MASTER SERVICES AGREEMENT NO. MSA-866349

This Master Services Agreement by and between Aetna Life Insurance Company, a Connecticut corporation located at 151 Farmington Avenue, Hartford, Connecticut, its affiliated HMOs, if indicated in Appendix V, its other affiliates and subsidiaries (collectively "Aetna") and Williamson County, a, a political subdivision of the State of Texas and a body politic duly organized and existing under the laws of the State of Texas, with its principal place of business located at 710 Main Street, Suite 101, Georgetown, Texas 78626 ("Customer") is effective as of November 1, 2014 ("Effective Date"). This Master Services Agreement, Statements of Available Services ("SAS"s), Williamson County Request for Proposals 15RFP101, Aetna's Proposal in response to Williamson County Request for Proposals 15RFP101 and any additional Schedules and Appendices, as so identified and agreed, shall be hereinafter collectively referred to as the "Services Agreement."

1. INTRODUCTION

WHEREAS, Customer has established a self-funded employee health benefits plan (the "Plan"), for certain eligible Plan Participants (employees, dependents, beneficiaries, retirees, or members as referenced in the Plan documents, or any term used by the Customer to designate participants in the Plan) described in Appendix I of this Services Agreement; and

WHEREAS, pursuant to the Plan, Customer wishes to make available one or more products offered by Aetna ("the Products"), as specified in the SASs; and

WHEREAS, Aetna has arranged to provide integrated claim administration of these Product(s) and supplemental administrative services ("Services");

THEREFORE, in consideration of the mutual covenants and promises stated herein and other good and valuable consideration, the parties hereby enter into this Services Agreement, which sets forth the terms and conditions under which Aetna agrees to render the Services, and under which Customer hereby agrees to receive and compensate Aetna for such Services.

2. TERM

Unless one party informs the other of its intent to allow the Services Agreement to terminate in accordance with Section 7 of this Master Services Agreement, the initial term of this Services Agreement shall be three (3) years beginning on the Effective Date (referred to as an "Agreement Period"). This Agreement will automatically renew for up to two (2) additional successive one-year terms unless otherwise terminated pursuant to Section 7 of this Master Services Agreement.

3. SERVICES

Aetna shall perform only those services expressly described in this Services Agreement. In the event of a conflict between the terms of this Master Services Agreement and of the attached SASs, the terms of the SASs will control.

4. STANDARD OF CARE

Aetna or Customer will discharge their obligations under the Services Agreement with that level of reasonable care which a similarly situated Services provider or plan administrator, as applicable, would exercise under similar circumstances. In connection with fiduciary powers and duties hereunder, if delegated by Customer to Aetna as noted in the Claim Fiduciary section of the applicable SAS, Aetna shall observe the standard of care and diligence required of a fiduciary under applicable state law.

5. FIDUCIARY DUTY

It is understood and agreed that the Customer 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 Customer in connection with the Plan only to the extent expressly stated in the Services Agreement or as agreed to in writing by Aetna and Customer.

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 Statement of Available Services ("SAS").

6. SERVICE FEES

Customer shall pay Aetna the Service Fees in accordance with the Service and Fee Schedule(s). No Services other than those identified in the Service and Fee Schedule(s) are included in the Service Fees. Subject to the terms of the Service and Fee Schedule(s) and except as otherwise set forth herein, the Services to be provided by Aetna and the Service Fees may be adjusted annually effective on the anniversary of the Effective Date (the "Contract Anniversary Date") by Aetna upon ninety (90) days prior written notice, or at other times as indicated in the Service and Fee Schedule(s). Any change to the Service Fees must be in accordance with the guarantees set forth in the Service and Fee Schedule(s).

Aetna shall provide Customer with a monthly statement indicating the Service Fees owed for the current month. On or before the first of each month, Aetna shall provide Customer with a monthly statement indicating the Service Fees owed for the current month. Any employee added between the 1st and the 15th of the previous month will be accounted for on the invoice for purposes of calculating any per employee per month fees. Any employee terminated between the 1st and 15th of the month will be a credit to the Customer's invoice the following month. Any employee added between the 16th and the end of the preceding month will be accounted for on the next month's invoice. Any employee terminated between the 16th and the end of the preceding month will be accounted for on the next month's invoice. Customer shall pay Aetna the amount of the Service Fees in accordance with Chapter 2251 of the Texas Government Code. A monthly statement shall be deemed overdue the 31st day after the later of (1) the last day of the month for which the Service Fees are billed and Services rendered; or (2) the date the Williamson County Benefit Department receives a monthly statement for the Services (the "Payment Due Date").

In the event that an error appears in an invoice submitted by Aetna, Customer shall notify Aetna of the error not later than the twenty first (21st) day after the date Customer receives the invoice. If the error is resolved in favor of Aetna, Aetna shall be entitled to receive interest on the unpaid balance of the invoice submitted by Aetna beginning on the date that the payment for the invoice became overdue. If the error is resolved in favor of the Customer, Aetna shall submit a corrected invoice that must be paid in accordance within the time set forth above. The unpaid balance accrues interest as provided by Chapter 2251 of the Texas Government Code if the corrected invoice is not paid by the appropriate date.

Customer shall reimburse Aetna for additional expenses incurred by Aetna and agreed to by the parties on behalf of the Plan or Customer which are necessary for the administration of the Plan, including, but not limited to: special hospital audit fees, fees paid or expenses incurred to recover Plan assets, customized printing fees, clerical listing of eligibility, Customer audits exceeding limits in the Services Agreement, and for any other services performed which are not Services under the Services Agreement. The payment by Aetna on behalf of Customer of any such expenses shall constitute part of the Services hereunder, provided, however, with respect to any payments made by Aetna on behalf of and at the request of the Customer to vendors, as a result of Aetna issuing such payment, Aetna will assume the tax reporting obligation, such as Form 1099-MISC or other applicable forms.

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 onetime 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, Customer, as may be the case, based upon specific applicable claims, proportional membership or some other allocation methodology, after taking into account Aetna's costs including Aetna's internal costs of recovery and distribution.

Interest charges for any overdue payments shall be paid by Customer in accordance with Texas Government Code Section 2251.025. More specifically, the rate of interest that shall accrue on a late payment is the rate in effect on September 1 of Customer's fiscal year (October 1-September 30) in which the payment becomes due. The said rate in effect on September 1 shall be equal to the sum of one percent (1%) and the prime rate published in the Wall Street Journal on the first day of July of the preceding fiscal year that does not fall on a Saturday or Sunday.

Following the close of an Agreement Period, Aetna will prepare and submit to the Customer a report showing the Service Fees paid.

7. TERMINATION

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

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

(B) Customer Termination - Customer may terminate the Services Agreement with respect to all Plan Participants or any group of Plan Participants included under the Services Agreement or any subsidiary or affiliate of Customer that is covered under the Services Agreement, or for a particular Product and/or SAS, by giving Aetna at least thirty-one (31) days written notice stating when, after the date of such notice, such termination shall become effective.

(C) Aetna Termination -

(1) Aetna may terminate the Services Agreement or any SAS attached hereto by giving to Customer at least thirty-one (31) days written notice stating when, after the date of such notice, such termination shall become effective.

(2) If Customer fails to respond to an initial request by Aetna, or the bank selected by Aetna, on which benefit payment checks are drawn in satisfaction of a claim for Plan benefits ("Bank"), to provide funds to the Bank for the payment of checks or other payments approved and recorded by Aetna, Aetna shall have the right to cease processing benefit payment requests and suspend other Services until the requested funds have been provided. Aetna may terminate the Services Agreement immediately upon transmission of notice to Customer by mail, facsimile transmission or other means of communication (including electronic mail) if (a) Customer fails to provide the requested funds within five (5) business days of written notice by Aetna, or (b) Aetna determines that Customer will not meet its obligation to provide such funds within such five (5) business days.

(3) If Customer fails to pay Service Fees by the Payment Due Date, Aetna shall have the right to suspend Services until the Service Fees have been paid. Aetna may terminate the Services Agreement immediately upon transmission of notice to Customer by mail, facsimile transmission or other means of communication (including electronic mail) if (a) Customer either fails to pay such Service Fees within five (5) business days of written notice of unpaid Service Fees by Aetna, or (b) Aetna determines that Customer will not meet its obligation to pay such Service Fees within such five (5) business days.

(4) Any acceptance by Aetna of funds or Service Fees described in paragraphs (2) or (3) above, after the grace periods specified therein have elapsed and prior to any action by Aetna to suspend Services or terminate the Services Agreement, shall not constitute a waiver of Aetna's right to suspend Services or terminate the Services Agreement in accordance with this section with respect to any other failure of Customer to meet its obligations hereunder.

(D) Responsibilities on Termination - Upon termination of the Services Agreement, for any reason other than termination under Section 7 (C) (2), Aetna will continue to process runoff claims for Plan benefits that were incurred prior to, but not processed as of, the termination date, which are received by Aetna not more than twelve (12) months following the termination date. The Service Fee for such activity is included in the Service Fees described in Section 6 of this Master Services Agreement. The procedures and obligations described in the Services Agreement, to the extent applicable, shall survive the termination of the Services Agreement and remain in effect with respect to such claims. Benefit payments processed by Aetna with respect to such claims which are pended or disputed will be handled to their conclusion by Aetna, and the procedures and obligations described in the Services Agreement, to the extent applicable, shall survive the expiration of the twelve (12) month period. Requests for benefit payments received after such twelve (12) month period will be returned to the Customer or, upon its direction, to a successor administrator at the Customer's expense.

Customer will be liable for all Plan benefit payments made by Aetna in accordance with the preceding paragraph (D) following the termination date or which are outstanding on the termination date. Customer will continue to fund Plan benefit payments through the banking arrangement described in Section 8 of this Master Services Agreement and agrees to instruct its bank to continue to make funds available until all outstanding Plan benefit payments have been funded by the Customer or until such time as mutually agreed upon by Aetna and Customer (e.g., Customer's wire line and bank account from which the Bank requests funds must remain open for one (1) year after runoff processing ends, two (2) years after termination).

Upon termination of the Services Agreement and provided all Service Fees have been paid, Aetna will release to Customer or to a successor administrator, in Aetna's standard format, all claim data, records and files within thirty-one (31) days following the termination date. All reasonable costs associated with the release of data, records and files from Aetna to Customer shall be paid by Customer.

8. BENEFIT FUNDING

Plan benefit payments and related charges of any amount payable under the Plan shall be made by check drawn by Aetna payable through the Bank or by electronic funds transfer or other reasonable transfer method. Customer, by execution of the Services Agreement, expressly authorizes Aetna to issue and accept such checks on behalf of Customer for the purpose of payment of Plan benefits and other related charges. Customer agrees to provide funds through its designated bank sufficient to satisfy all Plan benefits (and which also may include Service Fees in satisfaction of the obligations of Section 6 and any late charges under the Services Agreement) and related charges upon notice from Aetna or the Bank of the amount of payments made by Aetna. Customer shall have two funding options:

(1) Daily Wire. The default option is Aetna's standard daily wire process. Unless Customer indicates otherwise by giving the required notice set forth in option 2 below Aetna will apply this default option and Aetna's base Service Fees reflect Aetna's charges for the default option. Under the daily wire process, Aetna will make a funding request on a daily basis each morning by providing notice to the designated Customer representative of the amount to be funded. Customer will send via ACH wire the funds requested on the day of the request using the ACH Wire Push method. Aetna shall make available an on-line "Detail at Time of Wire" report (which is only available under this Daily Wire option), accessible by desk top tool, to allow Customer to audit Pharmacy, Medical, Dental and FSA funding requests. The Detail at Time of Wire tool will provide the necessary and appropriate detail to allow Customer to validate Pharmacy, Medical, Dental and FSA claims that have been processed, including date of service, claim identifier, personal identifier of Plan Participant and plan type. Additionally, upon no less than 48 hours prior written notice to Aetna and for no more than five days per plan year, Customer may elect to fund claims on the next succeeding business day rather than the same day. There is an additional fee for delayed funding as set forth in the Service and Fee Schedule.

(2) Weekly Wire. Upon no less than 60 days advance written notice to Aetna, Customer may instead elect to use Aetna's weekly wire process. An additional fee is required for the weekly wire option, as reflected in the Service and Fee Schedule . Under the weekly wire process, Aetna will make a funding request once per week on Thursday morning by providing notice to the designated Customer representative of the amount to be funded. Customer shall send via ACH wire the funds requested on the day of the request. Additionally, upon written notice to Aetna and for no more than five days per plan year, Customer may elect to fund claims on the next succeeding business day rather than the same day. There is an additional fee for delayed funding as set forth in the Service and Fee Schedule.

Under either the daily wire or weekly wire option, Aetna will also issue a monthly reconciliation invoice after the close of each month, and amounts reflected on such invoices must be funded by ACH wire by the end of business on Thursday of the week in which the invoice is received by Customer, provided such invoice is delivered no later than Thursday morning together with the daily wire invoice for that day.

As used herein "Plan benefits" means payments under the Plan, excluding any copayments, coinsurance or deductibles required by the Plan.

Aetna is not obligated to act on outstanding benefit checks unless directed to do so by Customer. Aetna reserves the right to place stop payments on all outstanding benefit checks (i.e., checks which have not been presented for payment) on the sooner of:

(A) one (1) year following the date Aetna completes its runoff processing obligations; or
(B) five (5) days following Customer's failure to provide requested funds or pay Service Fees due in accordance with Section 7(C).

Late Payment Charges
Any late fees associated with Customer's funding obligations shall be paid by Customer in accordance with Texas Government Code Section 2251.025. More specifically, the rate of interest that shall accrue on a late payment is the rate in effect on September 1 of Customer's fiscal year in which the payment becomes due. The said rate in effect on September 1 shall be equal to the sum of one percent (1%) and the prime rate published in the Wall Street Journal on the first day of July of the preceding fiscal year that does not fall on a Saturday or Sunday. Note: Additional fee for next day funding (no more than five days per plan year) is outlined in Section 8 above.

9. CUSTOMER'S RESPONSIBILITIES

(A) Eligibility - Customer shall supply Aetna in writing or by electronic medium acceptable to Aetna with all information regarding the eligibility of Plan Participants including but not limited to the identification of any Sponsored Dependents defined in Customer's Summary Plan Description (SPD) and shall notify Aetna by the tenth day of the month following any changes in Plan participation. Customer agrees that retroactive terminations of Plan Participants shall not exceed 30 days and that Aetna has no financial responsibility for any benefit payments owed under the Plan. Aetna has no responsibility for determining whether an individual meets the definition of a Sponsored Dependent. Aetna shall not be responsible in any manner, including but not limited to, any obligations set forth in Section 13 below, for any delay or error caused by the Customer's failure to furnish accurate eligibility information. Customer represents that it has informed its Plan Participants through enrollment forms executed by Customer's Plan Participants, or in another manner which satisfies applicable law, that confidential information relating to their benefit claims may be disclosed to third parties in connection with plan administration.

(B) Initial SPD Review - Customer shall provide Aetna with all Plan documents at least thirty (30) days prior to the Effective Date or such other date mutually agreed upon by the parties. Customer agrees that it will provide Aetna with a copy of its SPD, so that Aetna may reconcile any potential differences that may exist among the SPD, the description of Plan benefits in Appendix I and Aetna's internal policies and procedures. Aetna does NOT review Customer's SPD for compliance with applicable law. Customer also agrees that it is responsible for satisfying any and all Plan reporting and disclosure requirements imposed by law, including updating the SPD to reflect any changes in benefits.

(C) Notice of Benefit Change - Customer shall notify Aetna in writing of any changes in Plan documents or Plan benefits at least thirty (30) days prior to the effective date of such changes. Aetna shall have thirty (30) days following receipt of such notice to inform Customer of whether it will administer such proposed changes. Appendix I hereto shall be deemed to be automatically modified to reflect such proposed changes if Aetna either agrees to administer the changes as proposed or fails to object to such changes within thirty (30) days of receipt of the foregoing notice. The description of Plan benefits in Appendix I may otherwise be amended only by mutual written agreement of the parties. Aetna may charge additional fees relating to any increase in cost to administer the description of Plan benefits in Appendix I and otherwise revise this Services Agreement, including, without limitation, the financial terms set forth in the Service and Fee Schedule or the Performance Guarantees set forth in Appendix II because of changes which Aetna agrees to administer.

(D) Employee Notices - Customer agrees to furnish each employee covered by the Plan written notice, satisfactory to Aetna, that Customer has complete financial liability for the payment of Plan benefits. To the extent authorized under Texas law, Customer agrees to indemnify Aetna and hold Aetna harmless against any and all loss, damage and expense (including reasonable attorneys' fees) sustained by Aetna as a result of any failure by Customer to give such notice.

(E) Miscellaneous - Customer shall immediately provide Aetna with such information regarding administration of the Plan as Aetna may request from time to time. Aetna is entitled to rely on the information most recently supplied by Customer in connection with Aetna's Services and its other obligations under the Services Agreement. Aetna shall not be responsible for any delay or error caused by 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.

10. RECORDS

Customer acknowledges and agrees that Aetna or its affiliates or authorized agents shall have the right to use all documents, records, reports, and data, including data recorded in Aetna's data processing systems ("Documentation"), subject to compliance with privacy laws and regulations, including without limitation regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. All Documentation is stored in Aetna's data warehouses, and may be de-identified as to Plan Participants and Customer identity for purposes other than administration of Customer's claims, at Aetna's discretion. Customer is not compensated for any use of de-identified Documentation maintained in Aetna's data warehouse.

Upon reasonable prior written request, and subject to the provisions of Sections 11 and 12, and as permitted by applicable law, the Plan-related benefit payment information contained in the Documentation shall be made available to Customer or to a third party designated by Customer (1) in electronic format, where practicable, consistent with Aetna's security standards; (2) in person for inspection during regular business hours at the place or places of business where it is maintained by Aetna; or (3) by hardcopy delivered to Customer for a charge of $0.10 per page plus postage and handling, provided that the hardcopy option shall be available only for a reasonably sized request and only consistent with Aetna's security standards. All reasonable requests for electronic information that are consistent with Aetna's standard format and practices will be provided to Customer free of cost. Aetna shall advise Customer in advance if Customer has made a request for electronic information that is outside of the foregoing parameters, in which event Customer shall reimburse Aetna for any reasonable incremental personnel costs Aetna incurs to fulfill the request. Such Plan-related benefit payment Documentation will be kept by Aetna for seven (7) years after the year in which a claim is adjudicated, unless Aetna turns such Documentation over to Customer or a designee of Customer. In the event return or destruction is infeasible, Aetna shall extend protections required by HIPAA.

11. CONFIDENTIALITY

(A) Business Confidential Information - Each party acknowledges that performance of the Services Agreement may involve access to and disclosure of Customer and Aetna identifiable business proprietary data, rates, procedures, materials, lists, systems and information of the other (collectively "Business Confidential Information"). No Business Confidential Information shall be disclosed to any third party other than a party's representatives who have a need to know such Information in relation to administration of the Plan, and provided that such representatives are informed of the confidentiality provisions hereof and agree to abide by them. All such Information must be maintained in strict confidence. Customer agrees that Aetna may make lawful references to Customer in its marketing activities and in informing health care providers as to the organizations and plans for which Services are to be provided.

(B) Aetna Confidential Information – Any information with respect to Aetna's or any of its affiliate's fees or specific rates of payment to health care providers and any information which may allow determination of such fees or rates and any of the terms and provisions of the health care providers' agreements with Aetna or its affiliates are deemed to be Aetna Confidential Information. No disclosure of any such information may be made or permitted to Customer or to any third party whatsoever, including, but not limited to, any broker, consultant, auditor, reviewer, administrator or agent unless (i) Aetna has consented in writing to such disclosure and (ii) each such recipient has executed a confidentiality agreement in form satisfactory to Aetna's counsel.

(C) Plan Participant Confidential Information - In addition, each party will maintain the confidentiality of medical records and confidential Plan Participant-identifiable patient information ("Plan Participant Confidential Information"), and in accordance with the terms of the Business Associate Agreement attached as Appendix III to this Services Agreement.

(D) Upon Termination - Upon termination of the Services Agreement, each party, upon the request of the other, will return or destroy all copies of all of the other's Confidential Information in its possession or control except to the extent such Confidential Information must be retained pursuant to applicable law, to the extent such Confidential Information cannot be disaggregated from Aetna's databases, or except as otherwise provided under the Business Associate Addendum attached as Appendix III provided, however, that Aetna may retain copies of any such Confidential Information it deems necessary for the defense of litigation concerning the Services it provided under the Services Agreement and for use in the processing of runoff claims for Plan benefits, in accordance with the terms of Section 7(D) of this Master Services Agreement.

(E) Customer and Aetna acknowledge that compliance with the provisions of the foregoing paragraphs are necessary to protect the business and good will of each party and its affiliates and that any actual or potential breach will irreparably cause damage to each party or its affiliates for which money damages may not be adequate. Customer and Aetna therefore agree that if a party or party's representatives breach or attempt to breach paragraphs (A) through (D) hereof, the other party will not oppose such party's request for temporary, preliminary and permanent equitable relief, without bond, to restrain such breaches, together with any and all other legal and equitable remedies available under applicable law or under the Services Agreement. The prevailing party shall be entitled to recover from the non-prevailing party the attorneys' fees and costs it expends in any action related to such breach or attempted breach.

(F) To the extent, if any, that any provision in the Services Agreement is in conflict with Tex. Gov't Code 552.001 et seq., as amended (the "Public Information Act"), the same shall be of no force or effect. Furthermore, it is expressly understood and agreed that Customer, its officers and employees may request advice, decisions and opinions of the Attorney General of the State of Texas in regard to the application of the Public Information Act to any items or data furnished to Customer as to whether or not the same are available to the public. It is further understood that Customer's officers and employees shall have the right to rely on the advice, decisions and opinions of the Attorney General, and that Customer, its officers and employees shall have no liability or obligation to any party hereto for the disclosure to the public, or to any person or persons, of any items or data furnished to Customer by a party hereto, in reliance of any advice, decision or opinion of the Attorney General of the State of Texas. In the event Customer receives a request for any Aetna Business Confidential Information or Plan Participant Confidential Information pursuant to the Public Information Act, Customer shall make best efforts to provide Aetna timely notice of the request so that Aetna may take such action as permitted by law, at Aetna's cost, to seek protection for such information.

12. AUDIT RIGHTS

Customer or its duly authorized representatives shall, until the expiration of two (2) years after termination or expiration of the Agreement, have access to and the right to examine and photocopy any and all books, documents, papers and records, which are directly pertinent to the Plan and the Services for the purposes of making audits, examinations, excerpts and transcriptions. The costs of audit(s) reasonable in scope are included in Service Fees and there shall be no other costs for such audits. In the event Customer requests an audit that either (i) cannot be completed within a five (5) day period on Aetna's premises or (ii) containing a sample size in excess of 250 claim transactions, Customer shall reimburse Aetna for any reasonable incremental personnel costs Aetna incurs to fulfill the audit beyond such standard parameters. Customer would, under no circumstances, be charged for Aetna's costs of responding to follow-up inquiries, so long as such inquiries do not involve further on-site audit work. Customer shall have access during normal working hours to all necessary facilities and shall be provided adequate and appropriate work space in order to conduct audits in compliance with the provisions of this section. Customer shall give reasonable advance notice of intended audits.

In the ordinary course, audits of claim transactions will be conducted no more often than once per year and within two years following the period being audited. In the event such audits identify systemic or recurring issues that Customer wishes to investigate for prior periods, the parties will cooperate to conduct such investigations as Customer may reasonably request and Aetna's records for prior periods shall be freely available for such purposes. Audits of performance guarantees must be commenced in the year following the period to which the performance guarantee results apply.

Aetna shall provide a Post Implementation Audit. The Post Implementation Audit **will be at the expense** of Aetna. If Aetna does not have a 95% procedural accuracy as a result of the Post Implementation Audit, Aetna **will incur the cost of a focused claims audit at the end of year one.** Both of these audits will be conducted by Aetna personnel. Should Customer elect to use a third party firm to conduct either or both of the audits, Aetna will provide an allowance of $7500 for payment of the third party vendor (s) fees. If some or all of the $7500 allowance is not used for these audit purposes, Customer may use the allowance for other external costs incurred for plan related purposes.

Upon request, Aetna shall provide Customer with a copy of the most recent SSAE 16 SOC 1 (type II) report, or successor report.

13. RECOVERY OF OVERPAYMENTS

The parties will cooperate fully to make reasonable efforts to recover overpayments of Plan benefits. If it is determined that any payment has been made by Aetna to or on behalf of an ineligible person or if it is determined that more than the appropriate amount has been paid, Aetna shall undertake good faith efforts to recover the erroneous payment. For the purpose of this provision, "good faith efforts" constitute Aetna's outreach to the responsible party via letter, phone, email or other means to attempt to recover the payment at issue. If those efforts are unsuccessful in obtaining recovery, Aetna may use an outside vendor, collection agency or attorney to pursue recovery unless the Customer directs otherwise. With respect to contracted providers, Aetna may withhold the applicable overpayment amount from subsequent payments to the provider to the extent permitted by law, contract, and system capabilities. Except as stated in this section, Aetna has no other obligation with respect to the recovery of overpayments.

Overpayment recoveries made through third party recovery vendors, collection agencies, or attorneys are credited to Customer net of reasonable fees charged by Aetna or those entities. Aetna will be responsible for the cost of any collections that arise from a violation of the standard of care set forth in Section 4 of this Services Agreement.

Overpayments must be determined by direct proof of specific claims. 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, application of software or other review processes that analyze claims in a manner different from the claim determination and payment procedures and standards used by Aetna may not be used to determine overpayments.

Customer may not seek collection, or use a third party to seek collection, of benefit payments or overpayments from contracted providers, since all such recoveries are subject to the terms and provisions of the providers' proprietary contracts with Aetna. For the purpose of determining whether a provider has or has not been overpaid, Customer agrees that the rates paid to contracting providers for covered services shall be governed by Aetna's contracts with those providers, and shall be effective upon the loading of those contract rates into Aetna's systems, but no later than three (3) months after the effective date of the providers' contracts.

Customer may not seek collection, or use a third party to seek collection, of benefit payments or overpayments from parties other than contracted providers described above, until Aetna has had a reasonable opportunity to recover the overpayments. Aetna must confirm all overpayments before collection by a third party may commence. Customer may be charged for additional Aetna expenses incurred in overpayment confirmation.

14. INDEMNIFICATION

(A) Aetna shall indemnify and hold harmless Customer, its directors, officers, and employees (acting in the course of their employment, but not as Plan Participants) for that portion of any third party loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees but excluding payment of plan benefits) caused solely and directly by Aetna's willful misconduct, criminal conduct, breach of the Services Agreement, fraud, breach of fiduciary responsibility, or failure to comply with Section 4 above, related to or arising out of the Services provided under the Services Agreement.

