10) calendar days of the end of each month, PrudentRx shall provide to CVS Caremark and to the Customer a monthly report identifying Members that could not be reached and Members that could not be enrolled in the applicable Pharma Copayment Assistance Program.

- Pharma Copayment Assistance Program Enrollment: PrudentRx shall assist Participating Members with enrollment in Pharma Copayment Assistance Programs for Specialty Drugs and securing financial assistance under such Pharma Copayment Assistance Programs.

- Coordination with CVS Caremark. PrudentRx collaboratively works with CVS Caremark and, if requested by CVS Caremark, the dispensing pharmacies, to ensure timely prescription processing with minimal member abrasion by providing real time data feeds, to include notification to CVS Caremark of: (i) decision by a Member to not participate in the PrudentRx Solution; (ii) inability to contact a Member; (ii) election by a Member to participate in the PrudentRx Solution; and (iv) enrollment of a Participating Member in a Pharma Copayment Assistance Program.

  Customer hereby directs and authorizes CVS Caremark to: (i) exclude amounts paid under Pharma Copayment Assistance Programs from Member deductible and annual Member out of pocket

maximum obligation; (ii) provide to PrudentRx daily paid claims, daily reject files, and monthly claims files for Program Products dispensed to Participating Members so that PrudentRx may implement and operate the PrudentRx Solution (collectively, "**Customer Data**"); and (iii) provide PrudentRx with Member portal access for designated PrudentRx employees performing Participating Member benefit verification and eligibility in real time, if possible.

- Confidentiality. In the event Customer receives any Confidential Information (as such term is defined in the Agreement) of PrudentRx, Customer shall maintain the confidentiality of such Confidential Information consistent with the requirements imposed in the Agreement for confidential treatment of CVS Caremark Confidential Information.

- Release of Data. Customer hereby authorizes and directs CVS Caremark to disclose the Customer Data and other Customer or Member information to PrudentRx in order to provide the PrudentRx Solution to Customer. Customer acknowledges and agrees that to the extent any data disclosed to PrudentRx includes Member information, such Member information shall be disclosed by CVS Caremark subject to the Master Service Agreement or Administrative Service Agreement between Customer and Aetna Life Insurance Company.

- Claims Audits. On a monthly basis, Prudent Rx shall: (i) retroactively audit claims for the prior month to ensure the PrudentRx Solution was implemented appropriately for each Participating Member for whom a claim was adjudicated in such month, including implementation of the exception process whereby the Plan assumes responsibility for the Cost Share; and (ii) provide a written report with the results of such audit to CVS Caremark and Customer within thirty (30) days of the end of the month subject to the audit. If any issues are identified, PrudentRx shall consult with CVS Caremark to coordinate on an appropriate resolution.

- Control of Plans. Customer acknowledges and agrees that PrudentRx shall not be: (i) the administrator (as that term is defined in Section 3(16) of ERISA) of any Plan for any purpose; (ii) a named fiduciary with respect to any Plan for purposes of ERISA or any applicable state law; (iii) delegated discretionary authority or responsibility, or exercise discretionary authority or control, with respect to any Plan or its administration; or (iv) deemed to be a fiduciary with respect to any Plan for purposes of ERISA or any applicable state law.

- HDHP. Customer acknowledges that the PrudentRx Solution is not recommended for high-deductible health plans ("**HDHP**") with health savings accounts ("**HSA**"). Customer is solely responsible for evaluating compliance with the Internal Revenue Code and IRS guidance, in consultation with its own counsel, in connection with any contemplated implementation of the PrudentRx Solution for any HDHPs or HSAs and Customer is solely responsible for, and shall indemnify CVS Caremark and PrudentRx against, any loss, cost, damage or expense resulting from any such implementation.

- Reporting. PrudentRx shall provide the following reports to Customer:

  - On a monthly basis, PrudentRx will provide a summary to Customer of the claims it processed with respect to the Plan, which shall include the following metrics:
    - The service fee to PrudentRx resulting from the PrudentRx Generated Savings
    - PrudentRx will provide a monthly report and a monthly invoice. The monthly report will include the number of members and the number of claims under each therapeutic category

These reports shall include other information requested by the Customer. All information disclosed on the foregoing reports shall comply with the privacy requirements under HIPAA and any other applicable law.

- Early Termination: CVS Caremark may immediately terminate this VEF in the event CVS Caremark determines, in its reasonable discretion, that such termination is necessary to avoid or limit an adverse financial impact on CVS Caremark and/or Customer.

PrudentRx Solution Effective Date: XX/XX/20XX

Note: The PrudentRx Solution Effective Date must be the first day of the month, cannot be sooner than the effective date of the Point Solutions Management Amendment, and cannot be sooner than 90 calendar days from the date of delivery of an executed copy of this Vendor Election Form to PointSolutionsManagement@CVSHealth.com. In the event this Vendor Election Form is not delivered at least 90 calendar days prior to the proposed PrudentRx Solution Effective Date or otherwise fails to meet the timing requirements of the prior sentence, this Vendor Election Form shall not take effect and the Customer shall be requested to submit a new Vendor Election Form with a conforming PrudentRx Solution Effective Date.

Eligible Member Population:
☐ Customer's PBM-covered employees
☐ Dependents of Customer's employees

Compensation: Customer will pay a service fee equal to twenty-five percent (25%) of Generated Savings.