(B) Except as provided in (A) above and limited only to the extent authorized under Texas law, Customer shall indemnify and hold harmless Aetna, its affiliates and their respective directors, officers, and employees for that portion of any third party loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorney's fees): (i) which was caused solely and directly by Customer's willful misconduct, criminal conduct, breach of the Services Agreement, fraud, breach of fiduciary responsibility, or failure to comply with Section 4 above, related to or arising out of the Services Agreement or Customer's role as employer or Plan sponsor; (ii) resulting from taxes, assessments and penalties incurred by Aetna by reason of Plan benefit payments made or Services performed hereunder, and any interest thereon, provided that Customer shall not be required to pay any net income, franchise or other tax, however designated, based upon or measured by Aetna's net income, receipts, capital or net worth; (iii) in connection with the release or transfer of Plan Participant-identifiable information to Customer or a third party designated by Customer, or the use or further disclosure of such information by Customer or such third party; or (iv) resulting from the inclusion of third party vendor information on identification cards.

(C) The party seeking indemnification under (A) or (B) above must notify the indemnifying party within 20 days in writing of any actual or threatened action, suit or proceeding to which it claims such indemnification applies. Failure to so notify the indemnifying party shall 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 within the required time period.

The indemnifying party may then take steps to be joined as a party to such proceeding, and the party seeking indemnification shall not oppose any such joinder. Whether or not such joinder takes place, the indemnifying party shall provide the defense with respect to claims to which this Section applies and in doing so shall have the right to control the defense and settlement with respect to such claims.

The party seeking indemnification may assume responsibility for the direction of its own defense at any time, including the right to settle or compromise any claim against it without the consent of the indemnifying party, provided that in doing so it shall be deemed to have waived its right to indemnification, except in cases where the indemnifying party has declined to defend against the claim.

(D) Customer and Aetna agree that: (i) Aetna does not render medical services or treatments to Plan Participants; (ii) neither Customer nor Aetna is responsible for the health care that is delivered by contracting health care providers; (iii) health care providers are solely responsible for the health care they deliver to Plan Participants; (iv) health care providers are not the agents or employees of Customer or Aetna; and (v) the indemnification obligations of (A) or (B) above do not apply to any portion of any loss, liability, damage, expense, settlement, cost or obligation caused by the acts or omissions of health care providers with respect to Plan Participants.

(E) The indemnification obligations under (A) above shall not apply to that portion of any loss, liability, damage, expense, settlement, cost or obligation caused by (i) any act undertaken by Aetna at the direction of Customer, (ii) any failure, refusal, or omission to act, directed by the Customer (other than services described in the Services Agreement), or, (iii) with respect to intellectual property infringement, Customer's modification of the Services or materials delivered therewith, use of Services or materials delivered therewith for purposes not contemplated by the Services Agreement, other than as directed by Aetna or after the Services Agreement has terminated or expired, combination of the Services or materials delivered therewith with services, materials or processes not provided by Aetna where the combination is the basis for the claim of infringement, or failure to promptly notify Aetna of a claim and such failure increases Aetna's costs or expenses or otherwise compromises its ability to defend Customer hereunder. For purposes of the exclusions in this paragraph, the term "Customer" includes any person or entity acting on Customer's behalf or at Customer's direction. The indemnification obligations under (B) above shall not apply to that portion of any loss, liability, damage, expense, settlement, cost or obligation caused by any act undertaken by Customer at the direction of Aetna, or by any failure, refusal, or omission to act, directed by the Aetna.

(F) The indemnification obligations under this Section 14 shall terminate upon the expiration of this Services Agreement, except as to any matter concerning which a claim has been asserted by notice to the other party at the time of such expiration or within two (2) years thereafter.

(G) Aetna acknowledges and agrees that under the Constitution and the laws of the State of Texas, Customer cannot enter into an agreement whereby Customer agrees to indemnify or hold harmless any other party, including but not limited to Aetna.

15. 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. 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 14 Indemnification of the Master Services Agreement. Notwithstanding anything to the contrary in the Defense of Litigation clause above, in any multi-claim provider litigation, (including arbitration), disputing reimbursement for benefits for more than one Plan Sponsor, Customer authorizes Aetna to defend and reasonably settle Customer's benefit claims in such litigation.

16. 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.

17. DISPUTE RESOLUTION

Except as otherwise specifically set forth herein, the parties shall work together in good faith to resolve any controversy, dispute or claim between them which arises out of or relates to the Services Agreement, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"). If the parties are unable to resolve the Claim within thirty (30) days following the date in which one party sent written notice of the Claim to the other party, and if a party wishes to pursue the Claim, such Claim shall be addressed through non-binding mediation. A single mediator engaged in the practice of law, who is knowledgeable about subject matter of the Services Agreement, shall be selected by agreement of the parties and serve as the mediator. Any mediation under the Services Agreement shall be conducted in Williamson County, Texas. The mediator's fees shall be borne equally between the parties. Such non-binding mediation is a condition precedent to seeking redress in a court of competent jurisdiction. This provision shall survive the termination of the Services Agreement.

Except as may be expressly required by law, the parties hereby expressly agree that no claims or disputes between the parties arising out of or relating to the Services Agreement or a breach thereof shall be decided by any arbitration proceeding.

18. NON-AETNA NETWORKS

If Aetna is requested by Customer to arrange for network services to be provided for Plan Participants in a geographic area where Aetna does not have a network of providers under contract to provide those services, Aetna must attempt to contract with another network of non-contracted providers ("non-Aetna networks") to provide the requested services. With respect to the services provided by providers who are not under contract to Aetna or any of its subsidiaries ("non-Aetna providers"), Customer acknowledges and agrees that, any other provisions of the Services Agreement notwithstanding:

- Aetna does not credential, monitor or oversee the providers or the administrative procedures or practices of any non-Aetna networks;
- Although Aetna will attempt to obtain all available discounts, no particular discounts may, in fact, be provided or made available by any particular providers;
- Such providers may not necessarily be available, accessible or convenient;
- Any performance guarantees appearing in the Services Agreement shall not apply to services delivered by non-Aetna providers or networks;
- Neither non-Aetna providers nor non-Aetna networks are to be considered contractors or subcontractors of Aetna; and
- Such providers are providers in private practice, are neither agents nor employees of Aetna, and are solely responsible for the health care services they deliver.

Customer further agrees that, if Aetna subsequently establishes 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 Services Agreement. 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.

19. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

In accordance with the services being provided under the Services Agreement, Aetna will have access to, create and/or receive certain Protected Health Information ("PHI as defined in Appendix III), thus necessitating a written agreement that meets the applicable requirements of the privacy and security rules promulgated by the Federal Department of Health and Human Services ("HHS"). Customer and Aetna mutually agree to satisfy the foregoing regulatory requirements through Appendix III to the Services Agreement.

As of the effective dates set forth therein, the provisions of Appendix III supersede any other provision of the Services Agreement, which may be in conflict with such Appendix on or after the applicable effective date.

20. GENERAL

(A) Relationship of the Parties - It is understood and agreed that Aetna is an agent with respect to claim payments and an independent contractor with respect to all other Services being performed pursuant to the Services Agreement.

(B) Subcontractors - The work to be performed by Aetna under the Services Agreement may, at its discretion, be performed directly by it or wholly or in part through a subsidiary or affiliate or under a contract with an organization of its choosing provided such subsidiary or affiliate is acceptable to Customer. Aetna will remain liable for Services under the Services Agreement.

(C) Advancement of Funds - If, in the normal course of business under the Services Agreement, Aetna, or any other financial organization with which Aetna has a working arrangement, chooses to advance any funds, Customer shall reimburse Aetna or such other financial organization for such payment. In no event shall such advances by Aetna or any another financial organization be construed as obligating Aetna or such organization to make further advances, or to assume liability of Customer for the payment of Plan benefits.

(D) Communications - With respect to any communication, action, decision or determination which is to be taken or made by a party under the Services Agreement, such party's representatives may take such action or make such decision or determination or shall notify the other party in writing of an individual responsible for and capable of taking such action, decision or determination on behalf of such party and shall forward any communications and documentation to such individual for response or action.

Neither party shall be bound by any notice, direction, requisition or request unless and until it shall have been received in writing at (i) in the case of Aetna, 151 Farmington Avenue, Hartford, Connecticut 06156, Attention: Plan Sponsor Services Site Manager, Aetna, (ii) in the case of the Customer, at the address shown below, or (iii) at such other address as either party specifies for the purposes of the Services Agreement by notice in writing addressed to the other party. Notices or communications shall be sent by mail, facsimile transmission or other means of communication.

Address: **301 S.E. Inner Loop, Suite 108**
Georgetown, TX 78626

(E) Force Majeure - Neither party shall be liable for any failure to meet any of the obligations or provide any of the services, obligations or benefits specified or required under the Services Agreement including performance guarantees, where such failure to perform is due to any contingency beyond the reasonable control of such party, its employees, officers or directors. Such contingencies include, but are not limited to: acts or omissions of any person or entity not employed or reasonably controlled by Aetna, its employees, officers or directors; acts of God; terrorism, pandemic, fires; wars; accidents; labor disputes or shortages; governmental laws, ordinances, rules, regulations, or the opinions rendered by any Court, whether valid or invalid. Notwithstanding the foregoing, if Customer fails to respond to a request for benefit funding under Section 8, Aetna may, upon ten Business Days' notice to Customer, cease processing benefit payment requests and suspend other Services until the requested funds have been provided. Aetna may also terminate the Services Agreement immediately upon transmission of notice to Customer if Customer continues to fail to provide the requested funds for a total of 30 calendar days following the initial request.

(F) Health Care Reform - The Patient Protection and Affordable Care Act of 2010 contains provisions that may have a material effect on Customer's benefit Plans. Many of these provisions are subject to further clarification through rulemaking which has not been completed, and may be modified by subsequent legislative or judicial action. Customer is advised to seek its own legal counsel concerning the effect of the Act on Customer's Plans. Aetna reserves the right to modify its products, services, rates and fees, in response to legislation, regulation or requests of government authorities resulting in material changes to plan benefits and to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

(G) Severability - If any provision of the Services Agreement shall be held invalid or unenforceable by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision hereof, but rather this entire Services Agreement will be construed as if not containing the particular invalid or unenforceable provision or provisions, and the rights and obligation of the parties shall be construed and enforced in accordance therewith. The parties acknowledge that if any provision of the Services Agreement is determined to be invalid or unenforceable, it is the desire and intention of each that such provision be reformed and construed in such a manner that it will, to the maximum extent practicable, give effect to the intent of the Services Agreement and be deemed to be validated and enforceable.

(H)Venue and Governing Law - Each party to the Services Agreement hereby agrees and acknowledges that venue and jurisdiction of any suit, right, or cause of action arising out of or in connection with the Services Agreement shall lie exclusively in Williamson County, Texas, and the parties hereto expressly consent and submit to such jurisdiction. Furthermore, except to the extent that the Services Agreement is governed by the laws of the United States, the Services Agreement shall be governed by and construed in accordance with the laws of the State of Texas, excluding, however, its choice of law rules.

(I) Successors and Assigns; Assignment - The Services Agreement shall be binding upon and inure to the benefit of parties hereto and their respective successors and assigns. No party to the Services Agreement may assign or transfer its interest in or obligations under the Services Agreement without the prior written consent of all parties to the Services Agreement.

(J) Compliance with Laws - Each party to the Services Agreement shall comply with all federal, state, and local laws, statutes, ordinances, rules and regulations, and the orders and decrees of any courts or administrative bodies or tribunals in any matter affecting the performance of the Services Agreement, including, without limitation, salary and wage statutes and regulations, licensing laws and regulations. When required, Aetna shall furnish the Customer with certification of compliance with said laws, statutes, ordinances, rules, regulations, orders, and decrees above specified.

(K) No Waiver of Immunities - Nothing in the Services Agreement shall be deemed to waive, modify or amend any legal defense available at law or in equity to Customer, its past or present officers, employees, or agents, nor to create any legal rights or claim on behalf of any third party. Customer does not waive, modify, or alter to any extent whatsoever the availability of the defense of governmental immunity under the laws of the State of Texas and of the United States.

(L) Non-Appropriation and Fiscal Funding. The obligations of the parties under the Services Agreement do not constitute a general obligation or indebtedness of either Party for which such Party is obligated to levy, pledge, or collect any form of taxation. It is understood and agreed that Customer shall have the right to terminate the Services Agreement at the end of any Customer fiscal year (September 30th) if the governing body of Customer does not appropriate sufficient funds as determined by Customer's budget for the fiscal year in question. Customer may effect such termination by giving written notice of termination at the end of its then-current fiscal year.

(M) Miscellaneous - No delay or failure of either party in exercising any right hereunder shall be deemed to constitute a waiver of that right. There are no intended third party beneficiaries of the Services Agreement. This Section and Sections 3 through 13 and 15 through 17 shall survive termination of the Services Agreement. The provisions of Section 14 shall survive termination only to the extent stated therein. The headings in the Services Agreement are for reference only and shall not affect the interpretation or construction of the Services Agreement. All references herein to a "day" shall mean a calendar day.

(N) Entire Agreement - The Services Agreement (including incorporated attachments) represents the entire and integrated agreement between the parties hereto and supersedes all prior negotiations, representations, or agreements, either oral or written. The Services Agreement may be amended only by written instrument signed by each party to the Services Agreement. NO OFFICIAL, EMPLOYEE, AGENT, OR REPRESENTATIVE OF THE CUSTOMER HAS ANY AUTHORITY, EITHER EXPRESS OR IMPLIED, TO AMEND THE SERVICES AGREEMENT, EXCEPT PURSUANT TO SUCH EXPRESS AUTHORITY AS MAY BE GRANTED BY THE WILLIAMSON COUNTY COMMISSIONERS COURT. No modification or amendment of this Services Agreement on behalf of Aetna shall be valid unless in writing signed by a duly authorized representative of Aetna. By executing this Services Agreement, the parties acknowledge and agree that it has reviewed all terms and conditions incorporated into this Services Agreement and intends to be legally bound by the same. The parties incorporate the recitals (set forth in Section 1 of this Master Services Agreement) into this Services Agreement as representations of fact to each other.

IN WITNESS WHEREOF, the parties hereto have caused this Services Agreement to be executed by their duly authorized representatives as of the day and year first written herein.

CUSTOMER

WILLIAMSON COUNTY

By: _____

Name: Dan A. Gattis

Title: Williamson County Judge

Date: _____

AETNA LIFE INSURANCE COMPANY on behalf of itself and its affiliates and subsidiaries:

By: _____

Michael S. Copeck

Assistant Vice President and Actuary

Date: May 15, 2014

Financial Verification

Brian Donohue, Medical Director - Underwriting

SELF FUNDED MEDICAL PLAN
STATEMENT OF AVAILABLE SERVICES - MEDICAL PRODUCTS
EFFECTIVE November 1, 2014
MASTER SERVICES AGREEMENT No. MSA-866349

Subject to the terms and conditions of the Services Agreement, the Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to Section 6 of the Master Services Agreement) will be provided by Aetna. Additional Services may be provided at Customer's written request under the terms of the Services Agreement. This Statement of Available Services shall supersede any previous SAS or other document describing the Services.

I. Excluded and/or Superseded Provisions of Master Services Agreement:

- Section 9 (A) Eligibility of the Master Services Agreement is excluded and replaced by Section VI of this Statement of Available Services.

II. Claim Fiduciary

Customer has two claim fiduciary options. The default is Option 1 set forth below. Unless otherwise indicated, Aetna shall provide Option 1. The PEPM Service Fees set forth in the Service and Fee Schedule include the fee for Option 1. Customer may instead elect Option 6 as set forth below by giving Aetna at least 30 days advance written notice prior to the Effective Date. Upon implementation of Option 6, the PEPM Service Fees will be reduced by the amount set forth in the Service and Fee Schedule.

The two fiduciary options are as follows:

1. Fiduciary Option 1 (Default). Customer and Aetna agree that with respect to applicable state law, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. Customer understands that the performance of fiduciary duties under state law 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, 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 Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

2. Fiduciary Option 6 (Alternative Available on 30 Days Advance Written Notice). Customer and Aetna agree that with respect to applicable state law, Aetna will be the "appropriate named fiduciary" of the Plan for the first level of appeal for purpose of reviewing denied claims under the Plan. Customer understands that the performance of fiduciary duties under applicable state law 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, Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan. If the denial is upheld in the first level of appeal, then Aetna will inform the Participant of his right to appeal to the Customer. Customer shall be the "appropriate named fiduciary" of the Plan for the second level of appeal.

III. Administration Services:

A. Member and Claim Services:

1. Requests for Plan benefit payments for claims shall be made to Aetna on forms or other appropriate means approved by Aetna. Such forms (or other appropriate means) may include a consent to the release of medical, claims, and administrative records and information to Aetna. Aetna will process and pay the 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 and the Services Agreement. With respect to any Plan Participant who makes a request for Plan benefits which is denied on behalf of Customer, Aetna will notify said Plan Participant of the denial and of said Plan Participant's right of review of the denial in accordance with ERISA. Any reference to "Plan benefit payments" will also include capitation payments, provider fees and other amounts paid to providers, but does not include co-payments or coinsurance amounts paid by Plan Participants nor Service Fees.

2. Whenever it is determined that benefits and related charges are payable under the Plan, Aetna will issue a payment of such benefits and related charges on behalf of Customer. Funding of Plan benefits and related charges shall be made as provided in Section 8 of the Master Services Agreement.

3. Where the Plan contains a coordination of benefits clause or antiduplication clause, Aetna will administer all claims consistent with such provisions and any information concurrently in its possession as to 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 Subrogation Services are included herein, in which event its obligations are governed by Article VI of this Statement of Available Services.

B. Plan Sponsor Services:

1. Aetna will assign an Account Executive to Customer's account. The Account Executive will be available to assist Customer in connection with the general administration of the Services, ongoing communications with Customer and assistance in claims administration and record-keeping systems for Customer's ongoing operation of the Plan.

2. Upon request by Customer and consent by Aetna, Aetna will implement changes in claims administration consistent with Customer's modifications of its Plan. A charge may be assessed for implementing such changes. Customer's administration Services Fees, as set forth in the Service and Fee Schedule, will be revised if the foregoing amendments or modifications increase Aetna's costs.

3. Aetna will provide the following reports to Customer for no additional charge:

   Monthly/Quarterly/Annual Accounting Reports - Aetna shall prepare and provide the following accounting reports in excel format or other format that is acceptable to Customer and in accordance with the benefit-account structure for use by 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;

   (e) a monthly report that reconciles cleared transactions with the claims invoiced to the Customer for the month reported, including any outstanding transactions; and

   (f) an annual lag report as of September 30th each year that reports any liabilities that were incurred in the Customer's then current fiscal year (Customer's Fiscal Year is October 1st to September 30th) but that will not be paid during the Customer's then current fiscal year.

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

4. Aetna shall develop and install all agreed upon administrative and record keeping systems, including the production of employee identification cards.

5 Aetna shall design and install a benefit-account structure separately by class of employees, division, subsidiary, associated company, or other classification desired by Customer.

6. Aetna shall provide plan design and underwriting services in connection with benefit revisions, additions of new benefits and extensions of coverage to new Plan Participants.

7. Aetna shall provide cost estimates and actuarial advice for benefit revisions, new benefits and extensions of coverage being considered by Customer.

8. Upon request of Customer, Aetna will provide Customer with information reasonably available to Aetna which is reasonably necessary for Customer to prepare reports for the United States Internal Revenue Service and Department of Labor.

9. Aetna will provide assistance in connection with the initial set up, design and preparation of Customer's Plan and if requested, and at Customer's expense, the preparation of draft Summaries of Benefits and Coverage (SBCs) subject to the direction, review and approval by Customer. Customer shall have the final and sole authority regarding the benefits and provisions of the self-insured portion of the Plan, as outlined in Customer's Plan document. Customer acknowledges its responsibility to review and approve all Plan documents and SBCs and revisions thereto and to consult with Customer's legal counsel, at its discretion, in connection with said review and approval. Aetna shall have no responsibility or liability for the content of any of Customer's Plan documents or SBCs, regardless of the role Aetna may have played in the preparation of such documents.

10(a). Upon request of Customer, Aetna shall prepare an Aetna standard Plan description, including benefit revisions, additions of new benefits, and extension of coverage under the Plan. If the Customer elects to have an Aetna non-standard Plan description, Aetna will provide a custom Plan description with all costs borne by Customer; or

10(b). Upon request of Customer, Aetna will review 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.

If Customer requires both preparation (a) and review (b), there may be an additional charge.

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

12. Upon request by Customer, Aetna will arrange for the custom printing of forms and identification cards, with all costs borne by Customer.

IV. Aetna Health Connections℠ Services:

1. Utilization Management Inpatient and Outpatient Precertification:

Inpatient Precertification: A process for collecting information prior to an inpatient confinement. 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. Precertification also allows Aetna to identify Plan Participants for pre-service discharge planning and to identify and register Plan Participants for specialized programs such as Case Management and Disease Management.

- Outpatient Precertification: A process for reviewing selected ambulatory procedures, surgeries, diagnostic tests, home health care and durable medical equipment. The goals of this process are:
  - Assessment of the level and quality of the services provided;
  - Determination of the coverage of the proposed treatment;
  - Identification of care and treatment alternatives, when appropriate; and
  - Identification of Plan Participants for referral to specialized programs.

2. **Utilization Management 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.
- Inpatient concurrent review is conducted telephonically or on-site at the facility where care is delivered.
- The concurrent review process includes:
  - Obtaining necessary information from practitioners and providers regarding the care being provided to Plan Participants;
  - Assessing the clinical condition of Plan Participants and the ongoing provision of medical services and treatments to determine benefit coverage;
  - Notifying practitioners and providers of coverage determinations in the appropriate manner and within the appropriate timeframe;
  - Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting; and
  - Identifying Plan Participants for referral to covered specialty programs such as Case Management, Behavioral Health and Disease Management.

3. **Utilization Management 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.

4. **Utilization Management 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.

5. **Case Management Program:**

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 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 an 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. 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 and maximizing quality outcomes.

Aetna operates two types of case management programs:

- 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.

6. **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 Management Unit issues any appropriate authorizations required under the Plan.

7. **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.

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. IOE facilities have agreed to specific contractual terms and conditions and are selected and recognized by transplant type. The following criteria are applied to each facility prior to being selected for the IOE network:

- Quality – enhanced organ-specific credentialing and quality standards;
- Access – the national availability of, and need for, transplant facilities on a transplant-specific basis. Need is assessed relative to the distribution of membership and relative incidence of transplant types;
- Cost – provider contracts reflect lower negotiated rates.

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 bariatric surgery. Bariatric surgery, also known as weight loss surgery, refers to various surgical procedures to treat people living with morbid, or extreme, obesity.

Facilities selected for the network met the following criteria:

- Have significant experience in bariatric surgery, including a minimum of 125 procedures in the most recent calendar year - aligns with nationally recognized organizations.
- Have evidence-based and recognized standards for clinical outcomes, processes of care and patient safety.
- Provide ongoing follow-up programs and support for their bariatric surgery patients.
- Adhere to Aetna's standards for Participant access to the facility and Aetna participating providers.
- Demonstrate efficiency in providing care based on overall cost of care, readmission rates and comprehensiveness of program.

8. **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 the buy-up of 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 a buy up option.

9. **Aetna Health Connections℠ Disease Management:**

Aetna Health Connections is Aetna's new approach to medical management, and is a critical component of Aetna's ongoing commitment to assisting to improve care for Plan Participants. Most traditional medical management programs focus only on the 20% of Plan Participants who are typically in poor health and represent the majority of medical costs. Aetna Health Connections will continue to identify those Plan Participants at highest risks of deteriorating health, but also expands its focus and programs to include well Plan Participants. Regardless of their health status, Plan Participants will find that Aetna offers programs or web-based tools to help them become more informed health consumers, more aware of their own health status, and more engaged in taking action to improve or maintain their health.

Aetna Health Connections Disease Management is an enhancement to Aetna's medical/disease management spectrum and will target Plan Participants at risk for high cost who have actionable gaps in care, engage the Plan Participants at the appropriate level, 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.

10. Beginning Right® Maternity Program:

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

11. Informed Health® Line:

Informed Health Line (IHL) provides Plan Participants with a toll-free 24-hour/7 day health 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. The nurses cannot diagnose, prescribe treatment or give medical advice, but they can provide Plan Participants with information on a broad spectrum of health issues, including: self-care, prevention, chronic conditions and complex medical situations. Plan Participants can also access the Audio Health Library, a recorded collection of more than 2,000 health topics, available in English and Spanish. Plan Participants can register on Aetna Navigator®, Aetna's member and consumer website, and access Healthwise Knowledgebase, another valuable resource of information on thousands of health topics.

The range of available service components are purchased according to the following categories:

A. Nurseline 1-800# Only: This includes toll-free telephone access to the Informed Health Line Nurseline.

B. Service Plus: This includes the following components:

1. Toll-free telephone access to the Informed Health Line Nurseline.
2. Introductory program announcement letter.
3. Reminder postcards mailed directly to Plan Participants' homes through the year.
4. Semi-annual Activity Utilization Report.

C. Optional Service Features: These features may be purchased in conjunction with the "Service Plus" package and include:

1. Additional introductory kit including Informed Health handbook, flyer with attached wallet cards and refrigerator magnet.
2. Annual Plan Participant survey and Comprehensive Results Report which reflects outcomes, Plan Participant satisfaction and savings results.

12. Wellness Counseling:

This service provides personalized decision support, educational materials, and targeted nurse outreach coaching Plan Participants to a healthier lifestyle through behavioral modification, education, and facilitation of the most effective utilization of Plan Participants benefits. Additionally, action plans may be developed and reviewed with Plan Participants, as appropriate. Plan Participants are identified for participation in wellness counseling through completion of the Simple Steps To A Healthier Life® health risk assessment.

13. Healthy Body. Healthy Weight℠:

This service is a voluntary, one-year program for eligible Plan Participants who access the program by taking the Web-based Simple Steps To A Healthier Life health assessment. Plan Participants are categorized as low, intermediate or high-risk. The frequency and intensity of program interactions are determined based on the Plan Participants' risk stratification and health status.

All program Plan Participants receive an initial call from an Aetna registered nurse/nutritionist who will:

- Provide information on nutrition, healthy menus and exercise.
- Review available health information resources.
- Provide motivational tools, including a pedometer and discounts to a participating community-based weight loss program.
- Identify opportunities for referral to other Aetna programs (e.g. disease management, case management, behavioral health).
- Place a follow-up call to review the Plan Participant's progress and offer support.
- Based on their individual risk factors and health status, Plan Participants may also receive:
  - Ongoing telephone outreach from and access to a weight loss therapist, to include a nutritional and "readiness-to-change" assessment.
  - Additional motivational tools to encourage participation.
  - Regular follow-up at 3-, 6-, and 9-month intervals to monitor weight loss, medication compliance (if applicable) and adherence to recommended exercise programs.

14. Healthy Insights Member Newsletter:

Healthy Insights is a 16-page newsletter that provides information to Plan Participants about Aetna's products, services and resources. It is the vehicle chosen to deliver many of Aetna's NCQA-required notices to its membership.

15. Preventive (Health and Wellness) Mailings:

To support Aetna's customers' ongoing health and wellness strategies, Aetna sends reminders to HMO-based Plan Participants by mail and electronically at certain ages and stages of their lives. These reminders, which are sent at no cost to Customer, make Plan Participants aware of important regular health screenings and other preventive services. They also assist Aetna with meeting regulatory and accreditation requirements. They include:

- Adolescent Immunization Reminder
- Childhood Immunization Reminder
- Preventive Reminder for Influenza and Pneumococcal Vaccines and Colorectal Cancer Screening
- Hypertension and Cholesterol Management Reminders
- Women's Health Recommended Preventive Care Guidelines (for women ages 18-39)
- Women's Health Recommended Preventive Care Guidelines (for women ages 40+)

In addition, Aetna will offer the following optional Health and Wellness mailings to customers:

- Women's Health Recommended Preventive Care Guidelines (for women ages 18-39 and women ages 40+). (Available to customers with PPO-based plans.)
- "How to Talk to Your Doctor" booklet (in English and Spanish). (Available to HMO and PPO customers.)