- "**Generated Savings**" are calculated as the amount by which the Current Plan Net Cost exceeds the New Plan Net Cost.
- "**Current Plan Net Cost**" is (i) the Plan's gross cost of a Specialty Drug, less (ii) the amount obtained by multiplying the Current Copayment Percentage by the gross cost of the Specialty Drug (without the application of any deductibles).
- **"New Plan Net Cost"** is (i) the Plan's gross cost of the Specialty Drug, less (ii) the amount of manufacturer copay assistance applied to the gross cost of the Specialty Drug.
- "**Current Copayment Percentage**" is the lesser of: (i) six percent (6%) or (ii) the percentage obtained by dividing the total copayments paid by Members for Specialty Drugs (without the application of any deductible) by the total gross cost of the Specialty Drugs for the Plan, each measured over the twelve (12) month period immediately preceding the implementation of the PrudentRx Solution. If historical claims data is not provided to PrudentRx to determine this amount, the Current Copayment Percentage will be deemed to be 2%.

PrudentRx may share a portion of the above service fee to third parties, including CVS Caremark, for services rendered in connection the PrudentRx Solution. There are no separate fees for administration, Member outreach and support, monthly reporting, or any of the other services provided by PrudentRx under the PrudentRx Solution.

Examples of the calculations of the PrudentRx Generated Savings and the service fee are illustrated below:

Examples Of The Calculations Of The Prudentrx Generated Savings And The Service Fee Are Illustrated Below:

How Prudentrx Generated Savings Are Calculated	Example 1 Copay Assistance Fully Funds Member Cost Share	Example 2 Copay Assistance Partially Funds Member Cost Share	Example 3 Copay Assistance Partially Funds Member Cost Share	Example 4 Copay Assistance Not Available	Example 5 Copay Assistance Partially Funds Member Cost Share	Example 6 Essential Drug Moop** Met	Example 7 Essential Drug Moop** Not Met Copay Assistance Not Available	Example 8 Essential Drug Moop** Not Met Copay Assistance Available
Total Amount Paid by all Sources (Total Gross Cost)	$6,000.00	$6,000.00	$6,000.00	$6,000.00	$6,000.00	$6,000.00	$6,000.00	$6,000.00
Initial Plan Cost	$4,200.00	$4,200.00	$4,200.00	$4,200.00	$4,200.00	$6,000.00	$5,000.00	$5,000.00
Manufacturer Bill Amount (Co-Insurance)	$1,800.00	$1,800.00	$1,800.00	$1,800.00	$1,800.00	$0.00	$1,000.00	$1,000.00
Manufacturer Copay Assistance Pay Amount	$1,800.00	$1,000.00	$1,790.00	$0	$50	$0	$0	$1,000
COB Amount*	$0.00	$800	$10	$1,800	$1,750	$0	$1,000	$0
Manufacturer Copay Assistance Paid Amount	$1,800.00	$1,000.00	$1,790.00	$0.00	$50.00	$0.00	$0.00	$1,000.00
Base line member savings (Current Copayment Percentage)***	$120.00	$120.00	$120.00	$120.00	$120.00	$120.00	$120.00	$120.00
PrudentRx Generated Savings	$1,680.00	$880.00	$1,670.00	($120.00)	($70.00)	($120.00)	($120.00)	$880.00
PrudentRx Fee	$420.00	$220.00	$417.50	($120.00)	($70.00)	($30.00)	($120.00)	$220.00
Net Plan Savings	$1,260.00	$660.00	$1,252.50	$0.00	$0.00	$30.00	$0.00	$660.00

*This shall include any amounts not paid by manufacturer copay assistance program, such as when there is a residual left over after applying the maximum copay assistance to the claim or when copay assistance is not available.

** Maximum-Out-Of-Pocket may vary by plan. The example above is set at $1,000 for illustration purposes

*** Baseline member savings (Current Copay Percentage) is set at 2% for illustration purposes. Example 4 above illustrates negative amounts for the PrudentRx Generated Savings and the program fee. To the extent a claim results in negative amounts as in this Example 4 (which such negative amounts are not generally intended by this program), the negative program fee amount will be netted against other positive program fee amounts occurring in the same reporting period, thereby reducing the total program fee amount (but not below $0) payable to PrudentRx. If, for any month, the aggregate program fee is negative, the amount will be carried forward and applied as a credit against the next month's invoice.

_____

Signature of Customer's Authorized Representative

Name (Print):_____

Title:_____

Date Signed: _____
(MM/DD/YYYY)

_____

Signature of Aetna's Authorized Representative

Date Signed: _____
(MM/DD/YYYY)

Attachment 1
Covered Classes

ACROMEGALY
ALPHA-1 ANTITRYPSIN DEFICIENCY
AMYLOIDOSIS
ANEMIA
ASTHMA
ATOPIC DERMATITIS
AUTOIMMUNE
COAGULATION DISORDERS
CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES
CYSTIC FIBROSIS
ELECTROLYTE DISORDERS
GASTROINTESTINAL DISORDERS-OTHER
GOUT
GROWTH HORMONE AND RELATED DISORDERS
HEMATOPOIETICS
HEMOPHILIA
HEPATITIS B*
HEPATITIS C
HEREDITARY ANGIOEDEMA
HORMONAL THERAPIES
HUMAN IMMUNODEFICIENCY VIRUS*
IMMUNE DEFICIENCIES AND RELATED DISORDERS
INFECTIOUS DISEASE - OTHER
INFERTILITY**
INFLAMMATORY BOWEL DISEASE
IRON OVERLOAD
LYSOSOMAL STORAGE DISORDER
MENTAL HEALTH CONDITIONS
MOVEMENT DISORDERS
MULTIPLE SCLEROSIS
NEUTROPENIA
OCULAR DISORDERS*
ONCOLOGY
OSTEOPOROSIS
PAROXYSMAL NOCTURNAL HEMOGLOBINURIA
PHENYLKETONURIA
PRE-TERM BIRTH
PULMONARY ARTERIAL HYPERTENSION
PULMONARY DISORDERS - OTHER