16. 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 (blood pressure, diabetes, cholesterol, BMI, biometric screening tests, etc.)
- Onsite Workshops: education on specific health conditions and diseases (cardiovascular disease, diabetes, cancer screening, etc.)
- Special Awareness Campaigns: health campaigns that can be customized to meet customer needs
- Worksite Educational Resources: turnkey educational programs that focus on Women's Health, Men's Health and Children's Health.

Aetna may contract with nationally recognized vendors to administer Onsite Health Screening Services, and such vendors may be subject to change.

17. 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 "Life Program") and located at www.aetna.com, to be hosted by Aetna and designed for the eligible employees and dependents of subscribing employers (the "Users"). The Life Program is an online service that offers advice relating to disease prevention, condition education, behavior modification and health promotion programs that may contribute to the health and productivity of employees. The Life Program allows Users to create a health assessment profile that generates personalized health reports. Upon completion of the health assessment, Users also have access to an action plan with links to personalized online wellness programs (offered through HealthMedia, Inc.)

Refer to Appendix IV for features and system requirements for use of this service.

18. 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 health plan Participant.

Aetna offers the Aetna ***CareEngine®*-Powered PHR** (for Customers who have elected this buy-up option). The CareEngine-Powered PHR combines the basic functions of a PHR with a personalized, proactive, evidence-based messaging platform. As above, it's pre-populated with health information from Aetna's claims system. Members 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.
- Original condition-specific content developed and reviewed by doctors from the Harvard Medical School and the Aetna InteliHealth editorial team.
- Aetna's personalized, interactive health and wellness program, Simple Steps To A Healthier Life.
- Informed Care Decisions, an online decision support tool that provides treatment information for more than 40 diseases and conditions.

Aetna offers a PHR program called Health Trackers Incentive that may include an incentive to encourage Plan Participants to enter their personal information and create a more complete picture of their health. This incentive will be paid out on a quarterly basis; the amount of the incentive is determined by the Customer.

19. Focused Psychiatric Review (FPR):

A program which provides phone-based utilization review of inpatient behavioral health admissions (mental health and chemical dependency) intended to contain confinements to appropriate lengths, assess medical necessity and appropriateness of care, and control costs. This program includes a precertification process which collects information prior to an inpatient confinement, determination of the coverage of the proposed treatment, assessment of the level of services provided, as well as concurrent review which monitors a Plan Participant's progress after a patient is admitted.

20. 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 specialized programs such as Behavioral Health Disease Management programs, Intensive Case Management or Medical Psychiatric Case Management.

- 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.

21. Intensive Case Management (Behavioral Health):

This program is designed for Plan Participants who have complex behavioral health (mental health and chemical dependency) conditions that require a specialized approach in order for care to be effective in relieving symptoms and improving the quality of their lives. Intensive Case Management is a process of identifying these high risk persons, assessing opportunities to coordinate care among multiple providers, identifying opportunities to improve treatment compliance, and facilitating coordination among support groups and supportive family members. These activities are designed to improve the individual Plan Participant's clinical condition and lower readmission rates.

22. Medical Psychiatric Case Management:

The Medical Psychiatric Case Management program ("Med Psych") is designed to help Plan Participants who have simultaneous medical and behavioral health conditions. As one condition may affect the successful treatment of the other, the need for care coordination between Medical Management nurses and Behavioral Health case managers is high. Plan Participants enrolled in this program are identified through the efforts of Aetna medical and behavioral health case/disease managers who screen for co-morbid conditions. Additionally, enrollees can be identified through Aetna's predictive models and clinical algorithms. The Med Psych case managers provide service coordination with medical case managers as well as follow-up support for the Plan Participant.

23. Depression Disease Management:

This program facilitates the application of evidence-based treatment intervention and enhances the cost-effective use of pharmacy benefits to maximize responses to antidepressant medication. The program consists of the following components: self-assessment for depression and co-morbid disorders; online services related to depression and its treatment; decision-support tools; and case management telephonic outreach and coordination with pharmacy, primary care physicians and behavioral health professionals to assist with access to services as well as enhanced compliance.

24. Anxiety Disease Management:

This program facilitates the application of evidence-based treatment interventions and enhances the cost-effective use of pharmacy benefits to maximize management of, and recovery from, the symptoms of anxiety disorders. Plan Participants are identified for this program using claims data and referrals, and are then screened by a behavioral health professional to determine appropriate intervention. For those Plan Participants identified with chronic anxiety diagnoses and/or medical diagnoses with associated anxiety, case management may be deemed appropriate.

25. Alcohol Disease Management:

A program with variability to assist in meeting the needs of the Plan Participant who has been identified as early in the course of the disease, as the more chronic alcoholic, or an individual with another psychiatric disorder such as depression. As appropriate, clinicians with expertise in alcohol treatment reach out to the Plan Participant to provide support and education using case management and relapse prevention strategies. There can be collaboration with behavioral health providers, the primary care physician or family members and facilitated linkages for services.

26. Enhanced Clinical Review:

The radiology program is to promote the most appropriate and effective use of outpatient diagnostic imaging services and procedures. Aetna will maintain broad and national or regional access and experience interacting with free-standing radiology and/or outpatient network facilities which include 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 be administered by Aetna vendors through a clinical prior authorization process. This program should result in the following benefits:

- Immediate reductions in current high tech radiology spending for unnecessary or inappropriate services.
- Utilization management for clinically appropriate and cost-effective use of diagnostic imaging services and procedures.
- Improved services, quality and customer satisfaction.

Vendors can assist physicians or their staff in finding the most cost-effective, quality radiology and/or outpatient facility closest to the managed Plan Participant's home. Aetna will maintain oversight on vendors operations and ensure procedures are consistent with company policies and procedures and meet with the accreditation standards of NCQA and URAC.

27. Flexible Medical Model

This program provides the Customer with the option to purchase more clinical resources devoted specifically to their Plan Participant. 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. Aetna will engage in outbound Plan Participant outreach calls to provide case management support based on specific criteria.

For Customers who elect Flex Option 1 only

Includes a designated team to provide centralized case management services for all case management activities (i.e., Case Management referrals, PULSE_assessment and High Dollar Claims)

*Single Point of Contact Nurse designated for the Customer, with appropriate backup.

*If the Plan Participant is engaged with a case manager, the Nurse Case Managers will assess the Plan Participant's health care needs and provide information that will help meet their specific needs. To accomplish this, the Case Managers:

- Assess the Plan Participant's preparedness for admission.
- Evaluate the potential for discharge planning needs.
- Provide guidance on how to avoid post-surgery complications, using pain medications as prescribed, following their treatment plan, and contacting their physician early if they have questions about the course of their recovery

*Some customization to the CM trigger list, such as High Dollar claims reviewed at a lower threshold.

For Customers who elect Flex Option 2: Includes Option 1 elements plus:

*Pre admission and Post Discharge calls for all diagnoses/conditions except maternity and behavioral health

*Outreach to Plan Participants based on PULSE assessment who have scores of 10 or greater or 1 or more action flags.

For Customers who elect Flex Option 3: Includes Option 2 elements plus:

*Additional outreach options as determined by the Customer. Customers can choose 2 from the list below:

- Frequent Emergency Room Visits
- Informed Health Line call backs
- Pharmacy Non-Compliance (Aetna pharmacy data or imported pharmacy data required)
- Multiple Visits to Multiple Providers
- Outpatient Cancer Program

28. 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 Plan Participants are able to spend their time with family and friends outside a hospital setting

Aetna Compassionate Care Website www.aetnacompassionatecareprogram.com is available to all Aetna customers as part of our standard medical plan offering. It provides:

- Information on the dying process, the grieving process, hospice and palliative care support
- Information about decisions to be made, a checklist of important documents to compile, plus printable Advanced Directives and Living Will forms for several states
- Tips for beginning a discussion with loved ones about end-of-life wishes

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 now included as part of the new 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 precertifying care for the Plan Participant. In addition, bereavement services are also available through the Aetna Employee Assistance Program ("EAP") for Customers without an EAP vendor.

Bereavement counseling shall be available both 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.

29. 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 Customer 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 allow the Plan Participant to get what they need from Aetna,
    - 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, and
    - Suggest other Aetna health and wellness programs that can help.

30. Aetna Health Connections Get Active! SM Program

Aetna Health Connections 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 personal challenges (exercise, sports, nutrition, smoking cessation, relaxation, etc.), ability to find activity partners, form health-related interest groups (e.g. healthy cooking club, lunch-time walking group), and share fitness plans with colleagues.

The competition can be paired with an on-going tracking program, which gives employers up to 3 formal challenges and allows employees to maintain the fitness tracking momentum, count their calories and track food consumption throughout the year.

Aetna Health Connections Get Active! will deliver or make available the following products or services:

- Marketing materials include: posters, flyers, emails and a marketing plan to help you promote the program to your employees. Employees will receive weekly communications and reminders to report their progress.
- Electronic versions of marketing materials (posters, flyers, emails) for distribution to employees.

- Maintenance of the Get Active website such that participants can register for and participate in the program, send peer-to-peer invitations and messages, access their personal website pages, set personal goals, track and report their progress, and view team standings.
- Access for administrators to view aggregate statistics about employee participation and success in the program.
- Welcome kits, which will include a welcome letter, pedometer and competition logbook, for registered team members, before the start of each competition (optional purchase).
- Free one-time replacement of lost or broken pedometers for all employees at any time during the competition, upon direct request.
- Toll-free phone line and e-mail technical support for all participants.
- Aggregate data reports for the purposes of analyzing the success of participants.
- Weekly electronic newsletters that will contain both updates about the competition and useful health tips and information for employees.

31. Aetna Benefits Advisor

Aetna 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 ("David") asks prospective enrollees questions relevant to the type of coverage the enrollee may wish to buy (regarding health care needs, lifestyle, financial status, etc.) and makes plan recommendations based on those responses and Customer's benefit options. The ABA tool is available to Customers as a Buy-up and is comprised of the following optional Aetna product modules: Medical, Dental, HSA / FSA Guidance, Life (includes Basic/Supplemental/AD&D/Spouse/Child), Disability (includes STD/LTD), Vision (when integrated with medical coverage), Aetna Pharmacy Management, Personal Health Record (PHR), Aetna EAP. Customer will have use of ABA throughout Customer's open enrollment period, and during the plan year as well for new hires or others eligible to make benefit changes during the year.

For an additional fee, Customer can purchase the "Important Messages" segment. This includes on-screen text complemented by up to 90 words of "David's" recorded audio to support key messages developed by Customer (e.g. Customer wishing to highlight a wellness initiative for the coming year might purchase this multimedia custom message buy-up.)

32. Healthy Lifestyle Coaching Tobacco Free:

The Healthy Lifestyle Coaching Tobacco Free program provides support to employees and dependents (18 and older) who want to stop using Tobacco, regardless if they are enrolled in an Aetna medical plan. Participants can enroll in the program by calling a toll-free phone number. The program also includes outreach to participant's homes. Outreach is based on identification through Simple Steps health assessment and claims data. Participants choose the coaching support method that meets their needs, and may switch between them:

- One-on-one coach support, provided by an experienced health coach who is 100 percent tobacco certified. Coaches will be determined based on the participant's individual needs. For example, the health coach may be a health educator, nutritionist or registered dietician.

- Group coaching support – Led by a health coach and offered in an online/"live-meeting" type of environment for a group of 15 participants with similar focus/goals. These goals may include:
  - Eliminating tobacco usage.
  - Achieving overall health goals.
  - Making positive lifestyle changes.
  - Reducing health risk factors.
  - Reducing stress.

Additionally, participants can receive peer-to-peer support through our clinically moderated online communities. Each community or online network has a different health focus. Participants may join one, or many, depending on their interests.

33. Healthy Lifestyle Coaching:

The Healthy Coaching Lifestyle program provides online educational materials, web-based tools and telephonic coaching interventions with a primary health coach that utilizes incentives and rewards to encourage engagement and continued program participation. The program is designed to help Plan Participants quit smoking, manage their weight, deal more effectively with stress and learn about proper nutrition and physical fitness.

34. Member Health Engagement Plan ("MHEP"):

The MHEP offering aims to help Plan Participants better identify health opportunities and take action to improve their health and wellness. Customers must have MedQuery®, Personal Health Record, Simple Steps to a Healthier Life® health assessment and online wellness programs to feed all critical MHEP Plan Participant touch points.

MHEP features include:

- An enhanced "Alerts & Reminders" tab within the PHR, renamed to "My Health Activities". This "to-do" list includes personalized tasks unique to each Plan Participant's health status and needs (each task will provide a link to the activity mentioned):
  - Complete your health assessment
  - Complete your HealthMedia® online programs (wellness and/or disease management)
  - Track your health metrics in your PHR
  - Acknowledge/review your Care Considerations

- 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.

Additional incentives supported by a more robust "My Health Activities" page. This option allows Customers to incent on more valuable and specific activities that drive healthier behaviors (for example, getting preventive exams/screenings and specific diagnostic work, preventing adverse drug interactions and managing conditions).

35. Mind-Body Stress Reduction Programs:

Available to Plan Participants and other eligible employees as determined by Customer not otherwise covered under Products provided under this Services Agreement ("Employee"). Aetna's Mind-Body Stress Reduction programs are evidence-based mind-body solutions that target Employees with stress. Our two solutions, Mindfulness at Work™ and Viniyoga™ Stress Reduction.

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

Teaches evidence-based stress management skills, including mindfulness awareness, breathing techniques and emotions management. Employee participants are required to have online access to participate.

Customer can choose between the following options:

- a 12-week class only. This option includes only the 12-week course and can be offered to all Employees or only those with high and chronic stress (based on pre-intervention measures).

-A monthly class only. This option features 12 consecutive monthly classes covering similar materials and curriculums as the 12-week class. This program can be offered to a Customer's full Employee population regardless of stress levels.

-A combined weekly and monthly offering. This option includes both the full 12-week course for Employees with high and chronic stress levels (based on pre-intervention measures) and a monthly program (12-month total) for those with moderate to low stress levels. There are pre-set measurement thresholds for determining stress levels and appropriate course assignments.

-All three options above can be offered in a single Customer dedicated or public class setting.

Program includes:

-Facilitation by a highly trained instructor
-Delivery in real time in a virtual classroom
-Online registration process
-Online purchase of headsets (if needed, not included in program cost)
-Online pre and post-intervention measurements (stress, productivity, pain and sleep)
-Program communications – all program communications with Employees except for "initial announcement" of program. Aetna will provide samples to Customer which may then be sent to Employees.

2. Viniyoga Stress Reduction (in coordination with American Viniyoga Institute):

Teaches tools for managing stress through Viniyoga postures (breath combined with movement), breathing techniques, guided relaxation and mental techniques. Helps reduce stress, relieve muscle tension and headaches, improves sleep and more.

Program features include:

- 12-week onsite class for one-hour per week
- Taught by highly trained, certified Viniyoga teachers and yoga therapists
- Adapted for individuals with structural and other health conditions
- Requires an onsite facility that can accommodate 25-30 people
- Employees can participate in business casual attire

36. Aetna Concierge:

Aetna Concierge is a level of customer service that provides a dedicated team of Aetna Concierges to support the delivery of high-touch, tailored service for Customers. Beyond the normal high-level of customer service Aetna provides, the dedicated Aetna Concierges will 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. Aetna Concierges also receive additional training emphasizing consultative soft-skills that support a more personalized approach when providing service to Plan Participants. The dedicated team provided by Aetna Concierge 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 key 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. The dedicated Aetna Concierge team serves as a single point of contact across the full-spectrum of available benefits and programs offered by a Customer, even if they are external to Aetna. The Aetna Concierge teams are trained on Customer-specific offerings so that they can facilitate person to person transfers of Plan Participants to external vendors and benefit carriers, creating a simplified Plan Participant experience and reducing the fragmentation that accompanies multiple benefit programs with multiple benefit carriers and vendors.

Additionally, there is an added emphasis on adult learning and motivational interviewing to drive positive behavior modifications that will support improved health care consumerism as it relates to the Customer-specific benefits and population health goals and strategies. This training is delivered within the context of Customer-specific cultural training to ensure a tailored, personalized Plan Participant experience. Because Aetna Concierge provides a dedicated team, individual Aetna Concierges will serve as an extension of the Customer benefits team, and as an available single point of contact for Plan Participants via a dedicated, toll-free 800-number, as well as via live web chat through Aetna Navigator®.

37. Aetna Fitness℠ Reimbursement Program:

The Aetna Fitness℠ Reimbursement Program (the "Program"), powered by GlobalFit®, is available to Plan Participants and other eligible employees as determined by Customer not otherwise covered under Products provided under this Services Agreement ("Employee"). The Program provides reporting and reimbursement for fitness expenses, which may include:

- Fitness club/gym dues, regardless of whether the fitness club/gym is in the GlobalFit network
- Group exercise class fees for classes led by certified instructors
- Fitness equipment purchases
- Personal training
- Weight management and nutrition counseling sessions

Employees who are Program subscribers submit eligible receipts for reimbursement to GlobalFit, through fax or a link from Aetna Navigator®. GlobalFit confirms eligibility, provides quarterly reports to Customer and performs member reimbursement (if applicable). Reimbursement payments are provided quarterly, up to the yearly maximum reimbursement limit as determined by Customer.

V. 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 are participating in the Plan covering the Plan Participants. Aetna shall also make available to Plan Participants the same credentialing of Network Providers and quality assurance services carried out by the applicable HMO for its insured business.

B. When a claim is submitted for services incurred after the Effective Date, covered by the Plan, and performed by a Network Provider, Aetna will issue a payment on behalf of Customer for those services in an amount determined in accordance with the Aetna contract with the Network Provider and the Plan benefits. In addition to standard fee-for-service rates, these contracted rates with Network Providers may also be based on case rates, per diems, capitation arrangements and in some circumstances, include risk-adjustment mechanisms, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. Retroactive adjustments are occasionally made to Aetna's contract rates (e.g., because 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 such cases, Aetna shall adjust Customer's payments accordingly. Customer's liability for all such adjustments shall survive the termination of this Services Agreement.

C. Aetna reserves the right to set a minimum plan benefit design structure for in-area network claims to which Customer must comply in order to participate in Aetna's Network Program.

D. Aetna will provide Customer with physician directories in an amount up to 100% of eligible employees plus 20% of the current enrolled employees. Customer shall pay the costs of providing any additional directories which it requests.

VI. Subrogation Services:

Aetna will provide assistance to Customer for subrogation/reimbursement services, which will be delegated to an organization of Aetna's choosing in accordance with Section 20.B of the Master Services Agreement. Any reference in this section to "Aetna" shall be deemed to include a reference to its contracted representative, unless a different meaning is clearly required by the context.

Subrogation/reimbursement language must be included in the Customer's summary plan description (SPD) and the SPD must be finalized and available to Customer's employees before subrogation/reimbursement matters can be investigated and pursued. Aetna will continue to process claims during the investigation process. Aetna will not pend or deny claims for subrogation/reimbursement purposes.

Aetna or its contracted representative shall retain a percentage of any monies collected while pursuing subrogation/reimbursement recoveries. This fee includes reasonable expenses. Reasonable expenses include but are not limited to (a) collection agency fees, (b) police and fire reports, (c) asset checks, (d) locate reports and (e) attorneys' fees.

Aetna shall advise Customer if the pursuit of recovery requires initiation of formal litigation. In such event, Customer shall have the option to approve or disapprove the initiation of litigation.

Aetna will credit net recoveries to the Customer. Aetna does not adjust individual Plan Participant claims for subrogation/reimbursement recoveries.

Aetna has the exclusive discretion: (a) to decide whether to pursue potential recoveries on subrogation/reimbursement claims; (b) to determine the reasonable methods used to pursue recoveries on such claims, subject to the proviso with respect to initiation of formal litigation above; and (c) to decide whether to accept any settlement offer relating to a subrogation/reimbursement claim.

If no monies are recovered as a result of the subrogation/reimbursement pursuit, no fees or expenses incurred by Aetna for subrogation/reimbursement activities will be charged to Customer.

Notwithstanding the above, should 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 its standard fee, which will be calculated based on the full amount of claims paid at the time Customer resolves the file or instructs Aetna to cease pursuit.

If Customer notifies Aetna of its election to terminate the 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 claims still under investigation, shall be handled to conclusion by Aetna and shall be governed by the terms of this provision, unless otherwise mutually agreed. Aetna will not investigate or handle subrogation/reimbursement cases or recoveries on any matters identified after Customer's termination date.

VII. Customer's Responsibilities

Eligibility – Customer shall supply Aetna in writing or by electronic medium acceptable to Aetna with all information regarding the eligibility of Plan Participants including but not limited to the identification of any Sponsored Dependents defined in Customer's Summary Plan Description and shall notify Aetna by the tenth day of the month following any changes in Plan participation. **Customer agrees that retroactive terminations of Plan Participants shall not exceed 60 days and that Aetna has no financial responsibility for any benefit payments owed under the Plan. Customer will be credited for the Plan Participant's administrative fee and for any primary capitation payments made on the Plan Participant's behalf. Additional recovery of overpayments will be made in accordance with the terms of the Services Agreement.** Aetna has no responsibility for determining whether an individual meets the definition of a Sponsored Dependent. Aetna shall not be responsible in any manner, including but not limited to, any obligations set forth in Section 13 of the Master Services Agreement, for any delay or error caused by the Customer's failure to furnish accurate eligibility information in a timely fashion. Customer represents that it has informed its Plan Participants through enrollment forms executed by Customer's Plan Participants, or in another manner which satisfies applicable law, that confidential information relating to their benefit claims may be disclosed to third parties in connection with plan administration.

VIII. Group Health Certification Services Relative to P.L. 104-191, the Health Insurance Portability and Accountability Act of 1996 and Related Regulations

Aetna will assist the Customer with the preparation and distribution of Certifications of Prior Group Health Coverage for health expense coverage which is administered under the terms of the Services Agreement. Aetna will be entitled to rely upon the information provided by the Customer in the production and distribution of such certifications.

IX. Performance Guarantees

Any Performance Guarantees applicable to Aetna's provision of Services pursuant to the Self Funded Medical Plan are shown in Appendix II of the Services Agreement.

X. Fees

The following administrative Service Fees are provided in conjunction with Aetna's Services relating to the self funded medical products offered under the Customer's self funded benefits plan. All administrative Service Fees from this SAS are summarized in the following Service and Fee Schedule.

SERVICE AND FEE SCHEDULE

The corresponding Service Fees effective for the period beginning November 1, 2014 and ending October 31, 2015 are specified below. They shall be amended for future periods, in accordance with Section 6 of the Master Services Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Master Services Agreement.

Product	Per Employee* Per Month Fee - *A person within classes that are specifically described in Appendix I, including employees, retirees, COBRA continues and any other persons including those of subsidiaries and affiliates of Customer who are reported, in writing, to Aetna for inclusion in the Services Agreement.

Self-Funded Medical Administrative Fee Exhibit

November 1, 2014 through October 31, 2015, Mature

Administrative Fees Per Employee Per Month	**Choice POS II**	**Seton ACO Open Access Aetna Select**
Assumed Enrollment	489	910
Total Per Employee Per Month	**$44.16**	**$47.58**

Our fees are based on the total number of employees enrolled in Aetna medical, pharmacy and vision products.

Please refer to the Financial Assumptions document for a detailed description of the services, terms, and conditions associated with our self-funded proposal.

We guarantee that the second-year fees will increase over the first-year mature fees by no more than 3%. We also guarantee that the third-year fees will increase over the second-year fees by no more than 3%. We also guarantee that the fourth-year fees will increase over third-year fees by no more than 4%. We also guarantee that the fifth-year fees will increase over fourth-year fees by no more than 4%.

Please note: The following fees are not included in the per-employee, per-month fees quoted above.

*** National Advantage™ Program is based on a percentage of savings achieved.**

*** Subrogation Resolution service is a percentage of the recovered amount.**

*** Institutes of Excellence™ transplant network is charged on a per-transplant basis.**

Included Services / Programs in Above Administrative Fees	**Choice POS II**	**Seton ACO Open Access Aetna Select**
Implementation & Communications		
$25,000 Transition Allowance (Year 1 Only)	Included	Included
$50,000 Wellness Allowance	Included	Included

$7,500 Post Implementation Audit Allowance (Year 1 Only)	Included	Included
Designated Implementation Manager	Included	Included
Open Enrollment Marketing Material (noncustomized)	Included	Included
Onsite Open Enrollment Meeting Preparation	Included	Included
Standard ID Cards	Included	Included
Claims and Member Services	Included	Included
24-Hour Nurse Line (Informed Health® Line toll-free number)	Included	Included
Integrated Voice Response	Included	Included
Plan Sponsor Liaison	Included	Included
Claim Processing and Adjudication	Included	Included
Special Investigations / Zero Tolerance Fraud Unit	Included	Included
Total Health Management		
Case Management	Included	Included
Patient Management	Included	Included
Inpatient Precertification	Included	Included
Outpatient Precertification	Included	Included
Utilization Management - Concurrent Review	Included	Included
Utilization Management - Discharge Planning	Included	Included
Utilization Management - Retrospective Review	Included	Included
Managed Behavioral Health	Included	Included
Compassionate Care Program	Included	Included
National Medical Excellence	Included	Included
Health Risk Assessment (Simple Steps To A Healthier Life®)	Included	Included
Plan Sponsor Services		
Experienced Service Team: Executive Sponsor, Account Executive, Account Manager, Account Coordinator	Included	Included
Designated Billing, Eligibility and Plan Set Up	Included	Included
SPD Review and Drafting	Included	Included
Administrative Services		
Claim Fiduciary - Option 1 (Aetna fiduciary for both levels of appeals))	Included	Included
External Review	Included	Included
Claim Fiduciary—Alternative Option 6 (Aetna fiduciary only for level 1 appeals)	Decrement of ($1.15)	Decrement of ($1.15)
Network		
Network Access / Full National Reciprocity	Included	Included
Online Directories (DocFind)	Included	Included
Paper Provider Directories (Doc Find)	Included	Included
Web Tools		
Aetna Navigator® - Member Self Service Web Portal	Included	Included
Web-Chat Technology - Virtual Assistant Ann	Included	Included
Health Improvement Decision Support Tools	Included	Included
Surgery Decision Support (Welvie) – Online Program Only	Included	Included
Aetna InteliHealth®	Included	Included
Reporting		
5 Hours of Ad Hoc Reports, Annual Restoration	Included	Included
Quarterly Utilization Reports - Aetna Informatics Level A	Included	Included

Quarterly Utilization Reports - Aetna Informatics Level B	Included	Included
Monthly Financial Claim Detail Reports	Included	Included
Claim Funding		
Standard Daily Wire Process	Included	Included
Additional fee for weekly wire	Additional $0.34	Additional $0.34
Additional fee for one additional day beyond normal due date	$250	$250
Other		
Aetna Vision℠ Discount Program	Included	Included
Aetna Fitness℠ Discount Health Club Program	Included	Included
Aetna Natural Products and Services℠ Program	Included	Included
Claim Wire Billing		
Enhanced Clinical Review	Charged through the claim wire. Not included in the PEPM fees above.	
Optional Buy-Up Services / Programs	**Choice POS II**	**Seton ACO Open Access Aetna Select**
HIPAA Certificates	$0.29	$0.29
Patient Safety (MedQuery®)	$1.80	$1.80
Disease Management (Aetna Health Connections℠)[1]	$2.40	$2.40
Designated Disease Management[2]	$0.52	$0.52
Teladoc[6]	$0.95	$0.95
Medical Psychiatric High Risk Case Management Program	$0.31	$0.31
Member Messaging (Standard)[3]	$0.20	$0.20
Member Messaging (Expanded - All Members)	$0.20	$0.20
Preventive Care Considerations (Electronic)[4]	$0.00	$0.00
Preventive Care Considerations (Paper)	$0.20	$0.20
Personal Health Record (PHR)[1]	$0.50	$0.50
Simple Steps Incentive Reporting	$0.10	$0.10
Lifestyle Management (Healthy Lifestyle Coaching)	$2.20	$2.20
Lifestyle Management (Healthy Lifestyle Coaching) - Lite	$0.72	$0.72
Lifestyle Management (Healthy Lifestyle Coaching) - Healthy Weight	$1.03	$1.03
Lifestyle Management (Healthy Lifestyle Coaching) - Tobacco Free	$1.15	$1.15
Maternity Management (Beginning Right®)	$0.65	$0.65
Behavioral Health Disease Management (Depression, Alcohol, Anxiety)	$0.76	$0.76
Surgery Decision Support (Welvie) – Online Program with Comprehensive Engagement Plan, Incentive Administration, and Reporting	$0.35	$0.35
Mindfulness at Work (Cost of Program varies by Class Type)	$0.60 - $1.10	$0.60 - $1.10
Aetna Health Connections Get Active!℠ (Standard)	$0.70	$0.70
Aetna Health Promise	$3.50	$3.50
Aetna Stratgic Desktop (ASD) (Per User Per Month)	$53.00	
EOS Health (Per Participant Per month)	$22.00	

Pharmacy Integration to Support Benefit Accumulators (Set-up)**	$5,000.00
Pharmacy Integration to Support Benefit Accumulators (Ongoing)**	$0.60
Pharmacy Integration to Support Aetna Health Connections (Annual Charge)	$5,000.00
Monthly Reports to 3rd Party Stop Loss Vendor	$4,600.00
Viniyoga Stress Reduction - 1 class (12 weeks, 25-30 students)	$5,200

[1] MedQuery® must be purchased in conjunction with Aetna Health Connections℠ Disease Management and PHR

[2] Requires the purchase of Aetna Health Connections℠ Disease Management

[3] Included at no additional charge with the purchase of Aetna Health Connections℠ Disease Management

[4] Included at no additional charge with the purchase of Personal Health Record

[6] Teladoc - In addition to the per employee per month fee as outlined above, there is also a $40 per Teladoc consult that is charged through the claim wire.

*Seton Health Alliance Charge is part of Option 2 and would be applicable to subscribers in the SHA designated plan(s).

**Aetna can only integrate with the following PBM's: Medco/ESI, Catamaran and CVS/Caremark on a realtime basis. Other's would require a manual integration where additional costs would apply.

***The base PEPM fee reflects Aetna's fiduciary Option 1, meaning that Aetna serves as full appeal fiduciary for Level 1 and Level 2 appeals. Customer may alternatively elect Aetna's fiduciary Option 6, meaning that Aetna would serve as appeal fiduciary for Level 1 appeals only. If Customer were to elect Option 6, the base PEPM fee would be reduced by $1.15.

Services applicable and included in above PEPM fees (except where indicated otherwise)	
I. Administration Services	Included
II. Aetna Health Connections℠ Services	
▪ Utilization Management Inpatient and Outpatient Precertification	Included
▪ Utilization Management Concurrent Review	Included
▪ Utilization Management Discharge Planning	Included
▪ Utilization Management Retrospective Review	Included
▪ Case Management Program	Included
▪ Infertility Case Management	Included
▪ National Medical Excellence/ Institutes of Excellence (with) transportation and lodging expense	Included

▪ MedQuery℠ with Member Messaging	Optional – Additional Cost
▪ MedQuery℠ without Member Messaging	Optional – Additional Cost
▪ Preventive Care Consideration (PCC) paper copy	Optional – Additional Cost
▪ Aetna Health Connections℠ Disease Management	Optional – Additional Cost
▪ Beginning Right℠ Maternity Program	Optional – Additional Cost
▪ Informed Health Line as follows Nurseline 1-800# Only	Included
▪ Wellness Counseling	Optional – Additional Cost
▪ Healthy Body, Healthy Weight	Optional – Additional Cost
▪ Healthy Insights Member Newsletter	Optional – Additional Cost
▪ Preventive Mailings	Optional – Additional Cost
▪ Onsite Health Screening Services	Optional – Additional Cost
▪ Simple Steps To A Healthier Life® ▪ Simple Steps Incentive Tracking	Included Optional – Additional Cost
▪ Personal Health Record CareEngine®-Powered PHR PHR Health Tracker Incentive	Optional – Additional Cost
▪ Focused Psychiatric Review	Not Applicable
▪ Managed Behavioral Health	Included
▪ Intensive Case Management (Behavioral Health)	Optional – Additional Cost

▪ Medical/Psychiatric Case Management	Optional – Additional Cost
▪ Depression Disease Management	Optional – Additional Cost
▪ Anxiety Disease Management	Optional – Additional Cost
▪ Alcohol Disease Management	Optional – Additional Cost
▪ Enhanced Clinical Review	Optional – Additional Cost
▪ Flexible Medical Model Flex Option 1 Flex Option 2 Flex Option 3 Frequent ER Visits Informed Health Line Call Backs Pharmacy Non-Compliance Multiple Visits to Providers Outpatient Cancer Program	Optional – Additional Cost
▪ Aetna's Compassionate Care[sm] Program	Included
▪ ACCP Enhanced Hospice Benefits Package	Included
▪ Designated Team ▪ Designated Team ▪ CAT (Care Advocate Team)	Optional – Additional Cost
Aetna Health Connections Get Active![SM] as follows: Shape up competition/tracking multi-week program (without) pedometer Stay in Shape Year-round Program (without) pedometer	Optional – Additional Cost
Aetna Benefits Advisor	Optional – Additional Cost

▪ Healthy Lifestyle Coaching Tobacco Free	Optional – Additional Cost
▪ Healthy Lifestyle Coaching	Optional – Additional Cost
Member Health Engagement Plan (MHEP) Progress Bar Incentive Administration	Optional – Additional Cost
Mindfulness at Work™	Optional – Additional Cost
The Aetna Fitness℠ Reimbursement Program	Optional – Additional Cost
Aetna Concierge	Optional – Additional Cost

IV. Aetna Subrogation Program	30% of recovered amount will be retained
V. Group Health Certification Services	Optional – Additional Cost of $0.29 per employee per month

VI. National Advantage Program (NAP)		National Advantage Access Fee:
National Advantage - Facility Charge Review (NAP-FCR)	Included	50% of Aggregate Savings – Fee will be included in Plan Benefit Funding Request from Bank
National Advantage– Itemized Bill Review(IBR)	Included	

VII. Draft SBC	Included at a charge of $1,500 per draft SBC, with an annual charge not to exceed $15,000.

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

(1) If, for any product, there is a:
- 10% decrease in the number of Employees from the number assumed by Aetna below.

Total Employees	1,399

Customer agrees that the ACO plan offering provides additional medical discounts from Seton Healthcare Family Facilities that are tied to enrollment in the ACO plan. The additional discounts reflected below are contingent on the enrollment in the ACO plan.

Customer's Percentage of Actual Enrollment in Seton ACO Plan	**Seton Facility AdditionalDiscount**
65%	17%
60%	13%
55%	9%
50%	6%
40%	3%
30%	1%

Customer also agrees that the Aetna Claim target Guarantee is contingent on 65% enrollment in the Seton ACO plan. If enrollment is less than 65% in the ACO plan, the Claim Target guarantee will be revised.

(2) Change in Plan - A material change in Plan is initiated by the Customer or by legislative action.

(3) Change in Claim 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 Services Agreement which may apply, if the Customer fails to provide funds on a timely basis to cover Plan benefit payments as provided in Section 8 of the Master Services Agreement, and/or fails to pay Service Fees on a timely basis as provided in Section 6 of the Master Services Agreement, Aetna will assess interest as a late payment charge. Interest charges for any late payments shall be paid by Customer in accordance with Texas Government Code Section 2251.025. More specifically, the rate of interest that shall accrue on a late payment is the rate in effect on September 1 of Customer's fiscal year in which the payment becomes due. The said rate in effect on September 1 shall be equal to the sum of one percent (1%) and the prime rate published in the Wall Street Journal on the first day of July of the preceding fiscal year that does not fall on a Saturday or Sunday.

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

SELF FUNDED DENTAL PLAN
STATEMENT OF AVAILABLE SERVICES
EFFECTIVE November 1, 2014
MASTER SERVICES AGREEMENT No. MSA-866349

Subject to the terms and conditions of the Services Agreement, the Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to Section 6 of the Master Services Agreement) will be provided by Aetna. Additional Services may be provided at Customer's written request under the terms of the Services Agreement. This Statement of Available Services ("SAS") shall supersede any previous SAS or other document describing the Services.

I. Excluded and/or Superseded Provisions of Master Services Agreement: NONE

II. Claim Fiduciary

Customer and Aetna agree that with respect to applicable state law, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. Customer understands that the performance of fiduciary duties under state law 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, 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 Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility..

III. Administration Services:

A. Member and Claim Services:

1. Requests for Plan benefit payments for claims shall be made to Aetna on forms or other appropriate means approved by Aetna. Such forms (or other appropriate means) may include a consent to the release of medical, dental, claims, and administrative records and information to Aetna. Aetna will process and pay the 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 and the Services Agreement. With respect to any Plan Participant who makes a request for Plan benefits which is denied on behalf of Customer, Aetna will notify said Plan Participant of the denial and of said Plan Participant's right of review of the denial in accordance with ERISA.

2. Whenever it is determined that benefits and related charges are payable under the Plan, Aetna will issue a payment of such benefits and related charges on behalf of Customer. Funding of Plan benefits and related charges shall be made as provided in Section 8 of the Master Services Agreement.

3. Where the Plan contains a coordination of benefits clause or antiduplication clause, Aetna will administer all claims consistent with such provisions and any information concurrently in its possession as to 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.

B. Plan Sponsor Services:

1. Aetna will assign an Account Executive to Customer's account. The Account Executive will be available to assist Customer in connection with the general administration of the Services, ongoing communications with Customer and assistance in claims administration and record-keeping systems for Customer's ongoing operation of the Plan.

2. Upon request by Customer and consent by Aetna, Aetna will implement changes in claims administration consistent with Customer's modifications of its Plan. A charge may be assessed for implementing such changes. Customer's administration Services Fees, as set forth in the Service and Fee Schedule, will be revised if the foregoing amendments or modifications increase Aetna's costs.

3. Aetna will provide the following reports to Customer for no additional charge:

   (a) Monthly/Quarterly/Annual Accounting Reports - Aetna shall prepare and provide the following accounting reports in excel format or other format that is acceptable to Customer and accordance with the benefit-account structure for use by Customer in the financial management and administrative control of the Plan benefits:

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

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

      (iii) a monthly or quarterly or annual listing of paid benefits;

      (iv) quarterly or annual standard claim analysis reports;

      (v) a monthly report that reconciles cleared transactions with the claims invoiced to the Customer for the month reported, including any outstanding transactions; and

      (vi) an annual lag report as of September 30th each year that reports any liabilities that were incurred in the Customer's then current fiscal year (Customer's Fiscal Year is October 1st to September 30th) but that will not be paid during the Customer's then current fiscal year.

(b) Annual Accounting Reports - Aetna shall prepare standard annual accounting reports for each major benefit line under the Plan for the Services Agreement Period that include the following:

(i) forecast of claim costs;

(ii) accounting of experience; and

(iii) calculation of Customer reserve.

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

4. Aetna shall develop and install all agreed upon administrative and record keeping systems, including the production of employee identification cards.

5. Aetna shall design and install a benefit-account structure separately by class of employees, division, subsidiary, associated company, or other classification desired by Customer.

6. Aetna shall provide plan design and underwriting services in connection with benefit revisions, additions of new benefits and extensions of coverage to new Plan Participants.

7. Aetna shall provide cost estimates and actuarial advice for benefit revisions, new benefits and extensions of coverage being considered by Customer.

8. Upon request of Customer, Aetna will provide Customer with information reasonably available to Aetna which is reasonably necessary for Customer to prepare reports for the United States Internal Revenue Service and Department of Labor.

9. Aetna will provide assistance in connection with the initial set up, design and preparation of Customer's Plan, subject to the direction, review and approval of Customer. Customer shall have the final and sole authority regarding the benefits and provisions of the self-insured portion of the Plan, as outlined in the Customer's Plan document. Customer acknowledges its responsibility to review and approve all Plan documents and revisions thereto and to consult with Customer's legal counsel, at its discretion, in connection with said review and approval. Aetna shall have no responsibility or liability for the content of any of Customer's plan documents, regardless of the role Aetna may have played in the preparation of such documents.

10(a). Upon request of Customer, Aetna shall prepare an Aetna standard Plan description, including benefit revisions, additions of new benefits, and extension of coverage under the Plan. If the Customer elects to have an Aetna non-standard Plan description, Aetna will provide a custom Plan description with all costs borne by Customer; or

10(b). Upon request of Customer, Aetna will review 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.

If Customer requires both preparation (a) and review (b), there may be an additional charge.

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

12. Upon request by Customer, Aetna will arrange for the custom printing of forms and identification cards, with all costs borne by Customer.

IV. Network Access Services: (For Dental PPO Plans ONLY)

A. Aetna shall provide Plan Participants with access to Aetna's network of dentists and other applicable dental care providers ("Network Providers") who (i) participate in the network applicable to the Plan Participant's Plan at negotiated rates with Aetna and (ii) are designated by Aetna for participation in the applicable network.

B. Aetna reserves the right to set a minimum plan benefit design structure for in-network claims to which Customer must comply in order to receive access to Network Providers at Aetna's agreed upon rates with such providers.

C. Aetna maintains an online directory for Plan Participants and Customers to access for information regarding Network Providers.

V. Dental Management Services:

A. Dental Utilization Management:

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

B. Dental/Medical Integration (DMI) Program:

The DMI program is designed to educate Plan Participants on the impact of good oral health care on the management of certain diseases and conditions. Plan Participants identified with diabetes, coronary artery disease/cerebrovascular disease or who are pregnant, are sent educational materials explaining the correlation between their disease or condition and periodontal disease. The following programs are included:

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

VI. Performance Guarantees

Any Performance Guarantees applicable to Aetna's provision of Services pursuant to the Self Funded Dental Plan are attached in Appendix II to the Services Agreement.

VII. Fees

The following administrative Service Fees are provided in conjunction with Aetna's Services relating to the self funded dental products offered under the Customer's self funded benefits plan. All administrative Service Fees from this SAS are summarized in the following Service and Fee Schedule.

SERVICE AND FEE SCHEDULE

The corresponding Service Fees effective for the period beginning November 1, 2014 and ending October 31, 2015 are specified below. They shall be amended for future periods, in accordance with Section 6 of the Master Services Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Master Services Agreement.

Product	**Per Employee* Per Month Fee -** *A person within classes that are specifically described in Appendix I, including employees, retirees, COBRA continues and any other persons including those of subsidiaries and affiliates of Customer who are reported, in writing, to Aetna for inclusion in the Services Agreement.
PPO Dental	$ 2.86

Services applicable and included in above PEPM fees (except where indicated otherwise)	
I. Administration Services	Included
II. Network Access Services	Included
▪ Access to Network Providers	Included
▪ Minimum Plan Benefit Design Structure Set by Aetna	Included
▪ Online Directory Maintained by Aetna	Included
III. Dental Management Services	Included
▪ Dental Utilization Management	Included
▪ Dental/Medical Integration	Included

Dental Network Discount Arrangement	Included
Dental Network Access Charge as follows: 40 % of the savings resulting from the application of Aetna's negotiated arrangements with providers, i.e., the difference between the average charges for the area as determined under the FAIR Health Healthcare Common Procedure Code (HCPC) and the allowed negotiated fees. Aetna reserves the right to change the Dental Network Access Charge Percentage if there is a 15% change in the employee distribution by Market (as shown in Appendix 1).	

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

(1) If, for this product, there is a:

- 15 % decrease in the number of Employees from the number assumed by Aetna below.

Name of Product(s)	Assumed Number of Employees
PPO Dental	1,268 Employees

- 15% increase in the Member to Employee ratio from the ratio assumed by Aetna below.

Name of Product(s)	Assumed Ratio
PPO Dental	2.27 Members to 1 Employee

(2) Change in Plan - A material change in Plan is initiated by the Customer or by legislative action.

(3) Change in Claim 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 Services Agreement which may apply, if the Customer fails to provide funds on a timely basis to cover Plan benefit payments as provided in Section 8 of the Master Services Agreement, and/or fails to pay Service Fees on a timely basis as provided in Section 6 of the Master Services Agreement, Aetna will assess interest as a late payment charge. Interest charges for any late payments shall be paid by Customer in accordance with Texas Government Code Section 2251.025. More specifically, the rate of interest that shall accrue on a late payment is the rate in effect on September 1 of Customer's fiscal year in which the payment becomes due. The said rate in effect on September 1 shall be equal to the sum of one percent (1%) and the prime rate published in the Wall Street Journal on the first day of July of the preceding fiscal year that does not fall on a Saturday or Sunday.

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

SELF FUNDED PRESCRIPTION DRUG BENEFITS PLAN
STATEMENT OF AVAILABLE SERVICES
EFFECTIVE 11/01/2014

Subject to the terms and conditions of the Services Agreement, the Services available from Aetna are described below in this Statement of Available Services (or "SAS") and in the accompanying Service and Fee Schedule. Unless otherwise agreed in writing, Subject to the terms and conditions of the Services Agreement, only the Services selected by Customer in the Service and Fee Schedule (as may be modified by Aetna from time to time pursuant to this Statement of Available Services) and the Agreement will be provided by Aetna. Additional Services may be provided at Customer's written request under the terms of this Statement of Available Services and the Agreement. This SAS and the Service and Fee Schedule which is incorporated by reference herein shall be provided by Aetna. Additional Services may be provided at Customer's written request under the terms of this Statement of Available Services and the Agreement. This SAS and the Service and Fee Schedule which is incorporated by reference herein shall supersede any previous SAS or other document describing the Services herein. In the event of a conflict between the terms of this SAS and the Agreement or between the terms of this SAS and any other agreement previously entered into by Customer and Aetna, the terms of this SAS shall control.

I. Excluded and/or Superseded Provisions of Agreement:

A. Term

Unless one party informs the other of its intent to allow this SAS to terminate in accordance with the Agreement, the initial term of this SAS shall be 3 Years beginning on the Effective Date as first written above (referred to as an "Agreement Period"). This SAS will automatically renew for up to two successive one-year terms unless otherwise terminated pursuant to the Agreement, subject to mutual agreement on fees. If the Agreement does not provide a termination clause, either party may terminate this SAS by giving the other party at least thirty-one (31) days written notice stating when, after the date of such notice, such termination shall become effective.

B. Benefit Funding

The "Benefit Funding" or "Funding of Plan Benefits" section of the Agreement is superseded by Section IV.B.1.of this SAS.

C. Audit Rights

The "Audit Rights" section of the Agreement is superseded by Section VII of this SAS.

II. Claim Fiduciary

Customer has two claim fiduciary options. The default is Option 1 set forth below. Unless otherwise indicated, Aetna shall provide Option 1. Customer may instead elect Option 6 as set forth below by giving Aetna at least 30 days advance written notice prior to the Effective Date.

The two fiduciary options are as follows:

1. <u>Fiduciary Option 1 (Default)</u>. Customer and Aetna agree that with respect to applicable state law, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. Customer understands that the performance of fiduciary duties under state law 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, 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 Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.

2. Fiduciary Option 6 (Alternative Available on 30 Days Advance Written Notice). Customer and Aetna agree that with respect to applicable state law, Aetna will be the "appropriate named fiduciary" of the Plan for the first level of appeal for purpose of reviewing denied claims under the Plan. Customer understands that the performance of fiduciary duties under applicable state law 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, Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan. If the denial is upheld in the first level of appeal, then Aetna will inform the Participant of his right to appeal to the Customer. Customer shall be the "appropriate named fiduciary" of the Plan for the second level of appeal.

III. Definitions:

When used in this Statement of Available Services and/or the Self Funded Prescription Drug Benefits Plan Service and Fee Schedule, all capitalized terms shall have the following meanings:

"**Administrative Fees**" or "**Services Fees**" means an amount agreed to by Customer and Aetna in consideration of the Services.

"**Aetna**" shall include a subsidiary, affiliate or subcontractor of its choosing for the purposes of services to be performed under this Statement of Available Services and/or Service and Fee Schedule.

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

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

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

"**Bank**" means the bank selected by Aetna on which benefit payment costs are paid.

"**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 Customer to Aetna in accordance with any implementation procedures described herein. Customer shall disclose to Plan Participants any and all matters relating to the Benefit Plan Design that are required by law to be disclosed, including information relating to the calculation of Cost Share or any other amounts that are payable by a Plan Participant in connection with the Benefit Plan Design.

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

"**Calculated Ingredient Cost**" means the lesser of:

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

The Calculated Ingredient Cost does not include the Dispensing Fee, the Cost Share or sales tax, if any.

"**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 Agreement, 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 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 Calculated Ingredient Cost rate or MAC to be charged by Aetna to Customer for Prescription Drugs. The Discount excludes the Dispensing Fee, Cost Share and sales tax, if any.

"**Dispensing Fee**" means an amount agreed by 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.

"**Effective Date**" means the Effective Date set forth above in the heading of the SAS.

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

"**Generic Drug**" means a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that (a) is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient, or (b) is deemed by Aetna to be pharmaceutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

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

"**Law**" means any law, statute, rule, regulation, ordinance and other pronouncement having the effect of law of the United States of America, any foreign country or any domestic or foreign state, county, city or other political subdivision, or of any governmental or regulatory body, including without limitation, any court, tribunal, arbitrator, or any agency, authority, official or instrumentality of any governmental or political subdivision.

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

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

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

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

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

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

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

"**Pharmacy Audits**" shall have the meaning set forth in Section VII.A.1.

"**Plan**" shall mean the self-funded employee health benefits plan for certain eligible Plan Participants pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA").

"**Plan Participants**" shall mean employees, dependents, beneficiaries, retirees, or members as referenced in the Plan documents, or any term used by Customer to designate participants in the Plan.

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

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

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

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

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

"Bank" means the bank selected by Aetna on which benefit payment costs are paid.

"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 Customer to Aetna in accordance with any implementation procedures described herein. Customer shall disclose to Plan Participants any and all matters relating to the Benefit Plan Design that are required by law to be disclosed, including information relating to the calculation of Cost Share or any other amounts that are payable by a Plan Participant in connection with the Benefit Plan Design.

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

"**Calculated Ingredient Cost**" means the lesser of:

d) AWP less the applicable percentage Discount;
e) MAC; or
f) U&C Price.

"**Rebate Contract Excerpts**", if any, shall have the meaning set forth in Section VII.

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

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

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

"**Services**" shall have the meaning set forth in Section IV.A.1.

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

"**Termination Notice Date**", if applicable, shall have the meaning set forth in Section VI.

"**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.

IV. Administration Services:

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

A. General Responsibilities and Obligations

1. Services

Customer will purchase and Aetna will provide to Customer the services designated in this Statement of Available Services, if selected in the Service and Fee Schedule, and such other services Customer requests of Aetna and Aetna agrees in writing to perform, as further described herein (the "**Services**"). Customer acknowledges that Aetna may utilize the services of external reviewers or contractors in performing these Services. The Services to be provided by Aetna and the Service Fees may be adjusted by Aetna effective on the commencement of any Agreement Period, or at other times as indicated in the Service and Fee Schedule.

2. Customer's Responsibilities

Customer shall perform the obligations set forth in the Agreement and in this Statement of Available Services, including without limitation, the Service and Fee Schedule.

3. Exclusivity

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

B. Pharmacy Benefit Management Services

1. Pharmacy Claims Processing

a. On-Line Claims Processing. Using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the description of Plan benefits and this Statement of Available Services, 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 Statement of Available Services, determination of Covered Services, and adjudication of the On-Line Claims. Aetna or Customer, as applicable, shall have ultimate and final responsibility for all decisions with respect to coverage of an On-Line Claim and the benefits allowed under the Plan as set forth in the Agreement.

b. DMR Claims Processing. If specified on the description of Plan benefits, Aetna will process DMR Claims using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the description of Plan benefits. The Plan Participant or Medicaid agency where applicable, shall be responsible for submitting DMR Claims directly to Aetna on such form(s) provided by Aetna within the timeframe specified on the description of Plan benefits. Aetna will process DMR Claims and, where appropriate, will reimburse such Plan Participant or Medicaid agency on behalf of Customer 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. With respect to any Plan Participant who submits a DMR Claim which is denied on behalf of Customer, Aetna will notify said Plan Participant of the denial and of said Plan Participant's right of review of the denial in accordance with ERISA. Aetna or Customer, as applicable, shall have ultimate and final responsibility for all decisions with respect to coverage of a DMR Claim and the benefits allowed under the Plan as set forth in the Agreement.

c. Additional Services Related to Claims Processing. Whenever Aetna determines that benefits and related charges are payable under the Plan, Aetna will issue a payment of such benefits and related charges on behalf of Customer. Plan benefit payments and related charges of any amount payable under the Plan shall be made by check drawn by Aetna payable through the Bank or by electronic funds transfer or other reasonable transfer method. Customer, by execution of the Agreement, expressly authorizes Aetna to issue and accept such checks on behalf of Customer for the purpose of payment of Plan benefits and other related charges. Customer agrees to provide funds through its designated bank sufficient to satisfy all Plan benefits (and which also may include Service Fees and any late charges under the Agreement) and related charges upon notice from Aetna or the Bank of the amount of payments made by Aetna. Customer agrees to instruct its bank to forward an amount in Federal funds on the day of the request equal to such liability by wire transfer or such other transfer method agreed upon between Customer and Aetna. As used herein "Plan benefits" means payments under the Plan, excluding any copayments, coinsurance or deductibles required by the Plan.

   Aetna reserves the right to place stop payments on all outstanding benefit checks (i.e., checks which have not been presented for payment) on the sooner of:

   (A) one (1) year following the date Aetna completes its runoff processing obligations; or
   (B) five (5) days following Customer's failure to provide requested funds or pay Service Fees due in accordance with the Termination section of the Agreement.

d. Where the Plan contains a coordination of benefits clause or antiduplication clause, Aetna will administer all Claims consistent with such provisions and any information concurrently in its possession as to 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.