RARE DISORDERS - OTHER
RENAL DISEASE
RESPIRATORY SYNCYTIAL VIRUS
SEIZURE DISORDERS
SICKLE CELL DISEASE
SLEEP DISORDER
SYSTEMIC LUPUS ERYTHEMATOSUS
THROMBOCYTOPENIA
TRANSPLANT*
UREA CYCLE DISORDERS

* ONLY AVAILABLE IF CUSTOMER HAS ENHANCED EXCLUSIVE SPECIALTY
** NOT AVAILABLE IF THE PARTICIPATING CUSTOMER HAS A FERTILITY MAB

Attachment 2
Summary Plan Description

Disclaimer: The following summary plan description language is a suggested template, and neither CVS Caremark nor PrudentRx take responsibility for the summary plan description that is published by the Plan. Final language should be tailored to customer plan design and reviewed by customer legal counsel.

PrudentRx Solution for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, [Insert Plan name] has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the Plan's specialty drug list are included in the program and will be subject to a 30% co-insurance. However, if a member enrolls in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you choose to opt out of the program, you must call 1-800-578-4403. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. Eligible members who choose to decline enrollment in an available manufacturer copay assistance program will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

No. 724379

Amendment 3 rev.

Attached to and made a part of the Master Services Agreement MSA-724379

an agreement between

Aetna Life Insurance Company
(hereinafter referred to as Aetna)

and the Customer

Hillsborough County Aviation Authority

Nothing contained in this amendment shall be held to alter or affect any of the terms of the Services Agreement other than as herein specifically stated.

It is understood and agreed that the Services Agreement is changed by the addition of the section listed below.

Section Added	Effective Date
Reimbursement Statement of Available Services Schedule	August 1, 2022
Reimbursement Services and Fee Schedule	August 1, 2022

In Witness Whereof, Aetna has signed this amendment at **Hartford**, **Connecticut**, to become effective August 1, 2022.

Signed by Aetna March 8, 2022.

By 

Dan Finke
President

Signed by the Customer _____
Date

_____ _____
Signature Official Title

REIMBURSEMENT STATEMENT OF AVAILABLE SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA- 724379
EFFECTIVE August 1, 2022

Subject to the terms and conditions of the Agreement, the reimbursement 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 6, 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. 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 state law, as applicable, the Customer will be the "appropriate named fiduciary" for the purpose of reviewing denied claims under the reimbursement account(s). It is also agreed that Aetna's responsibilities under this schedule are ministerial and Aetna has no fiduciary responsibility under this schedule.

II. CUSTOMER RESPONSIBILITIES:

1. The Customer shall provide Aetna with the necessary records of the Plan Participants covered under this reimbursement schedule, and promptly notify Aetna of any changes or corrections of such Plan Participants.

2. The Customer shall be solely responsible for the collection and administration of contributions to the Plan Participants' account.

3. The Customer shall maintain a supply of forms, which, upon the Customer's request, will be provided by Aetna, and the Customer shall distribute or make such forms available to the Plan Participants for the filing of claims for benefits or to report changes in participation.

4. The Customer shall be solely responsible for satisfying any and all reporting and disclosure requirements imposed on the reimbursement account under applicable law. When requested by the Customer, Aetna will assist Customer with such requirements.

5. The Customer shall be responsible for the final proper preparation and timely filing of the following documents, and performance and compliance with the following tests in connection with the Plan:

   (a) "Plan Document" and "Summary Plan Description";

   (b) Corporate resolution approving and adopting the Plan;

   (c) IRS Form 5500; and

   (d) Non-discrimination testing and compliance.

The Customer acknowledges that it has the responsibility to review and approve all Plan documents 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 regardless of the role Aetna may have played in the preparation of such documents.

6. The Customer agrees to verify all deductions and annual elections and notify Aetna in writing of any changes or corrections within thirty (30) days following delivery of the Election Report (as defined below) by Aetna.

III. AETNA RESPONSIBILITIES:

1. Aetna shall assign an 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.

2. Aetna shall provide customer service support for Plan Participants by toll free telephone in accordance with its then-current policies.

3. Aetna shall provide Plan Participants with current account balance and activity information via electronic means, including web portal and call center. Periodic balance information shall be provided with Aetna's responses to submitted claims. Aetna shall not produce or mail separate periodic statements to Plan Participants.

4. Aetna shall make available to the Customer, an account history showing the name of the Plan Participant, name of payee, and amount of benefit payable based on Aetna's initial determination of the claim.

5. Upon request, Aetna shall provide the Customer with the then current administration manual for the orderly operation of the Plan as relates to the Services. Such manual may be modified by Aetna from time-to-time.

6. Aetna shall provide the Customer with forms or comparable electronic means for the enrollment and maintenance of a Plan Participant's records and for the Plan Participant's submission of claims for payment of benefits provided under the Plan.

7. Upon request, Aetna may assist the Customer, or its designated agent, by providing information relating to the preparation and filing of any report, form or document required by any state or federal agency with respect to the Plan. Aetna will also assist the Customer by providing the following:

   (a) Electronic sample of the "Plan Document" and "Summary Plan Description," when requested by the Customer;

   (b) Available information requested by the Customer in connection with the filing of the IRS Form 5500; and

   (c) Available information requested by the Customer in connection with conducting non-discrimination testing.

   Aetna shall have no responsibility or liability for the information provided or the content of any of the Customer's Plan documents regardless of the role Aetna may have played in the provision of such information or the preparation of such documents.

8. Aetna shall make the following standard reports available to the Customer at no additional cost:

   (a) **Ledger Summary Report (Monthly)** – List of deposits, payments and account balances by Plan Participant account for the period and plan year to date.

(b) **Election Report (Beginning of Plan Year)** – List of elections by Plan Participant account.

   (c) **Funding Notification Reports (Settlement and Production)** – Voucher-style report sent each time funding transactions are initiated.

   (d) **Production and Settlement Payment Registers** – Supporting detail for the Funding Notification Report referenced above, which lists Plan Participant reimbursements by account type, plan year and division (if applicable).

   Custom reports may be provided subject to feasibility and data availability for an additional cost as mutually agreed to by the parties in writing. The Customer shall be billed for programming time in accordance with the Service and Fee Schedule.

9. Where applicable and upon request of the Customer, Aetna shall provide debit cards to all Plan Participants. Debit card use shall be bound by and subject to the terms of the "Card Association Rules" as described in the "Cardholder Agreement" that Aetna provides to each Plan Participant upon card issuance.

IV. CLAIM SERVICES:

A. Claim Services:

1. Aetna shall process each claim for reimbursement made by a Plan Participant after determining that the claim for benefits is consistent with the terms of the Plan, and will make the initial determination of the amounts due and payable pursuant to the Plan.

2. Aetna shall arrange for the payment of all approved claims from funds made available by the Customer. The claim checks shall be made payable to the Plan Participant, their assignee or to such other person designated by the Plan Participant not otherwise restricted or prohibited by the Plan. The Customer authorizes Aetna to prepare and issue checks signed by Aetna from an Aetna account funded by the Customer for the purpose of paying claims. Any interest generated on such funds shall be used to pay the fees of the financial institution with respect to such account. To the extent that such interest is not sufficient to pay such fees, Aetna shall pay such fees. To the extent that such interest is in excess of such fees and it does not exceed LIBOR plus 2-percent, Aetna shall be entitled to retain such interest. Aetna will return interest in excess of these permissible amounts to the Customer and the Customer agrees that it will use such amounts consistent with applicable law. Aetna shall request payment from the Customer on a periodic basis for the total amount of reimbursements representing payment of claims. Funding shall take the form of an ACH debit that Aetna will initiate against the Customer's designated bank account. This may be the same account designated for Aetna administration fees and expense reimbursements, or may be a unique account, at the Customer's discretion. Aetna reserves the right to not release claim reimbursements until current funds are received by Aetna from the Customer. The Customer shall advise the Plan Participant of any delays in payment of any claim due to the failure of the Customer to fund a claim payment and the effect of such delay on the payment of the claim processed pursuant to this schedule. In the event that claims are released prior to funds receipt by Aetna, the Customer shall be subject to a "Failure to Fund Claims" fee as referenced in the Service and Fee Schedule.

3. All debit card transactions posted to the account, regardless of final disposition, are deemed to be claims and shall be the responsibility of the Plan and shall be funded by the Plan. Funding shall take the form of an ACH debit that Aetna will initiate against the Customer's designated bank account on each day that transactions post, which may be up to daily.

4. Following an adverse benefit determination of a claim during its initial submission, Aetna shall issue a written notification of its decision to the Plan Participant consistent with Department of Labor ("DOL") regulations or other prevailing law, which shall include: the basis for the adverse benefit determination; reference to the specific Plan provisions on which the determination is based; a description of additional information which may be required in order to perfect the claim; how to formally appeal the claim; and a general statement of rights under the Plan or prevailing law.

5. Upon receipt of an initial appeal by a Plan Participant, Aetna will evaluate the appeal and advise the Customer of Aetna's recommendation as to the determination of the claim. The Customer shall be responsible for, and has otherwise reserved unto itself, final discretionary authority to render benefit determinations, including interpreting the terms of the Plan, during the review on appeal. The Customer shall issue written notice of any adverse benefit determination to the Plan Participant and Aetna, which shall include all the requirements of applicable law.

V. ADDITIONAL ADMINISTRATION INFORMATION:

1. Billing and Payment of Administration Fees.

Administrative Fees are payable via an ACH debit which shall be initiated by Aetna ten days after the invoice is delivered to the Customer. Aetna shall initiate the ACH debit against an account designated for this purpose by the Customer. This may be the same account designated for contributions, or may be a unique account, at the Customer's discretion. Alternate funding methods may be available.

The Customer shall promptly review and verify the accuracy of each invoice and notify Aetna in writing of any inaccuracy or discrepancy with respect to any amount referenced therein within sixty days after receipt of such invoice, failing which such invoice shall be deemed final, complete and correct for all purposes. Any payments which are not timely paid shall be subject to Late Payment Charges as indicated in the Service and Fee Schedule. In determining applicable Administrative Fees Aetna will be entitled to rely on current enrollment information provided by the Customer.