2. Pharmacy Network Management

a. Participating Retail Pharmacies. Aetna shall provide Plan Participants access to Participating Retail Pharmacies. Aetna shall make available an updated listing of Participating Retail Pharmacies on its internet website and via its member services call center. Any additions or deletions to the network of Participating Retail Pharmacies shall be made in Aetna's sole discretion. Aetna shall provide notice to 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-Claims for Covered Services from Participating Retail Pharmacies using the negotiated rates that Aetna has in place with the applicable Participating Retail Pharmacy.

i. 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 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.

ii. Aetna shall establish and maintain policies and procedures which it may revise from time to time specifying how and when a Participating Retail Pharmacy will be audited to review compliance with such pharmacy's agreement with Aetna. The audit may be conducted by Aetna's internal auditors and/or outside auditors, and may consist of a "desktop" audit of Claims submitted by the Participating Retail Pharmacy and/or a review of prescription and other records located onsite at such pharmacy. Any overpaid or erroneously paid amounts recovered by Aetna from a Participating Retail Pharmacy pursuant to an audit shall be credited to Customer net of any fees charged by Aetna in accordance with the Service and Fee Schedule or by Aetna's designated outside auditors, as applicable. Aetna shall attempt recovery of overpayments or payments made in error through offsets or demand of amounts due. In no event will Aetna be required to initiate litigation to recover any overpayments or payments made in error.

iii. 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 Customer. For the avoidance of doubt, the Benefit Cost paid by 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.

b. Aetna Mail Order Pharmacy. Aetna shall provide Plan Participants with access to the Aetna Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Aetna Mail Order Pharmacy on its internet website and via its member services call center. The Aetna Mail Order Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and shall charge and collect the applicable Cost Share from Plan Participants for each Covered Service. The Aetna Mail Order Pharmacy generally will require that medications and supplies be dispensed in quantities not to exceed a 90-day supply, unless otherwise specified in the description of Plan benefits. If the prescription and applicable Law do not prohibit substitution of a Generic Drug equivalent, if any, for the prescribed drug, or if the Aetna Mail Order Pharmacy obtains consent of the Prescriber, the Aetna Mail Order Pharmacy shall require that the Generic Drug equivalent be dispensed to the Plan Participant. Certain Specialty Drugs, some acute drug products or certain compounds cannot be ordered through the Aetna Mail Order Pharmacy. The Aetna Mail Order Pharmacy shall make refill reminder and on-line ordering services available to Plan Participants. Aetna and/or the Aetna Mail Order Pharmacy may promote the use of the Aetna Mail Order Pharmacy to Plan Participants through informational mailings, coupons or other financial incentives at Aetna's and/or the Aetna Mail Order Pharmacy's cost, unless otherwise agreed upon by Aetna and Customer.

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

3. Clinical Programs

a. Formulary Management. Aetna shall implement the Formulary and Aetna's formulary management programs, which may include cost containment initiatives and formulary education programs. Customer hereby elects to adopt the Formulary for use with the Plan. Subject to the terms and conditions set forth in this Statement of Available Services, Aetna grants Customer the right to use the Formulary during the term of this Statement of Available Services solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary for the Plan. Customer further acknowledges and agrees that the Formulary is subject to change at Aetna's sole discretion as a result of a variety of factors, including without limitation, market conditions, clinical information, cost, rebates and other factors. Customer also acknowledges and agrees that the Formulary is the Confidential Information of Aetna and is subject to the requirements set forth in this Statement of Available Services and the Agreement.

b. 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, that 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.

c. 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 Members. 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.

d. 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.

e. Aetna Rx Check Program. If purchased by Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Aetna Rx Check Program. Aetna Rx Check programs use a rapid Retrospective DUR approach. Claims are systematically analyzed, often within 24 hours of adjudication, for possible physician outreach based on program algorithms. The specific outreach programs are designed to promote quality, cost-effective care in accordance with accepted clinical guidelines through mailings or telephone calls to physicians and Plan Participants.

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

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

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

f. Save-A-Copay℠: If purchased by Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Save-A-Copay program. Aetna's Save-A-Copay program is designed to encourage Plan Participants to use Generic Drugs, where appropriate and with the approval of their physician. If Plan Participants switch to a generic alternative from a brand-name product, the Plan Participant Cost Share is reduced for a six month period. In such circumstances, the Customer incurs an additional cost for such Claim equal to the amount the Cost Share is reduced.

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

h. 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 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.

4. **Plan Participant Services and Programs**

Internet services including Aetna Navigator and Aetna Pharmacy Website.

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

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

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

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

5. **Rebate Administration**

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

b. If Customer is eligible to receive Rebates under this Statement of Available Services, 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 Customer in accordance with this Statement of Available Services. Aetna may delay payment of Rebates to Customer to allow for final adjustments or reconciliation of Service Fees or other amounts owed by Customer upon termination of this Statement of Available Services.

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

i. Election of, and compliance with, Aetna's Formulary;

ii. Adoption of and conformance to certain benefit plan design requirements related to the Formulary as described in Service and Fee Schedule;

iii. Distribution of the Formulary (or a summary thereof) to Plan Participants and/or physicians, as applicable; and

iv. Compliance with other generally applicable requirements for participation in Aetna's rebate program, as communicated by Aetna to Customer from time to time.

Customer further acknowledges and agrees that if it is eligible to receive a portion of Rebates under this Statement of Available Services, such eligibility shall be subject to the condition that 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 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, Customer as necessary to prevent duplicative Rebates on such drugs.

C. General Administration Services

1. Eligibility Transmission

The Service Fees set forth under the Service and Fee Schedule assume that Customer will provide eligibility information monthly, or more frequently, from one (1) location by electronic connectivity. Submission of eligibility information by more than one location or via multiple methods will result in additional charges to Customer as determined by Aetna. Costs associated with any custom programming necessary to accept eligibility information from Customer are excluded from the Service Fees set forth in the Service and Fee Schedule.

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

2. Customer Services

a. Aetna will assign an Account Executive to Customer's account. The Account Executive will be available to assist Customer in connection with the general administration of the Services, ongoing communications with Customer and assistance in claims administration and record-keeping systems for Customer's ongoing operation of the Plan.

b. Upon request by Customer and consent by Aetna, Aetna will implement changes in Claims administration consistent with Customer's modifications of its Plan. A charge may be assessed for implementing such changes. Customer's Services Fees, as set forth in the Service and Fee Schedule, will be revised if the foregoing amendments or modifications increase Aetna's costs.

c. Aetna will provide the following reports to Customer for no additional charge:

i. Monthly/Quarterly/Annual Accounting Reports - Aetna shall prepare and provide the following accounting reports in excel format or other format that is acceptable to Customer and in accordance with the benefit-account structure for use by Customer in the financial management and administrative control of the Plan benefits:

- a monthly listing of funds requested and received for payment of Plan benefits;
- a monthly reconciliation of funds requested to Claims paid within the benefit-account structure;
- a monthly or quarterly or annual listing of paid benefits;
- quarterly or annual standard claim analysis reports
- a monthly report that reconciles cleared transactions with the claims invoiced to the Customer for the month reported, including any outstanding transactions; and
- an annual lag report as of September 30th each year that reports any liabilities that were incurred in the Customer's then current fiscal year (Customer's Fiscal Year is October 1st to September 30th) but that will not be paid during the Customer's then current fiscal year.

ii. Annual Accounting Reports - Aetna shall prepare standard annual accounting reports for each major benefit line under the Plan for the Agreement Period that include the following:

- forecast of Claim costs;
- accounting of experience; and
- calculation of Customer reserve.

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

d. Customer shall adopt Aetna's administrative and record keeping systems, including the production of Plan Participant identification cards.

e. Aetna shall design and install a benefit-account structure separately by class of employees, division, subsidiary, associated company, or other classification reasonably desired by Customer.

f. Aetna shall provide plan design and underwriting services in connection with benefit revisions, additions of new benefits and extensions of coverage to new Plan Participants.

g. Aetna shall provide cost estimates and actuarial advice for benefit revisions, new benefits and extensions of coverage being considered by Customer.

h. Upon request of Customer, Aetna will provide Customer with information reasonably available to Aetna which is reasonably necessary for Customer to prepare reports for the United States Internal Revenue Service and Department of Labor.

i. Upon request, Aetna shall provide the following Plan description services:

(i). Upon request of Customer, Aetna shall prepare an Aetna standard Plan description, including benefit revisions, additions of new benefits, and extension of coverage under the Plan. If the Customer elects to have an Aetna non-standard Plan description, Aetna will provide a custom Plan description with all costs borne by Customer; or

(ii) Upon request of Customer, Aetna will review 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. Customer acknowledges its responsibility to review and approve all Plan descriptions and any revisions thereto and to consult Customer's legal counsel, at its discretion, with said review and approval.

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

If Customer requires both preparation (a) and review (b), there may be an additional charge.

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

k. Upon request by Customer, Aetna will arrange for the custom printing of forms and identification cards, with all costs borne by Customer.

V. Important Information about the Pharmacy Benefit Management Services

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

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

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

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

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

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

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

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

D. Customer acknowledges that Aetna contracts with Participating Retail Pharmacies directly or through a pharmacy benefit management ("PBM") subcontract to provide Customer and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna or PBM to Participating Retail Pharmacies vary among Participating Retail Pharmacies in Aetna's network, and can vary from one pharmacy product, plan or network to another.

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

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

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

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

Claims for certain Generic Drugs ordered through Aetna Mail Order Delivery that cannot be purchased from manufacturers, wholesalers and other suppliers at reduced prices typical of multi-source generic drugs are paid by Aetna at the negotiated prices applicable to Brand Drugs ordered through Aetna Mail Order Pharmacy. Examples of these Generic Drugs include Brand Drugs that are incorrectly coded as generic by the drug pricing publication used by Aetna, trademarked Generic Drugs, any Generic Drug that is manufactured by one (1) manufacturer (or multiple manufacturers in the case of "authorized" Generic Drugs), and any Generic Drug that has an AWP price within twenty-five percent (25%) of the equivalent Brand Drug. Aetna excludes Aetna Mail Order Pharmacy claims for such Generic Drugs from the reconciliation of its standard pharmacy Discount and Dispensing Fee financial guarantees.

VI. Early Termination

Consequences of Early Termination

Without limiting Aetna's other rights or remedies, the following shall apply in the event this Statement of Available Services is terminated (i) by Customer without cause or (ii) by Aetna with cause pursuant to the Agreement:

Customer acknowledges and agrees that Aetna shall retain any Rebates earned by, but not yet paid to, Customer as of the effective date of the termination of the Statement of Available Services.

VII. Audit Rights

Customer or its duly authorized representatives shall, until the expiration of two (2) years after termination or expiration of the Agreement, have access to and the right to examine and photocopy any and all books, documents, papers and records, which are directly pertinent to the Plan and the Services for the purposes of making audits, examinations, excerpts and transcriptions. The costs of audit(s) reasonable in scope are included in Service Fees and there shall be no other costs for such audits. In the event Customer requests an audit that either (i) cannot be completed within a five (5) day period on Aetna's premises or (ii) containing a sample size in excess of 250 claim transactions, Customer shall reimburse Aetna for any reasonable incremental personnel costs Aetna incurs to fulfill the audit beyond such standard parameters. Customer would, under no circumstances, be charged for Aetna's costs of responding to follow-up inquiries, so long as such inquiries do not involve further on-site audit work. Customer shall have access during normal working hours to all necessary facilities and shall be provided adequate and appropriate work space in order to conduct audits in compliance with the provisions of this section. Customer shall give reasonable advance notice of intended audits.

In the ordinary course, audits of claim transactions will be conducted no more often than once per year and within two years following the period being audited. In the event such audits identify systemic or recurring issues that Customer wishes to investigate for prior periods, the parties will cooperate to conduct such investigations as Customer may reasonably request and Aetna's records for prior periods shall be freely available for such purposes. Audits of performance guarantees must be commenced in the year following the period to which the performance guarantee results apply.

Upon request, Aetna will provide Customer with a copy of the most recent SSAE 16 SOC 1 (type II) report, or successor report.

Aetna's agreements with pharmaceutical manufacturers are subject to confidentiality agreements. 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. Pharmacy Auditors shall enter into an appropriate confidentiality agreement with, and acceptable to, Aetna prior to conducting any a rebate audit hereunder. Subject to the terms and limitations of this Statement of Available Services, the Agreement, and the Service and Fee Schedule including without limitation the general Pharmacy Audit terms and conditions set forth in this Section VII, Customer shall be entitled to audit Aetna's calculation of up to 15% of the Rebates received by Customer which are attributable to the drugs most highly utilized by Plan Participants. 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 Customer's Rebates; and (b) are subject to manufacturer rebate agreements that do not contain restrictions prohibiting Aetna from disclosing to Customer portions of such contracts concerning the rebates, payments or fees payable there under (hereinafter the "**Rebate Contract Excerpts**"). 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 Statement of Available Services. Prior to the commencement of a Rebate verification audit, Aetna will provide to Customer a report identifying the drugs to be included in such audit. Customer is entitled to only one annual Rebate audit.

VIII. Fees

Administrative Fees are provided in conjunction with Aetna's Services relating to the Benefit Plan Design and summarized in the Service and Fee Schedule.

IX. Financial Guarantees

In conjunction with the Services provided by Aetna under this Statement of Available Services, Aetna shall provide any financial guarantees set forth in the Service and Fee Schedule.

X. Performance Guarantees

Any Performance Guarantees applicable to this Statement of Available Services are attached in the Performance Guarantee Appendix as referenced in the Agreement.

Service & Fee Schedule
Williamson County

Table of Contents

Benefit Plan

Effective Date 11/01/2014 Benefit Plan Single Tier [1]			
Price Points		**Participating Retail Pharmacy Network**	**Aetna Rx Home Delivery**
Brand Drugs	Guaranteed AWP Discount	Year 1: AWP – 16.00%	Year 1: AWP – 24.00%
		Year 2: AWP – 16.10%	Year 2: AWP – 24.10%
		Year 3: AWP – 16.20%	Year 3: AWP – 24.20%
	Guaranteed Dispensing Fee / Rx	Year 1: $1.40	Year 1: $0.00
		Year 2: $1.40	Year 2: $0.00
		Year 3: $1.40	Year 3: $0.00
Generic Drugs	Guaranteed[2] AWP Discount	Year 1: AWP – 71.50% (overall, includes MAC and non-MAC)	Year 1: AWP – 73.50% (overall, includes MAC and non-MAC)
		Year 2: AWP – 71.70% (overall, includes MAC and non-MAC)	Year 2: AWP – 73.70% (overall, includes MAC and non-MAC)
		Year 3: AWP – 71.90% (overall, includes MAC and non-MAC)	Year 3: AWP – 73.90% (overall, includes MAC and non-MAC)
	Guaranteed Dispensing Fee / Rx	Year 1: $1.40	Year 1: $0.00
		Year 2: $1.40	Year 2: $0.00
		Year 3: $1.40	Year 3: $0.00
	[2]Retail and Mail discount includes all generics (single-source and multi-source)		
Administrative Fee	The following administrative fee will apply:	Year 1: $0.00 (PEPM)	
		Year 2: $0.00 (PEPM)	
		Year 3: $0.00 (PEPM)	
Rebates	Plan sponsor will receive the following minimum rebate guarantees:	Year 1: Greater of 100.00% or $29.25 Per Brand Script	Year 1: Greater of 100.00% or $76.25 Per Brand Script
		Year 2: Greater of 100.00% or $30.50 Per Brand Script	Year 2: Greater of 100.00% or $79.25 Per Brand Script
		Year 3: Greater of 100.00% or $31.75 Per Brand Script	Year 3: Greater of 100.00% or $83.00 Per Brand Script

[1]To qualify for 3-tier rebates, the members in this plan must be covered by a plan design which contains at least three tiers, where the first tier consists of generic drugs, the second tier consists of preferred brand drugs, and the third tier consists of non-preferred brand drugs, with a minimum $15.00 retail/$30.00 mail order copay differential between the second and third tier, or in the case of co-insurance plans a minimum 1.5 times difference in the co-insurance percentage between the second and third tier (for example, if the second tier co-insurance is 20%, the third tier co-insurance must be at least 30%); for plans that have co-insurance with minimums, there must be a minimum $15.00 retail/$30.00 mail order copay differential between the second and third tier regardless of the co-insurance percentage; if there are copay maximums, the minimum copay on the third tier must be greater than the maximum copay on the second tier.

Aetna will adjudicate Claims through our retail pharmacy network at the lowest of U&C, MAC, or discounted AWP. Words beginning with capital letters shall have the meaning set forth in Section II of the Statement of Available Services. Any reference to "Member" shall mean a Plan Participant as defined in the Statement of Available Services.

Pricing Updates & New To Market Products

When new Specialty Products gain FDA approval, Aetna Pharmacy Management notifies Customer on a monthly basis of the availability and projected pricing of these Specialty Products. However, whether such Specialty Products will be included as Covered Services will depend on the Customer's Plan design. Aetna Pharmacy Management also notifies Customer on a monthly basis of limited distribution Specialty Products newly available through Aetna Specialty Pharmacy.

Aetna Specialty Pharmacy determines the pricing for new to market Specialty Products by considering various factors, such as acquisition cost, expected dosages, package sizes and utilization. In any case, such Specialty Products will have a minimum market introduction guarantee of AWP less 10%.

Producer Compensation

Aetna may pay a varying producer compensation to Customer's benefit consultant for services provided to Aetna or Customer and Customer acknowledges and consents to Aetna paying such producer compensation. Information regarding the producer compensation is available through the Customer's benefit consultant or Aetna.

Assumptions

The Service Fees and Services set forth herein are based on, among other things, the assumption that a total of 1,399 of Customer's employees will be receiving Covered Services through Aetna. If there is a change of greater than 15% of this enrollment or in the geographic, demographic or eligible mix of the population, Aetna reserves the right to revisit the structure and/or conditions of this Service and Fee Schedule.

For the purposes of Discounts, the savings percentage will be calculated by dividing the AWP less the ingredient cost for the drugs dispensed by the AWP for such drugs. For each eligible prescription-drug claim, Calculated Ingredient Cost will be calculated at the lesser of the applicable MAC, or AWP Discount price in determining the Discount achieved for purposes of calculating Discounts, including 100% Plan Participant Cost Share Claims at the applicable calculated Discount prior to the application of the Plan Participant Cost Share. Cost Share will be calculated on the basis of the rates charged to Customer by Aetna for Covered Services except as required by law to be otherwise.

Discount and Dispensing Fee guarantees shall not apply to Compound drug claims, claims that process at U&C, direct member reimbursement (DMR) claims, and claims for products dispensed by Aetna Specialty Pharmacy. Aetna reserves the right to exclude claims for over-the-counter products, supplies, vaccines, workers compensation claims, and in-house pharmacy or 340b claims from the discount and dispensing fee guarantees.

Rebates will be distributed on a Quarterly basis. Rebate allocations will be made within 180 days from the end of such allocation period. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. Customer shall adopt the Aetna Formulary in order to be eligible to receive Rebates as provided in the Service and Fee Schedule as set forth herein unless otherwise agree upon by Customer and Aetna. Rebates are paid on Specialty Products dispensed through Participating Pharmacies and covered under the Plan.

Rebate, Discount and Dispensing Fee Guarantees are based on the Plan in effect and as disclosed to Aetna during any Agreement Period. Accordingly, if Customer fails to disclose to Aetna that it employs, or intends to employ, a consumer driven health plan, major cost sharing changes, any utilization management program promoting Generic or OTC Drugs over Brand Drugs during any Agreement Period, Aetna reserves the right to adjust Guarantees.

Retail and Mail Order rebate guarantee components are measured individually and reconciled in aggregate on an annual basis.

Retail brand, retail generic, mail order brand and mail order generic discount guarantee components are measured individually and reconciled in aggregate on an annual basis.

Retail brand, retail generic, mail order brand and mail order generic dispensing fee guarantee components are

measured individually and reconciled in aggregate on an annual basis.

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

Aetna reserves the right to make appropriate changes to these guarantees if (a) there are any significant changes in the composition of Aetna's pharmacy network or in Aetna's pharmacy network contract compensation rates, or the structure of the pharmacy stores/chains/vendors that are contracted with Aetna, including but not limited to disruption in the retail pharmacy delivery model, and bankruptcy of a chain pharmacy, or (b) there is a change in government laws or regulations which have a significant impact on pharmacy claim costs, or (c) any material manufacturer rebate contracts with Aetna are terminated or modified in whole or in part, (d) there is any legal action or Law that materially affects or could materially affect the manner in which Aetna administers the rebate program, or if an existing Law is interpreted so as to materially affect or potentially have a material affect on Aetna's administration of the program, or (e) there is a material change in the Plan that is initiated by the Customer which impacts Aetna's costs.

Customer and Aetna agree that AWP, the underlying financial basis of the Statement of Available Services and this Service and Fee Schedule, may become modified or discontinued by means outside of the control of Customer and Aetna, thereby impairing the financial intent of the parties hereunder. In the event of such modification or discontinuance, the parties agree that Aetna, in order to preserve such financial intent, may opt to (i) change the AWP source from MediSpan to another AWP source, (ii) maintain the AWP as modified but make appropriate adjustments with Customer and/or Participating Pharmacies, or (iii) change the pricing index from AWP to another industry standard index, such as Wholesale Acquisition Cost. Aetna shall provide Customer with at least ninety (90) days written notice of the option taken by Aetna together with a sufficiently detailed explanation demonstrating how such option has preserved the parties' financial intent. If ninety (90) days notice is not practicable under the circumstances, Aetna shall provide notice as soon as practicable. If Customer disputes this explanation, the parties agree to cooperate in good faith to resolve such dispute.

If (a) Williamson County terminates the Agreement prior to the date the pharmacy rebate check is issued, or (b) the Agreement is terminated by Aetna for Williamson County's failure to meet its obligations to fund benefits or pay administrative fees (medical or pharmacy) under the Agreement, Aetna will be entitled to deduct deferred administrative fees or other plan expenses due to the termination date from any rebate check due Williamson County following the termination date. If the Aetna Pharmacy Management (APM) plan is terminated by Williamson County prior to October 31, 2017, Aetna will retain any rebates earned but not issued as of the APM cancellation date.

To the extent this Service and Fee Schedule is part of a proposal to Customer, the Service Fees and Services set forth herein are valid for 90 days from the date of such proposal. All guarantees and underlying conditions are subject and limited to Prescription Drugs dispensed by Participating Pharmacies.

Programs & Services

Aetna offers a comprehensive suite of trend and integrated health management programs and services. Below is a list, by product, of those services and programs that are available to Williamson County. This offering may change or be discontinued from time to time as we update our offering to meet the needs of the marketplace. Please note the following:

- Services and programs included in our quoted pricing are indicated as "Included"
- Services and programs that are optional are noted as "Included (upon customer request)." Additional fees are noted when applicable.

Pharmacy Programs and Services

Categories	Included / Optional
General Administration	
Implementation Services	Included
Account Management	Included
Customer Team Services	Included
Banking	Included
Standard Communication Materials	Included
ID Cards	Included
Eligibility	Included
Standard Reporting	Included
Network Administration	
Pharmacy Network Management	Included
Claim & Member Services	
Claim Administration	Included
Member Services	Included
Aetna Rx Home Delivery	Included
Patient Management	
Formulary Management (Aetna Formulary)	Included
Custom Formulary Management - rebates are subject to change upon review	$1.00 PEPM if selected
Internet Services	
Aetna Navigator	Included
Public Site	Included
Secure Site (log in).	Included
Find-A-Pharmacy	Included
InteliHealth	Included
Safety	
Concurrent Drug Utilization Review (DUR)	Included
Point of Care Edits	Included
Safety Edits	Included
Expanded Age Edits	Included (upon customer request)
Expanded Gender Edits	Included (upon customer request)
Enhanced Safety Edits	Included (upon customer request)
Member Education and Value	
Controlled Substance Use Program	Included
Blood Glucose Monitor	Included
Prescription Savings Program	Included
ExtraCare® Health Card	Included (upon customer request)
Heart Care for Life	Included (upon customer request)
Migraine Management	Included (upon customer request)
Generic Solutions	
Brand to Generic Outreach	Included

Categories	Included / Optional
Generic Sampling	Included
Brand to Generic	Included
Generic Launch	Included
Aetna Rx Step	Included (upon customer request)
Specialty Solutions	
Specialty Utilization Management including National Precertification	Included
Aetna Specialty Health Care℠ Management	Included
Retail to Specialty Outreach	Included
Aetna Specialty CareRx: (Choice of Open Network or Preferred Network) (Please refer to Aetna Specialty Pricing Addendum for Aetna Specialty Pharmacy Discounts and Dispensing Fees)	Included (upon customer request)
Adherence	
Aetna Rx Courtesy Start℠	Included
Aetna Rx AutoFill	Included (upon customer request)
Adherence to Drug Therapy	Included (upon customer request)
Aetna Pharmacy Advisor*	Included (upon customer request)
Aetna Pharmacy Advisor Diabetes Buy-Up Option*	$0.13 Per Member Per Month
Aetna Pharmacy Advisor Diabetes and Cardiovascular Buy-Up Option*	$0.26 Per Member Per Month
Aetna Pharmacy Advisor All Conditions Complete Buy-Up Option*	$0.38 Per Member Per Month
Gaps in Care	Included (upon customer request)
Preventative and Chronic Drug List	Included (upon customer request)
*Requires Aetna Rx AutoFill and Adherence to Drug Therapy	
Access Solutions	
National Network	Included
Maintenance Choice® - Mandatory (Requires Mandatory Mail Order)*	Included (upon customer request)
Maintenance Choice® - Incentivized (Requires Incentivized Mail Order)*	Included (upon customer request)
Maintenance Choice® - Voluntary*	Included (upon customer request)
Aetna Rx Value Network*	Included (upon customer request)
Aetna Rx Preferred Network*	Included (upon customer request)
Aetna Rx Choice Network* (Includes National Network)	Included (upon customer request)
Extended Day Supply Network* (Includes National Network)	Included (upon customer request)
Retail to Mail Outreach	Included (upon customer request)
*cannot be offered together	
Clinical Management	
Smart Edit Technology Integrated Intelligence	Included
ePrior Authorization	Included
Programs Available at an Additional Charge	
Aetna Rx Check – Expanded Offering (Includes: Acute Frequency, Brand-to-Generic, High Utilization, Therapeutic Duplication, Patient Safety, Streamlining Therapy, Therapeutic Optimization, Length of Therapy, Maximum Dose, Prescription Cascade)	$0.55 Per Employee Per Month
Save-A-Copay	Optional at $1.00 Per Letter Per Targeted Member collected on a quarterly basis over the claim wire
Aetna Healthy Actions – Rx Claim Savings	

Categories	Included / Optional
o Care Engine Powered Condition-Based	$0.25 Per Employee Per Month
o Care Engine Powered Drug-Based	$0.15 Per Employee Per Month
o Drug Class Driven (Rx Claims Logic Only)	$0.15 Per Employee Per Month
Essentials Therapy Management Program	$30.00 Per Occurrence (Prior Authorization)
o Precertification	
o Quantity Limits	
o Dose Optimization	

Important Information About Aetna's Pharmacy Benefit Management Services

Other Payments

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

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

Late Payment Charges

If Williamson County fails to provide funds on a timely basis to cover benefit payments as provided in the Service and Fee Schedule, and/or fails to pay service fees on a timely basis provided in such Service and Fee Schedule, Aetna will assess interest as a late payment charge. Interest charges for any late payments shall be paid by Customer in accordance with Texas Government Code Section 2251.025. More specifically, the rate of interest that shall accrue on a late payment is the rate in effect on September 1 of Customer's fiscal year in which the payment becomes due. The said rate in effect on September 1 shall be equal to the sum of one percent (1%) and the prime rate published in the Wall Street Journal on the first day of July of the preceding fiscal year that does not fall on a Saturday or Sunday.