2. **Communications.** Any notices related to the administration of the reimbursement accounts should be directed to PayFlex Systems USA, Inc., 10802 Farnam Drive, Suite 100, Omaha, Nebraska, 68154, Attention: Chief Operating Officer.

3. **Subcontractors.** Aetna may subcontract reimbursement administration services, or may assign its obligations under this schedule to its subsidiaries or affiliates at any time without notice to the Customer.

4. **Termination.** If this schedule is terminated by either party, other than for the Customer's failure to pay Administrative Fees, Aetna agrees to continue to perform Services hereunder for up to three months thereafter in exchange for a fee paid by the Customer equal to three times the amount of the invoice for the last month prior to the effective date of termination. Such fee (and all other amounts owed to Aetna hereunder) shall be paid in full prior to further performance by Aetna.

REIMBURSEMENT SERVICES
SERVICE AND FEE SCHEDULE
Flexible Spending Account (FSA)

The Service Fees and Services effective for the period beginning August 1, 2022 and ending July 31, 2025 are specified below. They shall be amended for future periods, in accordance with section 6 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

Services	Service Fees
Implementation Fee	waived
Annual Fee*	waived
Monthly Administration Fee	$ 3.50 Per Participant/Per Month
Minimum Monthly Billing	$150 per month

*Annual Fee includes upon written request: (i) standard enrollment materials, limited to the number of eligible employees; and (ii) electronic sample of plan document and summary plan description.

Participants, as used in this Service and Fee Schedule are defined as:

An employee in an active status

A terminated employee with a balance greater than $10.00 (Billing for terminated employees continues for three billing cycles after termination, or until the participant's balance drops below $10.)

The fees listed below are only charged if the services are applicable/performed for the Customer.

Optional Services	Fee
PayFlex Onsite Enrollment Meeting Support	$500 per day, based on availability
Custom Reporting	$150.00 per hour
Single Sign On (SSO) to generic PayFlex member website (Assumes PayFlex standard for web service call) Lead-time: 60 days	No charge
Customized Member Flyers (Revisions to generic member flyers) Lead-time: 5 weeks	$1,000.00 per flyer including 2 rounds of edits
Customized Member Letters Lead-time: 5 weeks *System-generated FSA Welcome Letter	$1,500.00 per letter Including 2 rounds of edits plus mailing costs (If applicable)
Customized Card Carrier Lead-time: 5 weeks Cut-off for 1/1/ business is 10/15	$3,000 flat fee Including 2 rounds of edits Rush requests and/or requests after 10/15 for 1/1/ fulfillment is an additional $150.00 per hour (A minimum of 3 hours will be charged)

Co-branded Debit Card Lead-time: 5 weeks Cut-off for 1/1/ business is 10/15	$750.00 flat fee Rush requests and/or requests after 10/15 for 1/1 fulfillment is an additional $150.00 per hour (A minimum of 3 hours will be charged)
Election Confirmation (Reimbursement products) Lead-time: Done at the time of implementation/renewal	$0.12 Per Month Per Participant
Account Statements Lead-time: Done at the time of implementation / renewal	Available Free online or $1.50 Per Participant Per Month for monthly statements - (Reimbursement) $ 0.50 Per Month Per Participant for quarterly statements - (Reimbursement)
Customized KnowledgeVision Presentation Lead-time: 6 weeks	Based on Statement of Work (SOW) (Typically 20 slides, 5 minutes of content, 3 rounds of script reviews)
Development of Custom Communications (Postcards, brochures, flyers, email campaigns) Lead-time: Varies based on type of communication	Based on Statement of Work plus mailing costs (If applicable)
Takeover Administration (previous Plan year)	$2,000.00
Rejected/NSF Customer Funding ACH Transactions	$50 per occurrence of any Customer funding ACH pull that is rejected
Failure to Fund Released Claims	An interest charge assessed for each day in which an outstanding balance is not funded; calculated at a rate not to exceed regulatory rates and based on the average daily balance outstanding across all non-funded days
Debit Card Substantiation File	$1,000.00 per carrier

In general, the number of Plan Participants on which the per-Participant-per-month fee is based for any month is the sum of (1) the number of Plan Participants on the first day of the Plan Year plus (2) the number of Plan Participants that have been added during the Agreement Period. This number is determined as of the first day of each month of the Agreement Period. Plan Participants who terminate during a month are included in the Plan Participant count for purposes of determining that month's per-Participant fee.

The fees shown above are based on administrative services selected. Aetna may adjust the Service Fees effective as of the date on which any of the following occurs:

(a) If, for any Service, there is a 30 % change in the number of employees participating from the number assumed in Aetna's quotation or from any subsequently reset assumptions.
(b) Change in Plan – A material change in the Plan is initiated by the Customer or by legislative action.
(c) Change in Administration – A material change in claim payment requirements or procedures, account structure or any other change materially affecting the manner or cost of paying benefits.

Late Payment Charges: In addition to any termination rights under the Agreement which may apply, if the Customer fails to provide funds on a timely basis to cover Plan benefit payments, and/or fails to pay Service Fees on a timely basis as provided in the Agreement, Aetna will assess a late payment charge. The current charge is:

(a) late funds to cover benefit payments (e.g., late wire transfers): 12 % annual rate
(b) late payments of Service Fees: 12 % annual rate

In addition, Aetna will assess a charge to recover its costs of collection including reasonable attorneys' fees.

The late payment charge percentage specified above is subject to change annually.

No. 724379

Amendment 3 rev.

Attached to and made a part of the Master Services Agreement MSA-724379

an agreement between

Aetna Life Insurance Company
(hereinafter referred to as Aetna)

and the Customer

Hillsborough County Aviation Authority

Nothing contained in this amendment shall be held to alter or affect any of the terms of the Services Agreement other than as herein specifically stated.

It is understood and agreed that the Services Agreement is changed by the addition of the section listed below.

Section Added	Effective Date
Reimbursement Statement of Available Services Schedule	August 1, 2022
Reimbursement Services and Fee Schedule	August 1, 2022

In Witness Whereof, Aetna has signed this amendment at **Hartford**, **Connecticut**, to become effective August 1, 2022.

Signed by Aetna March 8, 2022.

By 

Dan Finke
President

Signed by the Customer _____
Date

_____ _____
Signature Official Title

REIMBURSEMENT STATEMENT OF AVAILABLE SERVICES SCHEDULE
MASTER SERVICES AGREEMENT MSA- 724379
EFFECTIVE August 1, 2022

Subject to the terms and conditions of the Agreement, the reimbursement 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 6, 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. 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 state law, as applicable, the Customer will be the "appropriate named fiduciary" for the purpose of reviewing denied claims under the reimbursement account(s). It is also agreed that Aetna's responsibilities under this schedule are ministerial and Aetna has no fiduciary responsibility under this schedule.

II. CUSTOMER RESPONSIBILITIES:

1. The Customer shall provide Aetna with the necessary records of the Plan Participants covered under this reimbursement schedule, and promptly notify Aetna of any changes or corrections of such Plan Participants.

2. The Customer shall be solely responsible for the collection and administration of contributions to the Plan Participants' account.

3. The Customer shall maintain a supply of forms, which, upon the Customer's request, will be provided by Aetna, and the Customer shall distribute or make such forms available to the Plan Participants for the filing of claims for benefits or to report changes in participation.

4. The Customer shall be solely responsible for satisfying any and all reporting and disclosure requirements imposed on the reimbursement account under applicable law. When requested by the Customer, Aetna will assist Customer with such requirements.

5. The Customer shall be responsible for the final proper preparation and timely filing of the following documents, and performance and compliance with the following tests in connection with the Plan:

   (a) "Plan Document" and "Summary Plan Description";

   (b) Corporate resolution approving and adopting the Plan;

   (c) IRS Form 5500; and

   (d) Non-discrimination testing and compliance.

The Customer acknowledges that it has the responsibility to review and approve all Plan documents 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 regardless of the role Aetna may have played in the preparation of such documents.

6. The Customer agrees to verify all deductions and annual elections and notify Aetna in writing of any changes or corrections within thirty (30) days following delivery of the Election Report (as defined below) by Aetna.

III. AETNA RESPONSIBILITIES:

1. Aetna shall assign an 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.

2. Aetna shall provide customer service support for Plan Participants by toll free telephone in accordance with its then-current policies.

3. Aetna shall provide Plan Participants with current account balance and activity information via electronic means, including web portal and call center. Periodic balance information shall be provided with Aetna's responses to submitted claims. Aetna shall not produce or mail separate periodic statements to Plan Participants.

4. Aetna shall make available to the Customer, an account history showing the name of the Plan Participant, name of payee, and amount of benefit payable based on Aetna's initial determination of the claim.

5. Upon request, Aetna shall provide the Customer with the then current administration manual for the orderly operation of the Plan as relates to the Services. Such manual may be modified by Aetna from time-to-time.

6. Aetna shall provide the Customer with forms or comparable electronic means for the enrollment and maintenance of a Plan Participant's records and for the Plan Participant's submission of claims for payment of benefits provided under the Plan.

7. Upon request, Aetna may assist the Customer, or its designated agent, by providing information relating to the preparation and filing of any report, form or document required by any state or federal agency with respect to the Plan. Aetna will also assist the Customer by providing the following:

   (a) Electronic sample of the "Plan Document" and "Summary Plan Description," when requested by the Customer;

   (b) Available information requested by the Customer in connection with the filing of the IRS Form 5500; and

   (c) Available information requested by the Customer in connection with conducting non-discrimination testing.

   Aetna shall have no responsibility or liability for the information provided or the content of any of the Customer's Plan documents regardless of the role Aetna may have played in the provision of such information or the preparation of such documents.

8. Aetna shall make the following standard reports available to the Customer at no additional cost:

   (a) **Ledger Summary Report (Monthly)** – List of deposits, payments and account balances by Plan Participant account for the period and plan year to date.

(b) **Election Report (Beginning of Plan Year)** – List of elections by Plan Participant account.

   (c) **Funding Notification Reports (Settlement and Production)** – Voucher-style report sent each time funding transactions are initiated.

   (d) **Production and Settlement Payment Registers** – Supporting detail for the Funding Notification Report referenced above, which lists Plan Participant reimbursements by account type, plan year and division (if applicable).

   Custom reports may be provided subject to feasibility and data availability for an additional cost as mutually agreed to by the parties in writing. The Customer shall be billed for programming time in accordance with the Service and Fee Schedule.