In addition, Aetna will make a charge to recover its costs of collection including reasonable attorney's fees.

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.

Participating Retail Pharmacy Network

Aetna contracts with Participating Retail Pharmacies directly or through a pharmacy benefit management ("PBM") subcontract to provide Customer and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna or PBM to Participating Retail Pharmacies vary among Participating Retail Pharmacies in Aetna's network, and can vary from one pharmacy product, plan or network to another.

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

Mail-Order and Specialty Covered Services

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

Pharmacy Audit Rights and Limitations

Aetna will share Rebate information with a qualified auditor under a strict confidentiality agreement that prohibits disclosure of such information to any third party, including Customer, and will not use such information for any purposes other than the Rebate audit. Auditor will be provided with the relevant portions of the applicable Formulary Rebate contracts, including, but not limited to, the manufacturer names, Prescription Drug names, details of all monies as defined by the term Rebate, and Rebate amounts for the Prescription Drugs being audited. The parties will reasonably cooperate to select Prescription Drugs for each audit that: (i) represent the fewest unique manufacturer Rebate contracts required for audit so that the selected drugs represent up to a maximum of 15% of Customer's Rebates; and (ii) are subject to manufacturer Rebate agreements that do not contain restrictions prohibiting Aetna from disclosing to Customer portions of such contracts concerning the Rebates, payments or fees payable thereunder. For purposes of this Section, the term "Aetna" as defined in Section III of the Statement of Available Services shall not include subcontractor.

In addition to the above stated auditor qualification, auditor must also have no conflict of interest or past business or other relationship which would prevent the auditor from performing an independent audit to conclusion. A conflict of interest includes, but is not limited to, a situation in which the audit agent: (i) is employed by an entity, or any affiliate of such entity, which is a competitor to Aetna's benefits or Claims administration business or Aetna's mail order or specialty pharmacy businesses; (ii) is affiliated with a vendor subcontracted by Aetna to adjudicate Claims or provide services in connection with Aetna's administration of benefits or provision of mail order or specialty pharmacy services. Auditors shall enter into an appropriate confidentiality agreement with, and acceptable to, Aetna prior to conducting any audit.

Customer is entitled to only one annual Rebate audit.

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, Customer may elect to audit 100% of Claims. Customer is entitled to only one annual Claim audit.

Maximum Allowable Cost ("MAC")

As part of the administration of Covered Services, Aetna maintains MAC Lists of Prescription Drug products identified as requiring pricing management due to the number of manufacturers, utilization and/or pricing volatility. Criteria for inclusion on a MAC List include whether the Prescription Drug has readily available Generic Drug equivalents and a cost basis that will allow for pricing below Brand Drug rates. Aetna maintains correlative MAC Lists based on current price references provided by drug data compendia, market pricing, availability information from Generic Drug manufacturers and other sources which are subject to change.

Aetna Specialty Pharmacy

Information regarding the pricing and limited distribution or restricted access of Specialty Products is set forth in Addendum I to this Service and Fee Schedule.

Aetna Specialty Pharmacy
Williamson County

Aetna Specialty Pharmacy

Except for the specific items listed in the Exceptions or Limited Distribution tables below, Specialty Products will have the following Discounts:

Distribution Channel	Standard Discounts	Dispensing Fee
Preferred	AWP - 13.50%	$0.00

Specialty Products will not be available through Aetna Rx Home Delivery.

Limited Distribution Drugs

Some Specialty Products may be subject to limited distribution or restricted access. This means that certain Specialty Products may only be available at one or a limited number of pharmacies. Limited distribution is generally due to (i) the FDA imposing restrictions on the distribution of a Specialty Product to certain pharmacies and (ii) special handling, coordination of care or patient education that cannot be handled by all pharmacies. While most Specialty Products may be ordered through Aetna Specialty Pharmacy, the Specialty Products listed below are currently not available. However, if Aetna receives a prescription order for any of these Specialty Products, it will transfer the order to a Participating Pharmacy where the Specialty Products are available and inform the prescribing physician and Plan Participant of same.

Limited Distributed Products		
ADAGEN	IRESSA	SABRIL
ARALAST	OFORTA	SUCRAID
ARCALYST	ONSOLIS	TIKOSYN
BERINERT	ORFADIN	TYVASO
CINRYZE	ORTHOCLONE	VENTAVIS
CYSTADANE	PROLASTIN	VISUDYNE
ELAPRASE	PROMACTA	XENAZINE
EXJADE	REMODULIN	XYREM
FLOLAN	RETISERT	ZAVESCA
ILARIS	RIASTAP	ZEMAIRA
IMPLANON		

Exceptions To Standard Pricing

The following Specialty Products have the Discounts shown for the Preferred distribution channel.

			Network	
Therapeutic Category	**Drug Name**	**Medication Form**	**AWP Discount**	**Dispensing Fee**
ANEMIA	ARANESP	INJ	12.50%	$0.00
ANEMIA	ATGAM	INJ	13.50%	$0.00
ANEMIA	EPOGEN	INJ	13.50%	$0.00
ANEMIA	INFED	INJ	13.50%	$0.00
ANEMIA	NIFEREX	OR	12.50%	$1.75
ANEMIA	PROCRIT	INJ	13.50%	$0.00
ANEMIA	REVLIMID	OR	12.50%	$1.75
ANEMIA	VENOFER	INJ	13.50%	$0.00
ASTHMA	PULMOZYME	INJ	13.50%	$0.00
ASTHMA	TOBI	OR	12.50%	$1.75
ASTHMA	XOLAIR	INJ	12.50%	$0.00

Therapeutic Category	Drug Name	Medication Form	Network	
			AWP Discount	Dispensing Fee
COLONY STIMULANT	LEUKINE	INJ	12.50%	$0.00
COLONY STIMULANT	MOZOBIL	INJ	13.50%	$0.00
COLONY STIMULANT	NEUMEGA	INJ	13.50%	$0.00
COLONY STIMULANT	NEULASTA	INJ	11.50%	$0.00
COLONY STIMULANT	NEUPOGEN	INJ	13.50%	$0.00
CROHN'S DISEASE	CIMZIA	INJ	13.50%	$0.00
CROHN'S DISEASE	REMICADE	INJ	13.50%	$0.00
DEEP VEIN THROMBOSIS	ARIXTRA	INJ	13.50%	$0.00
DEEP VEIN THROMBOSIS	FRAGMIN	INJ	13.50%	$0.00
DEEP VEIN THROMBOSIS	HEPARIN	INJ	13.50%	$0.00
DEEP VEIN THROMBOSIS	INNOHEP	INJ	13.50%	$0.00
DEEP VEIN THROMBOSIS	LOVENOX	INJ	11.50%	$0.00
ENZYME REPLACEMENT	ALDURAZYME	INJ	12.50%	$0.00
ENZYME REPLACEMENT	CEREZYME	INJ	11.50%	$0.00
ENZYME REPLACEMENT	FABRAZYME	INJ	10.25%	$0.00
GROWTH HORMONE	GENOTROPIN	INJ	10.50%	$0.00
GROWTH HORMONE	HUMATROPE	INJ	13.50%	$0.00
GROWTH HORMONE	NORDITROPIN	INJ	13.50%	$0.00
GROWTH HORMONE	NUTROPIN	INJ	12.50%	$0.00
GROWTH HORMONE	PROTROPIN	INJ	17.00%	$0.00
GROWTH HORMONE	SAIZEN	INJ	11.50%	$0.00
GROWTH HORMONE	SEROSTIM	INJ	12.50%	$0.00
GROWTH HORMONE	SOMATULINE DEPOT	INJ	13.50%	$0.00
GROWTH HORMONE	SUPPRELIN LA KIT	IMPL	13.50%	$0.00
GROWTH HORMONE	TEV-TROPIN	INJ	17.00%	$0.00
GROWTH HORMONE	ZORBTIVE	INJ	13.50%	$0.00
HEMOPHILIA	ADVATE	INJ	27.00%	$0.00
HEMOPHILIA	ALPHANATE	INJ	29.25%	$0.00
HEMOPHILIA	BENEFIX	INJ	14.50%	$0.00
HEMOPHILIA	FEIBA	INJ	37.50%	$0.00
HEMOPHILIA	HELIXATE	INJ	31.00%	$0.00
HEMOPHILIA	HEMOFIL	INJ	37.50%	$0.00
HEMOPHILIA	HUMATE - P	INJ	9.25%	$0.00
HEMOPHILIA	KOGENATE	INJ	42.50%	$0.00
HEMOPHILIA	MONARC	INJ	29.25%	$0.00
HEMOPHILIA	MONOCLATE	INJ	29.25%	$0.00
HEMOPHILIA	MONONINE	INJ	27.00%	$0.00
HEMOPHILIA	NOVOSEVEN	INJ	29.25%	$0.00
HEMOPHILIA	PROPLEX T	INJ	14.00%	$0.00
HEMOPHILIA	RECOMBINATE	INJ	29.25%	$0.00
HEMOPHILIA	STIMATE	INJ	12.50%	$0.00
HEMOPHILIA	XYNTHA	INJ	29.25%	$0.00
HEMOPHILIA	ALL OTHER HEMOPHILIA NOT LISTED ABOVE	INJ	11.50%	$0.00

			Network	
Therapeutic Category	Drug Name	Medication Form	AWP Discount	Dispensing Fee
HEPATITIS	ALFERON	INJ	13.50%	$0.00
HEPATITIS	BAYGAM	INJ	11.50%	$0.00
HEPATITIS	COPEGUS	OR	12.50%	$1.75
HEPATITIS	INFERGEN	INJ	17.00%	$0.00
HEPATITIS	HEPSERA	INJ	13.50%	$0.00
HEPATITIS	NABI HB	INJ	13.50%	$0.00
HEPATITIS	PEG INTRON	INJ	13.50%	$0.00
HEPATITIS	PEGASYS	INJ	13.50%	$0.00
HEPATITIS	REBETOL	OR	12.50%	$1.75
HEPATITIS	REBETRON	INJ	18.00%	$0.00
HEPATITIS	RIBAVIRIN (Generic)	OR	MAC	$1.75
HEPATITIS	ROFERON-A	INJ	12.50%	$0.00
HEPATITIS B	TYZEKA	OR	12.50%	$1.75
HIV / AIDS	ATRIPLA	OR	12.50%	$1.75
HIV / AIDS	FOSCAVIR	INJ	17.00%	$0.00
HIV / AIDS	FUZEON	INJ	13.50%	$0.00
HIV / AIDS	ISENTRESS	OR	12.50%	$1.75
HIV / AIDS	VISTIDE	INJ	13.50%	$0.00
IMMUNODEFICIENCY SYNDROME	CARIMUNE	INJ	38.00%	$0.00
IMMUNODEFICIENCY SYNDROME	FLEBOGAMMA	INJ	35.00%	$0.00
IMMUNODEFICIENCY SYNDROME	GAMIMUNE	INJ	17.00%	$0.00
IMMUNODEFICIENCY SYNDROME	GAMMAGARD S/D	INJ	42.50%	$0.00
IMMUNODEFICIENCY SYNDROME	GAMMAGARD LIQUID	INJ	29.25%	$0.00
IMMUNODEFICIENCY SYNDROME	GAMUNEX	INJ	27.00%	$0.00
IMMUNODEFICIENCY SYNDROME	PANGLOBULIN	INJ	38.00%	$0.00
IMMUNODEFICIENCY SYNDROME	POLYGAM	INJ	48.00%	$0.00
IMMUNODEFICIENCY SYNDROME	PRIVIGEN	INJ	11.50%	$0.00
IMMUNODEFICIENCY SYNDROME	RHOGAM PLUS	INJ	13.50%	$0.00
IMMUNODEFICIENCY SYNDROME	THYMOGLOBULIN	INJ	13.50%	$0.00
IMMUNODEFICIENCY SYNDROME	VIVAGLOBIN	INJ	37.50%	$0.00
IMMUNODEFICIENCY SYNDROME	WINRHO SDF	INJ	13.50%	$0.00
IMMUNODEFICIENCY SYNDROME	ALL OTHER IVIG NOT LISTED ABOVE	INJ	11.50%	$0.00
IMMUNOSUPPRESSION W/TRANSPLANT	ALPRAZOLAM	OR	16.00%	$1.75

Therapeutic Category	Drug Name	Medication Form	Network	
			AWP Discount	Dispensing Fee
IMMUNOSUPPRESSION W/TRANSPLANT	AZATHIOPRINE	OR	16.00%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	CELLCEPT	OR	12.50%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	CYCLOSPORINE	OR	16.00%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	CYTOGAM	INJ	12.50%	$0.00
IMMUNOSUPPRESSION W/TRANSPLANT	GENGRAF	OR	12.50%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	IMURAN	OR	12.50%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	KEPIVANCE	INJ	13.50%	$0.00
IMMUNOSUPPRESSION W/TRANSPLANT	MYFORTIC	OR	12.50%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	NEORAL	OR	12.50%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	PROGRAF	OR	12.50%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	PROGRAF	INJ	12.50%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	RAPAMUNE	OR	12.50%	$1.75
IMMUNOSUPPRESSION W/TRANSPLANT	SANDIMMUNE	INJ	12.50%	$0.00
IMMUNOSUPPRESSION W/TRANSPLANT	SANDIMMUNE	SOL	12.50%	$0.00
IMMUNOSUPPRESSION W/TRANSPLANT	SANDIMMUNE	OR	12.50%	$1.75
INFERTILITY	BRAVELLE	INJ	21.75%	$0.00
INFERTILITY	CETROTIDE	INJ	16.75%	$0.00
INFERTILITY	CHORIONIC GONADOTROPIN	INJ	16.75%	$0.00
INFERTILITY	FOLLISTIM AQ	INJ	13.50%	$0.00
INFERTILITY	GANIRELIX	INJ	16.75%	$0.00
INFERTILITY	GONAL F	INJ	12.50%	$0.00
INFERTILITY	LEUPROLIDE KIT	INJ	27.00%	$0.00
INFERTILITY	LUVERIS	INJ	21.75%	$0.00
INFERTILITY	MENOPUR	INJ	21.75%	$0.00
INFERTILITY	NOVAREL	INJ	16.50%	$0.00
INFERTILITY	OVIDREL	INJ	16.50%	$0.00
INFERTILITY	PREGNYL	INJ	21.75%	$0.00
INFERTILITY	REPRONEX	INJ	21.75%	$0.00
LHRH AGONIST	LUPRON	INJ	13.50%	$0.00
LHRH AGONIST	LUPRON DEPOT	INJ	13.50%	$0.00
LHRH AGONIST	PLENAXIS	INJ	13.50%	$0.00
LHRH AGONIST	ZOLADEX	INJ	24.00%	$0.00

Therapeutic Category	Drug Name	Medication Form	Network	
			AWP Discount	Dispensing Fee
MULTIPLE SCLEROSIS	AVONEX	INJ	12.50%	$0.00
MULTIPLE SCLEROSIS	BETASERON	INJ	11.50%	$0.00
MULTIPLE SCLEROSIS	COPAXONE	INJ	12.50%	$0.00
MULTIPLE SCLEROSIS	EXTAVIA	INJ	11.50%	$0.00
MULTIPLE SCLEROSIS	MYOBLOC	INJ	13.50%	$0.00
MULTIPLE SCLEROSIS	REBIF	INJ	12.50%	$0.00
MULTIPLE SCLEROSIS	TYSABRI	INJ	13.50%	$0.00
NEUROLOGY	BOTOX	INJ	9.25%	$0.00
NEUROLOGY	CEREBYX	INJ	17.00%	$0.00
NEUROLOGY	DYSPORT	INJ	11.50%	$0.00
NEUROLOGY	CLONAZEPAM	OR	16.00%	$1.75
NEUROLOGY	LIORESAL INTRATHECAL	INJ	17.00%	$0.00
ONC - ANTIEMETIC	ANZEMET	INJ	13.50%	$0.00
ONC - ANTIEMETIC	ATROPINE	INJ	13.50%	$0.00
ONC - ANTIANEMIC	CYANOCOBALAMIN	INJ	13.50%	$0.00
ONC - ANTIEMETIC	DELTASONE	OR	16.00%	$1.75
ONC - ANTIEMETIC	DEXAMETHASONE	INJ	13.50%	$0.00
ONC - ANTIEMETIC	EMEND	INJ	15.00%	$0.00
ONC - ANTIEMETIC	HYDROXYZINE	OR	13.50%	$1.75
ONC - ANTIEMETIC	KYTRIL	INJ	16.00%	$0.00
ONC - ANTIEMETIC	METHYLPREDNISOLONE	INJ	13.50%	$0.00
ONC - ANTIEMETIC	PROCHLORAPERAZINE - CPD	INJ	17.00%	$0.00
ONC - ANTIEMETIC	TIGAN	OR	13.50%	$1.75
ONC - ANTIEMETIC	ZOFRAN	OR	12.50%	$1.75
ONC - ANTIHYPERCALCEMIC	PAMIDRONATE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	ALOXI	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	ARIMIDEX	OR	12.50%	$1.75
ONC - CHEMOTHERAPY	AVASTIN	INJ	10.25%	$0.00
ONC - CHEMOTHERAPY	BCG LIVE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	BLEOMYCIN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	CAMPTOSAR	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	CASODEX	OR	12.50%	$1.75
ONC - CHEMOTHERAPY	COSMEGEN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	CYTARABINE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	CYTOXAN	INJ	12.50%	$0.00
ONC - CHEMOTHERAPY	DAUNORUBICIN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	DOXIL	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	DOXORUBICIN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	ELITEK	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	ELIGARD	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	ELOXATIN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	ERBITUX	INJ	13.50%	$0.00

Therapeutic Category	Drug Name	Medication Form	Network	
			AWP Discount	Dispensing Fee
ONC - CHEMOTHERAPY	ETHYOL	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	ETOPOSIDE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	FASLODEX	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	GEMZAR	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	GLEEVEC	OR	10.50%	$1.75
ONC - CHEMOTHERAPY	HERCEPTIN	INJ	10.50%	$0.00
ONC - CHEMOTHERAPY	HYCAMTIN	OR	12.50%	$1.75
ONC - CHEMOTHERAPY	HYCAMTIN	INJ	12.50%	$0.00
ONC - CHEMOTHERAPY	HYDROXYUREA	OR	16.00%	$1.75
ONC - CHEMOTHERAPY	INTRON A	INJ	12.50%	$0.00
ONC - CHEMOTHERAPY	LEUCOVORIN	OR	13.50%	$1.75
ONC - CHEMOTHERAPY	MERCAPTOPURINE	OR	16.00%	$1.75
ONC - CHEMOTHERAPY	METHOTREXATE	INJ	12.50%	$0.00
ONC - CHEMOTHERAPY	MUSTARGEN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	MITOMYCIN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	NAVELBINE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	NEXAVAR	OR	13.50%	$1.75
ONC - CHEMOTHERAPY	NOVANTRONE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	OCTREOTIDE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	PACLITAXEL	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	PARAPLATIN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	PROLEUKIN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	RITUXAN	INJ	12.50%	$0.00
ONC - CHEMOTHERAPY	TAMOXIFEN	OR	16.00%	$1.75
ONC - CHEMOTHERAPY	TARCEVA	OR	11.50%	$1.75
ONC - CHEMOTHERAPY	TAXOTERE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	TEMODAR	OR	12.50%	$1.75
ONC - CHEMOTHERAPY	THALOMID	OR	12.50%	$1.75
ONC - CHEMOTHERAPY	TICE BCG	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	SANDOSTATIN	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	SUTENT	OR	14.50%	$1.75
ONC - CHEMOTHERAPY	VELCADE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	VINCRISTINE	INJ	13.50%	$0.00
ONC - CHEMOTHERAPY	VOTRIENT	OR	12.50%	$1.75
ONC - CHEMOTHERAPY	XELODA	OR	12.50%	$1.75
ONC - CHEMOTHERAPY	ZENAPAX	INJ	13.50%	$0.00
ONC - DIURETIC	MANNITOL	INJ	13.50%	$0.00
ONC - HEMATOPOIETIC	NEULASTA	INJ	11.50%	$0.00
ONC - HYPERCALCEMIC	AREDIA	INJ	17.00%	$0.00
ONC - HYPERCALCEMIC	ZOMETA	INJ	13.50%	$0.00
OSTEOARTHRITIS	EUFLEXXA	INJ	13.50%	$0.00
OSTEOARTHRITIS	HYALGAN	INJ	13.50%	$0.00
OSTEOARTHRITIS	ORTHOVISC	INJ	13.50%	$0.00

Therapeutic Category	Drug Name	Medication Form	Network	
			AWP Discount	Dispensing Fee
OSTEOARTHRITIS	SUPARTZ	INJ	17.00%	$0.00
OSTEOARTHRITIS	SYNVISC	INJ	13.50%	$0.00
OSTEOPOROSIS	FORTEO	INJ	11.50%	$0.00
OTHER	ACTHAR GEL	INJ	13.50%	$0.00
OTHER	KUVAN	OR	13.50%	$1.75
OTHER	INCRELEX	INJ	13.50%	$0.00
OTHER	LUCENTIS	INJ	11.50%	$0.00
OTHER	RECLAST	INJ	13.50%	$0.00
OTHER	RETISERT	INJ	17.00%	$0.00
OTHER	ROCEPHIN	INJ	13.50%	$0.00
OTHER	SOMAVERT	INJ	13.50%	$0.00
OTHER	THYROGEN	INJ	10.50%	$0.00
OTHER	VIVITROL	INJ	10.50%	$0.00
OTHER	ALL OTHER INJECTABLE DRUGS NOT LISTED	INJ	13.50%	$0.00
OTHER	TRADITIONAL ORALS, CREAMS & INHALERS	OR	12.50%	$1.75
OTHER	COMPOUNDED MEDICATIONS & SUPPOSITORIES		16.00%	$11.75
PARKINSONS	APOKYN	INJ	13.50%	$0.00
PSORIASIS	AMEVIVE	INJ	13.50%	$0.00
PSORIASIS	SORIATANE KIT	OR	12.50%	$1.75
PSORIASIS	STELARA	INJ	11.50%	$0.00
PULMONARY ARTERIAL HYPERTENSION	ADCIRCA	OR	16.00%	$1.75
PULMONARY ARTERIAL HYPERTENSION	LETAIRIS	OR	12.50%	$1.75
PULMONARY ARTERIAL HYPERTENSION	TRACLEER	OR	13.50%	$1.75
PULMONARY FIBROSIS	ACTIMMUNE	INJ	12.50%	$0.00
RHEUMATOID ARTHRITIS	ENBREL	INJ	12.50%	$0.00
RHEUMATOID ARTHRITIS	HUMIRA	INJ	12.50%	$0.00
RHEUMATOID ARTHRITIS	HYDROXYCHLOROQUINE	OR	16.00%	$1.75
RHEUMATOID ARTHRITIS	KINERET	INJ	13.50%	$0.00
RHEUMATOID ARTHRITIS	MYOCHRYSINE	INJ	17.00%	$0.00
RHEUMATOID ARTHRITIS	ORENCIA	INJ	13.50%	$0.00
RHEUMATOID ARTHRITIS	SIMPONI	INJ	13.50%	$0.00
RSV	SYNAGIS	INJ	13.50%	$0.00

Note: This list will be updated from time to time and may include adjunct therapies used in the treatment of complex conditions. For drugs where an AB-rated generic equivalent is available, the pricing will be according to the current MAC list.

HEALTH CARE/DEPENDENT CARE
FLEXIBLE SPENDING ACCOUNT
STATEMENT OF AVAILABLE SERVICES
EFFECTIVE November 1, 2014
MASTER SERVICES AGREEMENT No. MSA-866349

Subject to the terms and conditions of the Services Agreement, the Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to Section 6 of the Master Services Agreement) will be provided by Aetna. Additional Services may be provided at Customer's written request under the terms of the Services Agreement. This Statement of Available Services ("SAS") shall supersede any previous SAS or other document describing the Services.

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

- Section 4 ("Standard of Care") is excluded and replaced by Section IV of this SAS (with respect to Dependent Care only);
- Section 6 ("Service Fees), second paragraph, is excluded and replaced by Section V of this SAS;
- Section 7(D) ("Responsibilities on Termination") is excluded and replaced by Section VI of this SAS;
- Section 12 (Audit Rights") is superseded by this SAS, but only with respect to the size of the audit sample, which shall be 150 claims;
- Section 13 ("Recovery of Overpayments") is excluded and replaced by Section VII of this SAS;
- Section 18 ("Non-Aetna Networks") does not apply with respect to the Services pursuant to this SAS.

II. Fiduciary Duty

It is understood and agreed that the Customer 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 Customer in connection with the Plan only to the extent expressly stated in the Services Agreement or as agreed to in writing by Aetna and Customer. Customer has the sole and complete authority to determine eligibility of persons to participate in the Plan.

Customer and Aetna agree that with respect to applicable state law, Aetna will be the "appropriate named fiduciary" with respect to the Health Care FSA and the Dependent Care FSA for the purpose of reviewing denied claims under the Health Care FSA and the Dependent Care FSA. Customer understands that the performance of fiduciary duties 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, 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 Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility under applicable state law.

III. Administration Services:

A. Member and Claim Services:

1. Requests for Plan benefit payments for claims shall be made to Aetna on forms or other appropriate means approved by Aetna. Such forms (or other appropriate means) may include a consent to the release of medical, claims, and administrative records and information to Aetna. Aetna will process and pay the claims for Plan benefits incurred 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 and the Services Agreement.

2. Whenever it is determined that benefits and related charges are payable under the Plan, Aetna will issue a payment of such benefits and related charges on behalf of Customer. Funding of Plan benefits and related charges shall be made as provided in Section 8 ("Benefit Funding") of the Master Services Agreement.

3. 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.

4. Upon receipt of an appeal by a Plan Participant, Aetna shall conduct a review of the claim consistent with the applicable law. In the event the adverse benefit determination is upheld on appeal, Aetna shall issue written notice to the Plan Participant which shall include, but is not limited to, the following: the basis for the adverse benefit determination; reference to the specific plan provision on which the adverse benefit determination is based; and a statement outlining other rights available under the Plan or prevailing law. Customer hereby delegates to Aetna discretionary authority to render benefit determinations and otherwise interpret terms of the Plan following the initial claim submission and on appeal.

5. Aetna shall provide customer service support for Plan Participants by toll free telephone, Monday through Friday, during the hours of 8 AM and 6 PM.

B. Plan Sponsor Services:

1. Aetna will assign an Account Executive to Customer's account. The Account Executive will be available to assist Customer in connection with the general administration of the Services, ongoing communications with Customer and assistance in claims administration and record-keeping systems for Customer's ongoing operation of the Plan.