9. Where applicable and upon request of the Customer, Aetna shall provide debit cards to all Plan Participants. Debit card use shall be bound by and subject to the terms of the "Card Association Rules" as described in the "Cardholder Agreement" that Aetna provides to each Plan Participant upon card issuance.

IV. CLAIM SERVICES:

A. Claim Services:

1. Aetna shall process each claim for reimbursement made by a Plan Participant after determining that the claim for benefits is consistent with the terms of the Plan, and will make the initial determination of the amounts due and payable pursuant to the Plan.

2. Aetna shall arrange for the payment of all approved claims from funds made available by the Customer. The claim checks shall be made payable to the Plan Participant, their assignee or to such other person designated by the Plan Participant not otherwise restricted or prohibited by the Plan. The Customer authorizes Aetna to prepare and issue checks signed by Aetna from an Aetna account funded by the Customer for the purpose of paying claims. Any interest generated on such funds shall be used to pay the fees of the financial institution with respect to such account. To the extent that such interest is not sufficient to pay such fees, Aetna shall pay such fees. To the extent that such interest is in excess of such fees and it does not exceed LIBOR plus 2-percent, Aetna shall be entitled to retain such interest. Aetna will return interest in excess of these permissible amounts to the Customer and the Customer agrees that it will use such amounts consistent with applicable law. Aetna shall request payment from the Customer on a periodic basis for the total amount of reimbursements representing payment of claims. Funding shall take the form of an ACH debit that Aetna will initiate against the Customer's designated bank account. This may be the same account designated for Aetna administration fees and expense reimbursements, or may be a unique account, at the Customer's discretion. Aetna reserves the right to not release claim reimbursements until current funds are received by Aetna from the Customer. The Customer shall advise the Plan Participant of any delays in payment of any claim due to the failure of the Customer to fund a claim payment and the effect of such delay on the payment of the claim processed pursuant to this schedule. In the event that claims are released prior to funds receipt by Aetna, the Customer shall be subject to a "Failure to Fund Claims" fee as referenced in the Service and Fee Schedule.

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REIMBURSEMENT SERVICES
SERVICE AND FEE SCHEDULE
Flexible Spending Account (FSA)

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Monthly Administration Fee	$ 3.50 Per Participant/Per Month
Minimum Monthly Billing	$150 per month

*Annual Fee includes upon written request: (i) standard enrollment materials, limited to the number of eligible employees; and (ii) electronic sample of plan document and summary plan description.

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A terminated employee with a balance greater than $10.00 (Billing for terminated employees continues for three billing cycles after termination, or until the participant's balance drops below $10.)

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Custom Reporting	$150.00 per hour
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Customized Member Flyers (Revisions to generic member flyers) Lead-time: 5 weeks	$1,000.00 per flyer including 2 rounds of edits
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Co-branded Debit Card Lead-time: 5 weeks Cut-off for 1/1/ business is 10/15	$750.00 flat fee Rush requests and/or requests after 10/15 for 1/1 fulfillment is an additional $150.00 per hour (A minimum of 3 hours will be charged)
Election Confirmation (Reimbursement products) Lead-time: Done at the time of implementation/renewal	$0.12 Per Month Per Participant
Account Statements Lead-time: Done at the time of implementation / renewal	Available Free online or $1.50 Per Participant Per Month for monthly statements - (Reimbursement) $ 0.50 Per Month Per Participant for quarterly statements - (Reimbursement)
Customized KnowledgeVision Presentation Lead-time: 6 weeks	Based on Statement of Work (SOW) (Typically 20 slides, 5 minutes of content, 3 rounds of script reviews)
Development of Custom Communications (Postcards, brochures, flyers, email campaigns) Lead-time: Varies based on type of communication	Based on Statement of Work plus mailing costs (If applicable)
Takeover Administration (previous Plan year)	$2,000.00
Rejected/NSF Customer Funding ACH Transactions	$50 per occurrence of any Customer funding ACH pull that is rejected
Failure to Fund Released Claims	An interest charge assessed for each day in which an outstanding balance is not funded; calculated at a rate not to exceed regulatory rates and based on the average daily balance outstanding across all non-funded days
Debit Card Substantiation File	$1,000.00 per carrier

In general, the number of Plan Participants on which the per-Participant-per-month fee is based for any month is the sum of (1) the number of Plan Participants on the first day of the Plan Year plus (2) the number of Plan Participants that have been added during the Agreement Period. This number is determined as of the first day of each month of the Agreement Period. Plan Participants who terminate during a month are included in the Plan Participant count for purposes of determining that month's per-Participant fee.

The fees shown above are based on administrative services selected. Aetna may adjust the Service Fees effective as of the date on which any of the following occurs:

(a) If, for any Service, there is a 30 % change in the number of employees participating from the number assumed in Aetna's quotation or from any subsequently reset assumptions.
(b) Change in Plan – A material change in the Plan is initiated by the Customer or by legislative action.
(c) Change in Administration – A material change in claim payment requirements or procedures, account structure or any other change materially affecting the manner or cost of paying benefits.

Late Payment Charges: In addition to any termination rights under the Agreement which may apply, if the Customer fails to provide funds on a timely basis to cover Plan benefit payments, and/or fails to pay Service Fees on a timely basis as provided in the Agreement, Aetna will assess a late payment charge. The current charge is:

(a) late funds to cover benefit payments (e.g., late wire transfers): 12 % annual rate
(b) late payments of Service Fees: 12 % annual rate

In addition, Aetna will assess a charge to recover its costs of collection including reasonable attorneys' fees.

The late payment charge percentage specified above is subject to change annually.

THE POINT SOLUTIONS MANAGEMENT AMENDMENT

MSA – 0724379

This Amendment, the "Point Solutions Management Amendment", effective August 1, 2022, amends the Services Agreement between Aetna Life Insurance Company, a Connecticut corporation, ("Aetna") and Hillsborough County Aviation Authority ("Customer"), dated August 1, 2013 (the "Agreement").

Whereas, Aetna desires to make available the point solutions management services which makes available to its clients certain third-party digital applications and other products and services ("Point Solutions Management Services") to Customer; and

Whereas, Customer desires to enroll in the Point Solutions Management Services.

Now, therefore, the parties agree to amend the Agreement as set forth herein.

1. The following provision shall be added to Section 2 (Services) of the Agreement:

   > "Aetna shall make available to Customer the Point Solutions Management Services in accordance with the terms and conditions thereof described in Exhibit A, a copy of which is attached hereto."

2. The terms and conditions of the Agreement remain in effect except as otherwise stated herein. With respect to the subject matter hereof, this Amendment constitutes the entire agreement between the parties, superseding all similar terms in any prior understandings, agreements, contracts or arrangements between the parties, whether oral or written.

3. All capitalized terms used in this Amendment and not otherwise defined shall have the meanings set forth in the Agreement. If any provision of this Amendment conflicts with any of the provisions set forth in the Agreement, the provisions of this Amendment shall govern and control.

4. If any provision of this Amendment is held to be void or unenforceable, the remaining provisions are severable, and their enforceability is not affected or impaired in any way by reason of such law or holding.

IN WITNESS WHEREOF, the undersigned have duly executed this Amendment as of the date first written above.

AETNA LIFE INSURANCE COMPANY:

By: 

Name: Dan Finke

Title: President, Aetna Life Insurance Company

Date: _____

CUSTOMER:
HILLSBOROUGH COUNTY AVIATION AUTHORITY

By: _____

Name: _____

Title: _____

Date: _____

Exhibit A

MSA - 0724379

Point Solutions Management Service Terms and Conditions

Customer has implemented the Point Solutions Management Service to engage in certain third-party digital applications and other products and services (each a "PSM Solution" provided by a "PSM Vendor") as set forth below. PSM Vendors are contracted as subcontractors of Aetna's affiliate, CaremarkPCS Health, L.L.C. ("CVS Caremark").

1. Customer will enroll in individual PSM Solutions by executing a "Vendor Election Form" provided by CVS Caremark. Implementation dates of individual PSM Solutions will be as described in their respective Vendor Election Forms. Aetna shall collect from Customer and remit to CVS Caremark and CVS Caremark shall remit to PSM Vendors, the fees described in each Vendor Election Form. Neither Aetna nor CVS Caremark shall be responsible for funding any portion of the PSM Solutions, but rather shall remit applicable fees only for amounts properly funded by Customer. The PSM Solution will be available to employees of Customer residing in the United States, even if they do not receive other pharmacy benefit services provided or arranged by Aetna through CVS Caremark.

2. The Point Solutions Management Service processes payments for third-party products and services. The PSM Solution may include access or use, or otherwise interact with third party applications, websites and services ("Third Party Applications") to make the PSM Solution available to Customer. These Third-Party Applications may have their own terms and conditions of use. Customer understands and agrees that CVS Caremark and Aetna do not endorse and are not responsible for the terms and conditions of use of those Third-Party Applications. PSM Solutions and related payments shall not constitute Claims under the Agreement and are excluded from the calculation of any and all financial and performance guarantees in the Agreement. Fees for PSM Solutions may not be paid from any allowances or credits made available to Customer by Aetna under the Agreement. In the event a PSM Solution impacts the underlying financial terms of the Agreement, Aetna will review such impact with Customer and may equitably adjust the same.

3. Communication campaigns, including but not limited to campaigns that raise awareness of the PSM Solutions, will be designed and executed by PSM Vendors in coordination with Customer. Data regarding PSM Solutions may be audited pursuant to Customer's existing audit rights and may take up to ninety (90) days from the date of the data request if records need to be secured from PSM Vendors. Neither CVS Caremark nor Aetna will be liable for any obligations arising from existing agreements with a PSM Vendor, or for services provided by PSM Vendors other than those provided pursuant to a Vendor Election Form. Customer is a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations at 45 CFR Parts 160-164 ("HIPAA Rules"). To the extent Customer authorizes the disclosure of protected health information of its members to a PSM Vendor for a PSM Solution, it will comply with and be subject to the HIPAA Rules.

4. The term of Customer's participation in the Point Solutions Management Service shall expire one (1) year from the date of execution of this Amendment, and shall thereafter automatically renew for additional one (1) year terms unless either party provides written

notice of non-renewal at least ninety (90) days before the end of the initial term or any renewal term; provided that either party may at any time terminate Customer's participation in the Point Solutions Management Service, or any individual PSM Solution, upon ninety (90) days' prior written notice to the other party. In the event safety concerns with a PSM Solution or breach of a PSM Vendor's contract with CVS Caremark require CVS Caremark to terminate a PSM Solution, CVS Caremark shall notify Aetna which, in turn, will notify Customer of the termination within five (5) business days. Upon the termination of Customer's participation in the Point Solutions Management Service, all Vendor Election Forms will terminate simultaneously with such termination.