2. Upon request by Customer and consent by Aetna, Aetna will implement changes in claims administration consistent with Customer's modifications of its Plan. A charge may be assessed for implementing such changes. Customer's administration services fees, as set forth in the Service and Fee Schedule, will be revised if the foregoing amendments or modifications increase Aetna's costs.

3. Aetna shall prepare the following standard accounting reports in accordance with the benefit-account structure for use by Customer in the financial management and administrative control of the Plan benefits:

   (a) Monthly accounting reports which show:

      (i) reimbursements made to members under the Plan, and

      (ii) current month and year-to-date plan contributions.

   (b) Upon Customer request, quarterly or semi-annual negative balance reports, if appropriate, under the Plan.

   (c) Annual plan closeout benefit payment reports in tape or paper format which include the following information by employee and in aggregate:

      (i) total employee deposits,

      (ii) total expense reimbursement,

      (iii) final account balance,

      (iv) monthly listing of checks cleared and funds called from Employer account, and

      (v) issued but unpaid benefits,

      (vi) Upon Customer request, negative balance reports.

4. Aetna shall provide the Customer account activity statements for each Employee at a schedule agreed upon between Aetna and Customer. Such statements will include the following information:

   (a) Total contributions,

   (b) Total reimbursed expenses, and

   (c) Remaining account balance.

5. Aetna shall develop and install all agreed-upon administrative and record keeping systems.

6. As to the Health Care portion, if Customer has elected to allow the use of debit cards with respect to the FSA, Aetna shall provide the capability for FSA participants to pay for health care FSA-eligible expenses using debit card technology, including the production of FSA debit cards and claim streamlining capabilities.

7. Aetna shall design and install a benefit-account structure separately by class of Employees, division, subsidiary, associated company, or other classification desired by Customer.

8. Aetna shall assist Customer with regard to plan design and underwriting issues in connection with benefit revisions, additions of new benefits and extensions of coverage to new Employees and their Dependents.

9. Aetna will provide assistance in connection with the initial set up and design of Customer's Plan, subject to the direction, review and approval by Customer. Customer shall have the final and sole authority regarding the benefits and provisions of the self-insured portion of the Plan, as outlined in Customer's Plan document. Customer acknowledges its responsibility to review and approve all Plan documents and revisions thereto and to consult with Customer's legal counsel, at its discretion, in connection with said review and approval. Aetna shall have no responsibility or liability for the content of any of Customer's Plan documents, regardless of the role Aetna may have played in the preparation of such documents.

10. Upon request of Customer, Aetna will provide Customer with information reasonably available to Aetna which is reasonably necessary for Customer to prepare reports for the United States Internal Revenue Service and Department of Labor.

11. Upon request of Customer, Aetna shall prepare an Aetna standard Plan description, including benefit revisions, additions of new benefits, and extension of coverage under the Plan. If the Customer elects to have an Aetna non-standard Plan description, Aetna will provide a custom Plan description with all costs borne by Customer.

12. Upon request of Customer, Aetna will review 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. Aetna shall have no responsibility or liability for the content of any of Customer's Plan description, regardless of the role Aetna may have played in the preparation of such description.

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

14. Upon request by Customer, Aetna will arrange for the custom printing of forms, with all costs borne by Customer.

IV. Standard of Care

Aetna will discharge its obligations under the Services Agreement for the Dependent Care portion with that level of reasonable care which a similarly situated Services provider would exercise under similar circumstances. In connection with its fiduciary powers and duties hereunder, Aetna shall observe the standard of care and diligence required of a fiduciary under applicable state law.

V. Service Fees

Second paragraph: Aetna shall submit to the Customer on a monthly basis a statement showing the installation fee and monthly fees due for each month of the Agreement Period. For each month, the fee may consist of the monthly administrative fee or any other fee applicable for that month. The fee is due and payable on the date shown on such statement (the "Payment Due Date").

VI. Responsibilities on Termination

Upon termination of the Services described in this Flexible Spending Account SAS for any reason other than termination under Section 7 (C) (2), Aetna may be requested by Customer, and Aetna may agree, to continue processing runoff claims for Plan benefits that were incurred prior to but not processed as of the termination date which are received by Aetna no later than the Last Claim Received Date, as defined in the Appendix attached to this SAS. Aetna will be entitled to the same fees (as shown in the Service and Fee Schedule) as were in effect on the date the SAS terminated. The procedures and obligations described in the Services Agreement, to the extent applicable, shall survive the termination of the Services Agreement and remain in effect with respect to such claims. Benefit payments processed by Aetna with respect to such claims which are pended or disputed will be handled to their conclusion by Aetna and the procedures and obligations described in this Services Agreement, to the extent applicable, shall survive the expiration date with respect to such claims. Requests for benefit payments received after the Plan Close Out Date will be returned to the Customer or, upon its direction, to a successor administrator at the Customer's expense.

Customer will be liable for all Plan benefit payments made by Aetna in accordance with the preceding paragraph (D) following the termination date or which are outstanding on the termination date. Customer will continue to fund Plan benefit payments through the banking arrangement described in Section 8 ("Benefit Funding") of this Master Services Agreement and agrees to instruct its bank to continue to make funds available until all outstanding benefit payments have been funded by Customer or until such time as mutually agreed upon by Aetna and Customer (e.g., Customer's wire line and bank account from which the Bank requests funds must remain open for one (1) year after runoff processing ends, two (2) years after termination).

Upon termination of the SAS and provided all Service Fees have been paid, Aetna will release to Customer or to a successor administrator, in Aetna's standard format, all claim data, records and files within thirty-one (31) days following the termination date. All reasonable costs associated with the release of data, records and files from Aetna to Customer shall be paid by Customer. Except as otherwise provided herein, any claims received by Aetna after the termination date will be forwarded to Customer or to the provider at Customer's expense; Aetna will bear no responsibility with respect to such claims.

VII. Recovery of Overpayments

The parties will cooperate fully to make reasonable efforts to recover overpayments of Plan benefits. If it is determined that any payment has been made by Aetna to or on behalf of an ineligible person or it is determined that more than the appropriate amount has been paid, Aetna shall undertake good faith efforts to recover the erroneous payment. For the purpose of this provision, "good faith efforts" means that Aetna will contact the responsible party twice via letter to try to make the recovery. Except as stated in this section, Aetna has no other duties with respect to the recovery of overpayments.

Overpayments must be determined by direct proof of specific claims. Indirect or inferential methods of proof – such as statistical sampling, etc. – may not be used to determine overpayments. In addition, application of only software may not be used to determine overpayments.

VIII. Performance Guarantees

Any Performance Guarantees applicable to Aetna's provision of Services provided pursuant to this SAS are displayed in Appendix II to the Services Agreement.

IX. Fees

The following Administrative Fees are provided in conjunction with Aetna's Services relating to the Health Care FSA and Dependent Care FSA. All Administrative Fees from this SAS are summarized in the following Service and Fee Schedule.

SERVICE AND FEE SCHEDULE

Customer hereby elects to receive the Services designated below. The corresponding Administrative Fees effective for the period beginning November 1, 2014 and ending October 31, 2015 are specified below. They shall be amended for future periods, in accordance with Section 6 of the Master Services Agreement.

Fees for services performed by Aetna in accordance with the SAS will be determined by Aetna in accordance with the following:

1. **In General.** Fees for standard services as described in the SAS consist of (a) an installation fee, (b) a monthly administration fee, and (c) other fees. The corresponding Fees effective for the period beginning November 1, 2014 and ending October 31, 2015 shall be as follows:

Services	Service Fees
Installation	$ 2,000
Monthly Administration Fee	$ 5.45 Per Participant/Per Month
Other Fees	$ 150 Per Month (Minimum Monthly Billing)

The one time Installation Fee above is priced according to health care flexible spending account participation and dependent care flexible account participation as of the Effective Date. The Installation Fee is payable in full with the first monthly bill.

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 and any Transition Period, as defined in the Appendix to this SAS. Plan Participants who terminate during an Agreement Period are included in the Plan Participant count for purposes of determining the monthly per Participant fee. The Plan Participant count may also include at Aetna's discretion Plan Participants who participated in the health care flexible spending account and dependent care spending account on the last day of the prior Plan Year but did not enroll in the health care flexible spending account and dependent care spending account in the current Plan Year.

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 15 % change in the number of employees participating in the health care flexible spending account and dependent care flexible spending account from the number assumed in Aetna's quotation of February 1, 2014.
(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.

2. **Late Payment Charges:** In addition to any termination rights under the Services Agreement which may apply, if the Customer fails to provide funds on a timely basis to cover Plan benefit payments as provided in Section 8 of the Master Services Agreement, and/or fails to pay Service Fees on a timely basis as provided in Section 6 of the Master Services Agreement, Aetna will assess interest as a late payment charge. Interest charges for any late payments shall be paid by Customer in accordance with Texas Government Code Section 2251.025. More specifically, the rate of interest that shall accrue on a late payment is the rate in effect on September 1 of Customer's fiscal year in which the payment becomes due. The said rate in effect on September 1 shall be equal to the sum of one percent (1%); and (2) the prime rate published in the Wall Street Journal on the first day of July of the preceding fiscal year that does not fall on a Saturday or Sunday.

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

COBRA SERVICES
STATEMENT OF AVAILABLE SERVICES
EFFECTIVE November 1, 2014
MASTER SERVICES AGREEMENT No. MSA- 866349

Subject to the terms and conditions of the Services Agreement, the COBRA Services available from Aetna are described below in this Statement of Available Services ("SAS"). Unless otherwise agreed in writing, only the Services selected by Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to Section 6 of the Master Services Agreement) will be provided by Aetna. Additional Services may be provided at Customer's written request under the terms of the Services Agreement. This Statement of Available Services shall supersede any previous SAS or other document describing the Services.

I. Excluded and/or Superseded Provisions of Master Services Agreement:

- Section 5 "Fiduciary Duty" is excluded and replaced by Section IV of this COBRA SAS;
- Section 7. "Termination" is excluded and replaced by Section V of this COBRA SAS;
- Section 8 "Benefit Funding" does not apply with respect to the Services provided pursuant to this COBRA SAS;
- Section 9 "Customer Responsibilities" is excluded in its entirety;
- Section 18: "Non-Aetna Networks" does not apply with respect to Services provided pursuant to this COBRA SAS;
- Section 20 (D): "Communications" does not apply with respect to Services provided pursuant to this COBRA SAS.

II. COBRA Standard Administration Services:

Throughout the term of this SAS and upon Aetna's receipt of any and all necessary information, Aetna will perform the COBRA services specified below ("Services").

A. INITIAL/GENERAL COBRA NOTICE

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

the date;
the names and addresses of each new Plan Participant; and
the names and addresses of family members of Plan Participants.
Within ten (10) business days after Aetna receives the notice described in Section V, item E, Aetna will send with proof of mailing, a letter notifying the appropriate qualified beneficiary(ies) of their right to COBRA continuation coverage upon the occurrence of a qualifying event.

If agreed to between Aetna and the Customer in writing, Aetna shall also include a "HIPAA Notice of Privacy Practices" statement on behalf of the Customer. The notice shall be drafted by the Customer and provided in the initial notice.

B. QUALIFYING EVENT NOTICE

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

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

Within ten (10) business days after Aetna receives the notice above, Aetna will send, with proof of mailing, a letter notifying the appropriate qualified beneficiary(ies) of their right to COBRA continuation coverage, along with an election form specifying the group health plan(s) and the cost of coverage thereof to such qualified beneficiaries.

C. NOTICE TO QUALIFIED BENEFICIARIES OF ENROLLMENT

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

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

D. NOTICE OF SUBSEQUENT QUALIFYING EVENT

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

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

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

E. NOTICE OF TOTALLY DISABLED QUALIFIED BENEFICIARIES

Qualified beneficiaries must notify Aetna within sixty (60) days of the date they receive a determination letter regarding total disability. By providing Aetna with this letter, the qualified beneficiary certifies that the qualified beneficiary is entitled to up to twenty-nine (29) months of COBRA continuation coverage.

Within ten (10) business days after receiving the foregoing letter, Aetna will determine the qualified beneficiary's ability to extend coverage as described in Code Section 4980B(f)(2)(B)(i). Upon determination, Aetna will send a letter notifying the totally disabled qualified beneficiary of their ability to extend the maximum period of continuation coverage to twenty-nine (29) months. Aetna will also provide notice to the disabled qualified beneficiary of the increase in premiums to 150% for months 19 through 29 if the Customer elects to charge the additional 48%. Aetna will provide the affected qualified beneficiary with a denial notice if it is determined that the qualified beneficiary is unable to extend coverage.

F. NOTICE OF EXPIRATION OR TERMINATION OF COBRA CONTINUATION COVERAGE

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

- failure of the COBRA Plan Participant to timely pay[1] the correct premium for COBRA continuation coverage;
- coverage of the COBRA Plan Participant under another group health plan, if such plan does not contain any exclusions or limitations with respect to any pre-existing condition of the COBRA Plan Participant;
- entitlement of the COBRA Plan Participant to Medicare;
- expiration of the maximum period for COBRA continuation coverage; or
- the Customer ceasing to provide any group health plan to any Customer employees and all of its commonly controlled trades or businesses (within the meaning of Code Section 414).

If the reason for notice is the expiration of the maximum period for COBRA continuation coverage, a notice of conversion rights (if available) shall be sent one hundred eighty (180) days prior to expiration of COBRA continuation coverage.

G. PREMIUMS FOR COBRA CONTINUATION COVERAGE

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

---

[1] For purposes of this Agreement "timely pay" means the initial premium payment is made within 45 days from the date of the COBRA election, thereafter premium payments will be considered timely if they are received within a 30 day grace period after the first day of the coverage period to which the premiums relate.

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

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

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

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

H. ANNUAL OPEN ENROLLMENT SERVICE

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

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

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

I. HIPAA ONLY EVENT REQUIRING CERTIFICATE OF CREDITABLE COVERAGE

Where agreed upon between Aetna and the Customer, for an additional fee Aetna will provide Services with respect to the HIPAA Certificate of Creditable Coverage as follows:

Customer shall notify Aetna of events requiring only the HIPAA Certificate of Creditable Coverage within thirty (30) days.

Within ten (10) business days after Aetna receives such notice, Aetna will send the HIPAA Certificate of Creditable Coverage to the individual.

III. Duties of the Customer:

A. The Customer shall furnish all records and information to Aetna as are needed for Aetna to perform Services under this Services Agreement. Aetna will rely in the records and information furnished by Customer to perform the Services described in this SAS.

B. The Customer shall notify in writing to Aetna of the required monthly premium rates for COBRA coverage. Modifications in monthly premium rates will be applied by Aetna sixty (60) days after the written notice from Customer is received by Aetna.

C. The Customer shall notify each affected entity (HMO or other health insurance carriers) of the existence of this Services Agreement and secure from each such entity, written acceptance of all of the provisions of this Services Agreement. Copies of such written acceptance shall be sent as soon as possible but no later than ninety (90) days after signing this Services Agreement, to the Aetna address included in Section VI below.

D. Customer shall pay Aetna the required Service Fees, as detailed in the Service and Fee Schedule on a timely and accurate basis.

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

IV. Fiduciary Responsibility:

A. For the purpose of this SAS and the responsibilities assumed by Aetna to perform the Services defined under this SAS, Aetna shall not be considered the "plan administrator" or the Plan's "named fiduciary", as those terms are defined under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

B. The Customer is the named fiduciary for the Plan and it retains final authority and responsibility for interpreting the Plan and for the Plan's operation. An appropriate fiduciary shall act on behalf of the Customer and/or Plan to resolve any and all disputes or disagreements with potential qualifying beneficiaries regarding eligibility determinations.

V. Termination:

A. Customer may terminate this SAS, by giving Aetna at least thirty-one (31) days written notice stating when, after the date of such notice, such termination shall become effective.

B. This SAS shall, at the option of Aetna, terminate in the event of:
   (1) The Customer's failure to pay the amounts referenced in the applicable Service and Fee Schedule by the due date;
   (2) Failure of the Customer to either timely fund a claim payment or reject the claim in writing, in either case within three (3) days after receipt by the Customer of the demand or history with respect to such claim;
   (3) Commencement of a bankruptcy proceeding of the Customer or the insolvency of the Customer;
   (4) Failure of the Customer to promptly deliver any data necessary for the proper performance of Aetna' duties hereunder within five (5) days following the request therefore;
   (5) Merger, sale or consolidation of the Customer, unless written consent has been given by Aetna to continue Services in advance of such event;
   (6) The enactment or change of any law or regulation which makes the continuance of this SAS illegal or commercially impracticable; or
   (g) Any other breach of this SAS by the Customer which is not cured (if curable) within thirty (30) days following written notice from Aetna.

C. In the event of the termination of this SAS, Aetna shall complete the processing of all reimbursement requests received by Aetna which are due and payable prior to the termination of this SAS, provided that, Aetna shall have no obligation to complete the processing of any such requests if the Customer has failed to provide funds for the reimbursement requests or payment, or the Customer has otherwise failed to pay any other amounts owed to Aetna hereunder. Aetna shall have no obligation to process requests for reimbursement or payments presented after the termination date. All payments made in accordance with this subsection C. shall under all circumstances continue to be the sole responsibility and liability of the Customer.

D. Upon termination of this SAS, Aetna shall, upon written request, deliver to the Customer, within a mutually agreed upon timeframe, a complete and final accounting as it relates to this SAS. All books and records in Aetna' possession with respect to the Services provided, any claim files, and any reports and other papers pertaining to the Services will be maintained by Aetna for a period of seven (7) years following their processing hereunder. All administration systems, computer systems and software developed by Aetna in connection with the Services performed hereunder constitute the sole property of Aetna and shall be retained by Aetna upon the termination of this SAS. The Customer hereby disclaims any interest in or to such items.

E. The Services Agreement shall terminate automatically if the Customer ceases to provide a health plan to its employees.

D. Upon termination of the Services Agreement, an accounting and settlement for Service Fees and charges accrued to the date of termination shall be made within ninety (90) days.

E. Aetna will return to Customer all amounts collected from qualifying beneficiaries but not remitted as provided hereunder as of the date of termination.

F. Both parties recognize the need of a transition period after the termination of this SAS or the Services Agreement. This transition will include the need of dealing with the new COBRA members. Customer shall notify Aetna in writing as soon as possible, but no later than thirty (30) days before the date of termination, of the transitional support which will be needed from Aetna. Customer will indicate whether or not Customer is going to be in charge of such transition or if Customer will require Aetna's support. If Customer requires Aetna's support during such transition it agrees to continue paying the fees as described in the Service and Fee Schedule during the transition period. The charges for additional services performed in support of such transition will be mutually agreed upon prior to the date of termination.

G. Upon termination of this SAS or Services Agreement, Customer will assume sole and immediate responsibility for all the Services herein.

VI. Notice:

Except as set forth in this Services Agreement, all notices required or permitted to be given, shall be in writing and shall be sent by mail, return receipt requested, or by facsimile with a confirmation by mail, to the parties at their respective addresses set forth below:

Aetna at: Attention:	Aetna Life Insurance Company 10802 Farnam Drive, Suite 100 Omaha, NE 68154 Attn: COBRA Eligibility
Employer at: Attention:	**WILLIAMSON COUNTY** **Shelley Loughrey, Benefits Administrator** **301 S.E. Inner Loop, Suite 108** **Georgetown, TX 78626**

or to any other address or to other persons designated by written notice given from time-to-time during the term of this SAS by one party to the other. Except as set forth, if mailed in accordance with the provisions of this paragraph, the notice shall be deemed to be received three (3) business days after mailing.

VII. Fees

The following initial administrative Service Fees are provided in conjunction with Aetna's Services relating to the self funded COBRA Services offered under the Customer's self funded benefits plan. All administrative fees from this SAS are summarized in the attached Service and Fee Schedule.

The fees described in this Service and Fee Schedule will not be modified by Aetna unless it provides the Customer with 30 days advance written notice of such modification. Such notice will be sent to the address indicated in section VI.

SERVICE AND FEE SCHEDULE

The corresponding Service Fees effective for the period beginning November 1, 2014 and ending October 31, 2015 are specified below. They shall be amended for future periods, in accordance with Section 6 of the Master Services Agreement.

Individual Billing Administration
COBRA Administrative Fees
Per Occurrence Pricing

Implementation Fees	**$1,500**
Subsequent Year Maintenance Fee	**$1,000**
Ongoing Service Fees	
New Hire COBRA/HIPAA General Rights Notice	**$4.55** per notice
Qualifying Event Notification w/HIPAA COC	**$25.00** per event
HIPAA Certificate of Creditable Coverage	**$7.50** per certificate
COBRA Participant Termination Notice w/HIPAA COC	**$5.00** per notice
Minimum Monthly Billing	**$250.00** per month
Optional Service Fees	
Re-notification of COBRA General Rights and HIPAA Special Enrollment Rights to current benefit-eligible employees	**$3.00** per letter
Custom Mailings (Non-standard notices)	**$5.00** per notice
Manual Notification Form Processing	**$10.00** per form
Annual Open Enrollment Services	**$15.00** per package + postage* (*per package with a $300 minimum + postage, available after Aetna has been providing administration for a minimum of 90 days)
Optional Government Mandated Notice	**$10.00** per notice
Premium Disbursement to Carriers	**$50.00** per carrier per month
Custom Reporting	$2500.00 Minimum (up to 20 hours of development time)
Additional Development	$150.00 per hour
Custom Website (Client URL)	$6,000.00 One-time fee
Custom Website with Single Sign On	$11,000.00 One-time fee
Customized HealthHub.com Website	$1,000.00 One-time fee

By the 15th working day of each month, Aetna will provide a bill for all administration from the prior month. Reports detailing the prior month's activity will also be provided for your records. Aetna shall retain the 2% administrative fee on the total premium administered for COBRA participants.

Appendix I - Temporary Appendix

PLAN OF BENEFITS
PAYABLE UNDER
MASTER SERVICES AGREEMENT No. MSA-866349
EFFECTIVE November 1, 2014

Describing benefits payable between

Aetna Life Insurance Company

and

Williamson County
("Customer")

While certain details of the Plan are being resolved:

the classes of employees eligible for coverage under the plan will be determined in accordance with the instructions furnished to Aetna by the Customer; and

the benefits applicable will be payable in accordance with the plan of benefits furnished to Aetna by the Customer, and in accordance with all standard Aetna claim practices.

The terms of this Temporary Appendix control until superseded by a subsequent Booklet, for any specific benefits applicable to any class(es) of employees, as indicated therein.

Appendix I - Flexible Spending Account - Dependent Care

PLAN OF BENEFITS FOR
MASTER SERVICES AGREEMENT No. MSA-866349
EFFECTIVE November 1, 2014

A Services Agreement between

Aetna Life Insurance Company ("Aetna")

and

Williamson County
(Customer)

Section 1
Purpose and Definition

1.1 Purpose

The Plan will provide Eligible Employees of the Customer with a choice of receiving certain tax free benefits provided by the Customer in lieu of taxable compensation.

As used in this Appendix, Plan means the Customer's Dependent Care Assistance Plan.

It is intended that the Plan provide, as part of the Customer's cafeteria plan within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, (hereinafter referred to as the "Code") Dependent Care Assistance, within the meaning of Section 129 of the Code, the benefits of which are eligible for exclusion from the Employee's income under Section 129(a) of the Code, and are allowable under the applicable rules of Section 125 of the Code.

1.2 Definitions

(a) Covered Expenses: those listed in Subsection 2.2(b) of this Appendix, subject to the limitations in Subsections 2.3 and 2.4.

(b) Dependent: any individual who, in the current calendar year, is a spouse of a Plan Participant or a dependent of a Plan Participant as defined in Section 152(a) of the Code.

(c) Eligible Employees: all full time Employees.

(d) Employee: any individual who is considered to be in a legal employer-employee relationship with the Customer. Such term includes former employees for the limited purposes of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by the Customer. or, if longer, the period during which a former employee has elected to continue coverage following termination of employment as provided by Section 4980B of the Code and Section 601 of the Employee Retirement Income Security Act as amended (hereinafter referred to as "ERISA").

(e) Maximum Benefit: the maximum amount allowable, as specified in Subsection 2.4 of this Appendix for Dependent Care Assistance, to a Plan Participant in any Plan Year.

(f) Plan Participant:

(i) any Eligible Employee who has elected to receive benefits under the Plan and who has entered into a salary reduction Services Agreement which provides funding for a Dependent Care Assistance Account.

(ii) a terminated employee who continues contributions pursuant to Subsection 3.2 of this Appendix, but only to the extent of such contribution.

(iii) a terminated employee whose eligibility for reimbursement continues for the period of coverage prior to termination.

(g) Plan Administrator: the Customer is the Plan Administrator for purposes of ERISA.

(h)

(i) Plan Year

For the first year the Plan is in effect, January 1 through December 31.
For each succeeding year, January 1 through December 31.

(ii) Extended Plan Year

January 1 (or the first day of the Plan Year) through March 31 of the following year.

(i) Dependent Care Center: a center that meets the standards set forth in Subsection 2.2(c) of this Appendix.

(j) Qualifying Individual: an individual who meets the definition set forth in Subsection 2.2(a) of this Appendix.

(k) Account: an account for each Plan Participant under the Plan to which are credited the contributions made by or on behalf of such Plan Participant.

Section 2
Dependent Care Assistance Coverage

2.1 Dependent Care Assistance - General

Every Plan Participant who has elected to receive benefits pursuant to this Section 2 will be eligible to receive a benefit for Covered Dependent Care Assistance Expenses incurred by the Plan Participant or the Plan Participant's spouse, subject to the limitations hereinafter described. Benefits will be payable only with respect to expenses that are "employment-related expenses" under Section 21 of the Code, and are otherwise reimbursable under the rules of Sections 125 and 129 of the Code. For any Plan Year, benefits will be payable under this Section 2 only for Covered Dependent Care Assistance Expenses which are incurred during the Plan Year and during the time that the Eligible Employee is a Plan Participant.

2.2 Covered Expenses

(a) Expenses for Dependent Care Assistance services will be reviewed as eligible for reimbursement only if the services are performed for the benefit of a "Qualifying Individual," A Qualifying Individual is:

(i) a Plan Participant's Dependent who is under the age of 13, and with respect to whom the Plan Participant is entitled to a deduction under Section 151(c) of the Code;

(ii) A Plan Participant's Dependent who is physically or mentally incapable of caring for him/herself;

(iii) the Plan Participant's spouse if he/she is physically or mentally incapable of caring for him/herself.

(b) In order to be reviewed as a reimbursable Dependent Care Expense, the expense must have been incurred for services which enable the Plan Participant and his/her spouse to remain gainfully employed. These services are:

(i) Household services, including, but not limited to, services performed by a maid or cook, provided such services are at least in part attributable to the care of one or more Qualifying Individuals;

(ii) Services for the care of one or more Qualifying Individuals in the Plan Participant's home;

(iii) Services for the care of one or more Qualifying Individuals outside of the home of a Plan Participant if the Qualifying Individuals are either (a) under age 13 or (b) regularly spend at least 8 hours each day in the Plan Participant's home;

(iv) The services of a Dependent Care Center.

(c) A Dependent Care Center is a facility which provides care for more than six individuals (other than individuals who reside in the facility), receives a fee, payment or grant for providing services for any of these individuals, and complies with all applicable laws and regulations of the state or unit of local government where it is located.

2.3 Limitations on Benefits

(a) Dependent Care Assistance benefits will not be paid for expenses:

(i) Paid to a Qualifying Individual with respect to whom, for the taxable year, a deduction under Section 151(c) of the Code is allowable to either the Plan Participant or his/her spouse.

(ii) Paid to the Plan Participant's child under age 19 at the close of the taxable year.

(iii) Of a Participant whose parent is in a Nursing Home with respect to the expense incurred for the parent's care provided by the Nursing Home.

(b) All benefits payable pursuant to this Section 2 shall be paid exclusively from the Plan Participant's Dependent Care Assistance Account. A Plan Participant may not receive a benefit for Covered Dependent Care Assistance Expenses incurred for any one month which is in excess of the balance in the Plan Participant's Dependent Care Assistance Account as of the date of the payment of the incurred expense. In no event shall the benefit payable under this Section 2 with respect to any Plan Year exceed the maximum amount allowable for dependent care assistance under the Plan as specified in Subsection 2.4 of this Appendix.

2.4 Maximum Benefit

Under this Plan, the maximum amount of coverage that may be elected by a Plan Participant for dependent care expense reimbursement per family per Plan Year is **$ 2,500**.

Section 3
General Provisions

3.1 Effective Date

The Plan described in this Appendix shall be effective **November 1, 2014**.

3.2 Post-Termination Contributions

With respect to terminated Employees only, contributions may be made on a post-tax basis the Dependent Care Assistance Account (COBRA continuation does not apply to Dependent Care) until the end of the Plan Year during which termination occurs. If however, contributions are discontinued upon termination of employment, coverage will cease immediately.

3.3 Changes in Participant Election

Changes in the Plan Participant's election may be made by the Plan Participant during the Plan Year provided there has been an applicable status event, as specified in Section 125 of the Code and any regulations there under. A status event includes, but is not limited to:

(i) change in marital status (e.g., marriage, death of spouse, divorce, legal separation, annulment);
(ii) change in number of Dependents (e.g., birth, death, adoption, placement for adoption);
(iii) change in employment status of Plan Participant, spouse or Dependent by reason of termination or commencement of employment, strike or lockout, commencement of or return from unpaid leave of absence, or change in worksite, including change in Plan eligibility resulting from change in employment status;
(iv) change in Dependent eligibility under the Plan (e.g., by reason of age or change in student status);
(v) change in residence of participant, spouse, or Dependent.

Changes in the Plan Participant's election pursuant Subsection 3.2 must be consistent with the status event.

3.4 Termination of Coverage

Coverage in this Plan will terminate immediately upon the earliest to occur of:

(a) the first day of a Plan Year for which the Eligible Employee has not elected to participate.

(b) termination of employment Reimbursements may not be made for claims incurred after termination except where a terminated employee has elected to continue to make contributions on a post-tax basis as specified in Subsection 3.2 of this Appendix for the Plan Year in which the termination occurs. If the terminated employee elects to continue to make contributions to the Plan on a post-tax basis, then claims for expenses incurred at any time during that Plan Year may be submitted up until the last day of the Extended Plan Year.

(c) the date on which contributions cease to be made by or on behalf of a Plan Participant.

(d) the discontinuance of the Plan.

(e) the discontinuance of the Master Services Agreement.

3.5 Payment of Benefits and Incurred Expenses

(a) A Plan Participant will make a claim for benefits by making a request to the Plan Administrator on a form acceptable to the Plan Administrator. A Plan Participant must provide (i) a written statement from "an independent third party" (e.g., health care provider, hospital, etc.) stating that the expense has been incurred and the amount of such expense and (ii) a written statement that such expense is not covered and not reimbursable under any other health plan coverage.

(b) Claims meeting the minimum reimbursement amount will be paid monthly. An explanation of claim settlement will be provided with each claim payment. All claims for Covered Expenses incurred during the Plan Year must be submitted by the last day of the Extended Plan Year.

(c) The maximum allowable reimbursement available for Dependent Care Assistance under the Plan shall be determined under Subsection 2.3(b) of this Appendix.

3.6 Administration

At least monthly, the Customer will send Aetna information regarding Plan Participant enrollment and account contributions which is sufficient to administer the Plan. Each month Aetna will send the Customer a listing of drafts cleared and funds called from the employer's account. Aetna will accumulate year-to-date deposits and maintain information on the claims paid and the resulting Account balances.

3.7 Settlement of Accounts

Any funds remaining in a Plan Participant's account as of the last day of the Extended Plan Year will be either (a) applied to administrative expenses of the Plan for the year, (b) used to reduce required charges for the following Plan Year, (c) refunded to Plan Participants on a "reasonable and uniform basis"--reasonable and uniform means contributions must be allocated among all participants regardless of claim experience, or (d) used in such other manner as permitted under Section 125 of the Code, Aetna will provide the Customer with account balance information for the previous Plan Year as soon as reasonably possible after such date. This information will include total contributions, total payments and any remaining account balance for each Plan Participant.

3.8 IRS Determination

Any determination as to qualification of an expense under this Plan is subject to interpretation by the Internal Revenue Service (IRS).Should the IRS take a position contrary to that applied under this Plan, this Plan will be administered according to IRS instructions. Plan Participants who disagree with the IRS position, and wish to appeal that position, must obtain their own counsel.

Appendix I - Flexible Spending Account Health Care

PLAN OF BENEFITS FOR
MASTER SERVICES AGREEMENT No. MSA-866349
EFFECTIVE November 1, 2014

An agreement between

Aetna Life Insurance Company ("Aetna")

and

Williamson County
(Customer)

Section 1
Purpose and Definition

1.1 Purpose

The Plan will provide Eligible Employees of the Customer with a choice of receiving certain tax free benefits provided by the Customer in lieu of taxable compensation.

As used in this Appendix, Plan means the Customer's Health Care Expense Reimbursement Plan.

It is intended that the Plan provide, as part of the Customer's cafeteria plan within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, (hereinafter referred to as the "Code"), Health Care Expense Reimbursement, to the extent such benefits are eligible for exclusion from the Employee's income under Sections 105, 106, other applicable provisions of the Code, and are allowable under the applicable rules of Section 125 of the Code.

1.2 Definitions

(a) Covered Expenses: those listed in Subsection 2.3 of this Appendix, subject to the limitations in Subsections 2.4 and 2.5.

(b) Dependent: any individual who, in the current calendar year, is a spouse of a Plan Participant or a dependent of a Plan Participant as defined in Section 152(a) of the Code.

(c) Eligible Employees: all full time Employees.

(d) Employee: any individual who is considered to be in a legal employer-employee relationship with the Customer. Such term includes former employees for the limited purposes of allowing continued eligibility for benefits hereunder for the remainder of the Plan Year in which an employee ceases to be employed by the Customer. or, if longer, the period during which a former employee has elected to continue coverage following termination of employment as provided by Section 4980B of the Code and Section 601 of the Employee Retirement Income Security Act as amended (hereinafter referred to as "ERISA").

(e) Maximum Benefit: the maximum amount allowable, as specified in Subsection 2.5 of this Appendix for Health Care Expense Reimbursement, to a Plan Participant in any Plan Year.

(f) Plan Participant:

(i) any Eligible Employee who has elected to receive benefits under the Plan and who has entered into a salary reduction agreement which provides funding for a Health Care Expense Reimbursement Account.

(ii) a terminated employee who continues contributions pursuant to Subsection 3.2 of this Appendix, but only to the extent of such contribution.

(iii) a terminated employee whose eligibility for reimbursement continues for the period of coverage prior to termination.

(g) Plan Administrator: the Customer is the Plan Administrator for purposes of ERISA.

(h)

(i) Plan Year

For the first year the Plan is in effect, January 1 through December 31.
For each succeeding year, January 1 through December 31.

(ii) Extended Plan Year

January 1 (or the first day of the Plan Year) through March 31 of the following year.

(i) Account: an account for each Plan Participant under the Plan to which are credited the contributions made by or on behalf of such Plan Participant.

Section 2
Health Care Expense Reimbursement Coverage

2.1 Health Care Expense Reimbursement - General

Every Plan Participant who has elected to receive benefits pursuant to this Section 2 will be eligible for reimbursement of Covered Expenses incurred by the Plan Participant and his/her Dependent subject to the limitations hereinafter described. For any Plan Year, benefits will be payable under this Section 2 only for Covered Expenses which are incurred during the Plan Year and during the time that the Eligible Employee is a Plan Participant.

2.2 Covered Expenses

In order for a Plan Participant to receive reimbursement from the Health Care Expense Reimbursement Account, a health care expense of the Plan Participant or his/her Dependent must be:

(a) approved by Aetna as reimbursable,

(b) of the type specified in Subsection 2.3 of this Appendix, and

(c) of the type that is recognized as properly reimbursable under Section 125 of the Code for the Plan Participant or his/her Dependents.

A Plan Participant's payments for any other health coverage shall not be considered a Covered Expense under the Plan. No Plan Participant may receive reimbursement under this Section 2 for any expense for which he/she is entitled to reimbursement under any other plan of medical, dental, pharmacy, vision or hearing expenses.

2.3 List of Covered Expenses

Covered Expenses will include:

(a) Expenses incurred for which no benefits are paid or payable under any hospital, medical, dental, vision or hearing coverage program solely because of any one or more of the following:

(i) deductibles or copayments;

(ii) coinsurance provisions;

(iii) the excess over reasonable and customary charges;

(iv) the excess over any scheduled maximum benefit limitation provisions; or

(v) Any other medical/dental expense that is considered a deductible health care expense under the Code and is properly reimbursable under the applicable rules of Section 125 of the Code.

2.4 Limitations on Benefits

All benefits payable pursuant to this Section 2 shall be paid exclusively from the Plan Participant's Health Care Expense Reimbursement Account. The amount available for reimbursement shall, at all times during the Plan Year, be equal to the amount of coverage elected by the Plan Participant less any reimbursement made previously during the Plan Year. However, in no event shall the benefits payable under this Section 2 with respect to any Plan Year exceed the maximum amount allowable for health care expense reimbursement under the Plan as specified in Subsection 2.5 of this Appendix.

2.5 Maximum Benefit

Under the Plan, the maximum amount of coverage that may be elected by a Plan Participant for health care expense reimbursement per family per Plan Year is $2,500.00.

Section 3
General Provisions

3.1 Effective Date

The Plan described in this Appendix shall be effective **November 1, 2014**.

3.2 Post-Termination Contributions

With respect to terminated Employees only, contributions may be made on a post-tax basis to the Health Care Expense Reimbursement Account until the end of the Plan Year during which termination occurs. If however, contributions are discontinued upon termination of employment, coverage will cease immediately.

3.3 Changes in Participant Election

Changes in the Plan Participant's election may be made by the Plan Participant during the Plan Year provided there has been an applicable status event, as specified in Section 125 of the Code and any regulations there under. A status event includes, but is not limited to:

(i) change in marital status (e.g., marriage, death of spouse, divorce, legal separation, annulment);
(ii) change in number of Dependents (e.g., birth, death, adoption, placement for adoption);
(iii) change in employment status of Plan Participant, spouse or Dependent by reason of termination or commencement of employment, strike or lockout, commencement of or return from unpaid leave of absence, or change in worksite, including change in Plan eligibility resulting from change in employment status;
(iv) change in Dependent eligibility under the Plan (e.g., by reason of age or change in student status);
(v) change in residence of participant, spouse, or Dependent.

Changes in the Plan Participant's election pursuant to Subsection 3.2 must be consistent with the status event.

3.4 Termination of Coverage

Coverage in this Plan will terminate immediately upon the earliest to occur of:

(a) the first day of a Plan Year for which the Eligible Employee has not elected to participate.

(b) termination of employment. Reimbursements may not be made for claims incurred after termination except where a terminated employee has elected to continue to make contributions on a post-tax basis as specified in Subsection 3.2 of this Appendix for the Plan Year in which the termination occurs. If the terminated employee elects to continue to make contributions to the Plan on a post-tax basis, then claims for expenses incurred at any time during that Plan Year may be submitted up until the last day of the Extended Plan Year.

(c) the date on which contributions cease to be made by or on behalf of a Plan Participant.

(d) the discontinuance of the Plan.

(e) the discontinuance of the Master Services Agreement.

3.5 Payment of Benefits and Incurred Expenses

(a) A Plan Participant will make a claim for benefits by making a request to the Plan Administrator on a form acceptable to the Plan Administrator. A Plan Participant must provide (i) a written statement from "an independent third party" (e.g., health care provider, hospital, etc.) stating that the expense has been incurred and the amount of such expense and (ii) a written statement that such expense is not covered and not reimbursable under any other health plan coverage.

(b) Claims meeting the minimum reimbursement amount will be paid monthly. An explanation of claim settlement will be provided with each claim payment. All claims for Covered Expenses incurred during the Plan Year must be submitted by the last day of the Extended Plan Year.

(c) For each Plan Participant, the maximum allowable reimbursement-available for health care expense reimbursement under the Plan shall be determined under Subsection 2.5 of this Appendix.

3.6 Administration

At least monthly, the Customer will send Aetna information regarding Plan Participant enrollment and account contributions which is sufficient to administer the Plan. Each month Aetna will send the Customer a listing of drafts cleared and funds called from the employer's account. Aetna will accumulate year-to-date deposits and maintain information on the claims paid and the resulting Account balances.

3.7 Settlement of Accounts

Any funds remaining in the account of a Plan Participant who has made contributions (i.e. annual or semi-annual Any funds remaining in a Plan Participant's account as of the last day of the Extended Plan Year will be either (a) applied to administrative expenses of the Plan for the year, (b) used to reduce required charges for the following Plan Year, (c) refunded to Plan Participants on a "reasonable and uniform basis"--reasonable and uniform means contributions must be allocated among all participants regardless of claim experience, or (d) used in such other manner as permitted under Section 125 of the Code, Aetna will provide the Customer with account balance information for the previous Plan Year as soon as reasonably possible after such date. This information will include total contributions, total payments and any remaining account balance for each Plan Participant.

3.8 IRS Determination

Any determination as to qualification of an expense under this Plan is subject to interpretation by the Internal Revenue Service (IRS). Should the IRS take a position contrary to that applied under this Plan, this Plan will be administered according to IRS instructions. Plan Participants who disagree with the IRS position, and wish to appeal that position, must obtain their own counsel.

Appendix II

PERFORMANCE GUARANTEES
FOR
MASTER SERVICES AGREEMENT No. MSA-866349
EFFECTIVE November 1, 2014

An agreement between

Aetna Life Insurance Company ("Aetna")

and

Williamson County
(Customer)

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

APPENDIX IV

SIMPLE STEPS TO A HEALTHIER LIFE
FEATURES AND SYSTEM REQUIREMENTS

I. **Base Features:**

Simple Steps to a Healthier Life (the "Life Program") includes the following base features:

Employer Features:

- Display of Employer Corporate Logo (optional feature) – the corporate logo of the Employer will be displayed within the Life Program navigation.

- Employer Broadcast Messaging by Location (optional feature) – text area used to broadcast health and benefits information to the User demographically. Limited to one update per quarter.

- Your Health Benefits – up to 10 links to Employer-specified Web sites of health-care insurers (Aetna Navigator).

- Other References & Resources - links to Employer-specified health and wellness references and resources. The User will need to register separately, if registration is applicable, to access these links from the Life Program.

- Standard Quarterly Management Reports are consistent with HIPAA guidelines (reports will not be provided to the Employer if the User population, by a specific category, is below 30).

- Aetna Healthy Actions Rewards (optional feature) – ability to track an event/activity and a certain time period in order to provide incentives to the User. The fulfillment of the incentives is on behalf of the Employer and Employer understands and agrees that Employer is solely responsible for all costs and expenses in connection with the Rewards and Incentive Program. Aetna to provide Employer with a report outlining Users who have completed events/activities, as defined by Employer.

- Communications and Promotional Kit – An on-line Employee Engagement Toolkit is provided at: http://www.aetna.com/employer/commMaterials/SimpleSteps/index.html.

User Features:

- Online Health Risk Assessment (the "HRA") – the User completes an online health risk assessment (the "HRA") that is a set of health-related questions. The HRA evaluates the answers, provided by the User, based on a series of clinical risk factors that are used to determine if the User is at risk for one or more medical conditions. The User will receive a summary report, identifying the at-risk conditions, as well as other health-related areas the User may need to focus on.

- Health Action Plan - in addition to the summary report, the User will receive a health action plan that is generated based upon the User's completed HRA. The health action plan provides information on certain ways to achieve better health.

- Online Wellness Programs - once a User completes the HRA, the User can access certain programs from the site. These programs provide information on particular health topics.

- Preventive Health Schedule - a listing of preventive health-care activities.

- Wellness Kits To Go – tools to enhance a User's knowledge about healthy lifestyle changes and how to effectively communicate with their health care providers.

- Informed Health Line Text Promotional Message (optional feature)– this is a separately purchased product outside of the Life Program. A text 800 number message, to contact a nurse virtually 24 hours a day, 7 days a week, will be displayed within the Life Program navigation if the Employer purchased the product through Aetna Inc.

II. User System Requirements

The User will need the following system requirements to access the Life Program:

- Standard Web Browser Requirement: Netscape Navigator 4.x or Microsoft Internet Explorer, versions 4.0 or higher. If the desktop is on a network with a firewall, the network must accept multiple cookies and javascripts; and

- Online Access Requirement: use of a computer system to connect to Aetna's system hosting the Life Program via the Internet using a standard Web browser.

APPENDIX IV

NATIONAL ADVANTAGE PROGRAM/DENTAL PPO II NETWORK PROGRAM

The National Advantage Program ("NAP") and the Dental PPO II Network Program (the "Dental PPO II Program") Appendix is an appendix to Master Services Agreement No. MSA-**866349** between Aetna and Customer (as identified herein) and is incorporated into the Services Agreement by reference.

I. National Advantage Program (NAP) and Dental PPO II Network Program (the "Dental PPO II Program")

A. Summary

NAP

NAP provides access to contracted rates for many medical claims that would otherwise be paid as billed under indemnity plans, the out-of-network portion of managed care plans, or for emergency/medically necessary services not provided within the network. When available, these contracted rates will produce savings for the Customer.

Aetna contracts with several national third-party vendors to access their contracted rates. In addition, a significant number of Aetna directly-contracted rates are available for members with indemnity benefits. Aetna will access third-party vendor rates where Aetna directly-contracted rates are not available. If no contracted rate is available, Aetna will attempt to negotiate an Ad-Hoc Rate (case specific discount) with non-NAP participating providers for certain larger claims or will apply Facility Charge Review, as applicable and as described below.

Dental PPO II Program

Dental Providers participating in the Dental PPO II Program network are considered participating providers under the terms of the Customer's Plan and Covered Services rendered by such Providers will be reimbursed, in accordance with the terms of the Customer's Plan, as in-network services. When available, the contracted rates associated with these Providers may result in savings for the Customer and Members. Aetna contracts with third party vendors to access the contracted rates associated with these Providers."

B. Claim Submission/Payment Process

NAP

Providers should bill Aetna directly for Covered Services. The Member should not make payment at the time of service. When the Provider submits the claim, Aetna will process it at the contracted rate (when applicable) and reflect the contracted amount in any explanation of payments made that the Member and Provider receives. The Member would then be responsible for any applicable coinsurance, deductible or non-covered service, based upon the plan of benefits.

Dental PPO II Program

The Dental Providers participating in the Dental PPO II Program may bill Aetna directly for Covered Services or may bill the Member at the time of service. When the claim is submitted, Aetna will process it at the contracted rate (when applicable) and reflect the contracted amount in any explanation of payments made that the Member and Provider receive. The Member would then be responsible for any applicable coinsurance, deductible or non-covered service, based upon the plan of benefits.

II. National Advantage Program – Facility Charge Review **(This section is not applicable to the Dental PPO II Program).**

Facility Charge Review is an optional component of NAP. It is only available in conjunction with the National Advantage Program, and is not available separately.

A. Summary

Where a contracted rate is not available under NAP, the Facility Charge Review Program provides reasonable charge allowances for most inpatient and outpatient facility claims under Members' indemnity plans and the out-of-network portion of Members' managed care plans or for emergency/medically necessary services not provided within the network. When utilized, these reasonable charges will produce savings for the Customer.

B. Claim Submission/Payment Process

When an inpatient or outpatient facility claim exceeds a threshold (currently $ 1,000) and Aetna does not have access to a contracted rate, Aetna will review billed charges for financial reasonableness for the geographic area where the service was provided. Payment to the facility will be based on the Reasonable Charge Amount. Any excess will be considered not covered as it exceeds the reasonable charge (as defined under the Plan).

Though many facilities accept the Reasonable Charge Amount as payment in full, there may be circumstances where facilities may not accept the determination of the reasonable charge and may balance bill the Member. In the event that a Member is balance billed, Aetna has a review process and will initiate negotiations with the facility in an attempt to come to a mutually agreeable payment amount.

However, should Aetna be unable to negotiate a mutually acceptable rate, consistent with the terms of the Member's plan of benefits, the Member may be responsible for any charges in excess of the reasonable charge. For claims that are to be paid at the preferred/in network level under the terms of the Member's plan of benefits (e.g., emergency services), Aetna will negotiate with the facility so that the Member is not responsible for any charges in excess of any applicable deductible and coinsurance/copayments.

The explanation of benefits that the Member receives from Aetna, if applicable, will indicate that the amount paid is based upon the Reasonable Charge Amount and will request that the Member contact Aetna should the Member be balance billed.

The amount actually paid to the provider under the Facility Charge Review Program will be used as the basis for the calculation of the Member's coinsurance and deductibles.

III. National Advantage Program – Itemized Bill Review **(This section is not applicable to the Dental PPO II Program)**

Itemized Bill Review is an optional component of NAP. It is only available in conjunction with the National Advantage Program, and is not available separately.

Prior to claim adjudication when an inpatient facility claim exceeds a threshold (currently $20,000) and Aetna's contracted rate with provider uses a "percentage of billed charges" methodology, Aetna will forward the claim to the vendor for review. The billed charges will be reviewed for billing inconsistencies and errors. The vendor examines each claim and provides Aetna with billing error detail and the amount of eligible covered (payable) charges. Aetna then pays the claim using the contracted rate, a percentage of this adjusted amount.

When an inpatient facility claim is reduced based on the bill review, the Member's EOB will identify an IBR reduction in the "not payable" column to show that the Member is not responsible for the difference between the billed charges and the actual paid amount. The amount actually paid to the provider under the Program will be used as the basis for the calculation of the Member's coinsurance and deductibles. The Member is only responsible for the applicable coinsurance and deductible. Our provider contracts do not permit the facility to bill the member for the billing adjustments.

IV. Terms and Conditions

A. Customer Charges for Provider Payments

NAP

Subject to the terms herein, Aetna agrees that for Covered Services rendered by a Provider for which Aetna has a) accessed a contracted rate, or b) negotiated an Ad-Hoc rate, or c) applied a Reasonable Charge Amount for facility services, or d) applied an Itemized Bill Review reduction, Customer shall be charged the amount paid to the Provider. This amount shall be equal to the contracted rate, Ad-Hoc Rate, or Reasonable Charge Amount less any payments made by the Member in accordance with the Plan.

Dental PPO II Program

Subject to the terms herein, Aetna agrees that for Covered Services rendered by a Provider for which Aetna has accessed a contracted rate, Customer shall be charged the amount paid to the Provider. This amount shall be equal to the contracted rate, less any payments made by the Member in accordance with the Plan.

B. Access Fees

1. As compensation for the services provided by Aetna under NAP and the Dental PPO II Programs for savings achieved, Customer shall pay Access Fees to Aetna as described in the Fee Schedule (excluding Aggregate Savings with respect to claims for which Aetna is liable for funding, e.g., claims in excess of an individual or aggregate stop loss point).

2. Access Fees shall be paid by the Bank to Aetna via wire transfer or such other reasonable transfer method agreed upon by Aetna and the Bank. The Customer agrees to provide funds through its designated bank sufficient to satisfy the Access Fee in accordance with the banking agreement between the Customer and the Bank, i.e., Access Fees will be included in the request from the Bank for payment/funding of claims.

3. An Access Fee will be credited to the Customer for any Aggregate Savings subsequently reduced or eliminated for which the Customer has already paid an Access Fee.

4. Aetna shall provide quarterly reports of Aggregate Savings and Access Fees. Access Fees may be included with claims in other reports for NAP and the Dental PPO II Program.

C. Member Information Regarding National Advantage Program and Dental PPO II Program.

For most products/plans, Customer will inform Members of the availability of NAP and Dental PPO II Program. Further, a Customer's Plan document language defining reasonable charge or recognized charge must conform to Aetna requirements. Aetna shall provide information regarding participating Providers on DocFind®, Aetna's online provider listing, on our website at www.Aetna.com or by other comparable means.

D. Definitions

As used herein:

"Access Fee" means the amount(s) to be paid by Customer to Aetna for access to the savings provided under NAP and the Dental PPO II Program.

"Ad-Hoc Rate" means the rate which was negotiated for a specific claim in the absence of a pre-negotiated contracted rate with a Provider.

"Aggregate Savings" as to NAP - means the difference between (i) the amount which would have been due or otherwise paid to Providers for Covered Services without the benefit of NAP, and (ii) the amount due Providers for Covered Services as a result of NAP.

"Aggregate Savings" as to the Dental PPO II Program - means the difference between: (i) the trended average charges for the applicable geographic area, as determined by Aetna, in its sole discretion, and (ii) the amount due to Providers as a result of the Dental PPO II Program negotiated rates.

"Covered Services" means the health services subject for which charges are paid pursuant to the Plan.

"Member" means a person who is eligible for coverage as identified and specified under the terms of the Plan.

"Plan" means the portion of Customer's employee welfare benefit plan, which provides health benefits to Members as administered by Aetna.

"Providers" means those physicians, hospitals, dental providers and other health care providers whose services are available at a savings under NAP and the Dental PPO II Program.

"Reasonable Charge Amount" means the amount determined by Aetna to be a reasonable charge for a service in the geographic area where the service was provided to the Member.

E. Customer Acknowledgements

Customer acknowledges that:

1. The NAP listing of Providers includes Providers that are (i) participating by virtue of direct contracts with Aetna and its affiliates, and (ii) participating by virtue of Aetna's contracts with unaffiliated third parties that have contracts with Providers, and provide Aetna with access to these contracted rates for the purpose of NAP. **(This section is not applicable to the Dental PPO II Program)**

2. Aetna does not guarantee (a) any particular discounts or any level of discount will be made available through providers listed as participating in NAP and the Dental PPO II Program; (b) any obligation to make any specific Providers or any particular number of Providers available for use by Plan participants. Aetna does not credential, monitor or oversee those Providers who participate through third party contracts. Providers listed as participating in NAP and the Dental PPO II Program may not necessarily be available or convenient.

3. Aetna is not responsible for the acts or omissions of any provider listed as participating in NAP and the Dental PPO II Program. All such providers are providers in private practice, are neither agents nor employees of Aetna, and are solely responsible for the health care services they deliver.

4. The following claim situations may not be eligible for NAP: **(This section is not applicable to the Dental PPO II Program)**

   - 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 Member.

F. General Provisions

1. Neither party shall be liable to the other for any consequential or incidental damages whatsoever. Aetna's aggregate cumulative liability to the Customer for all losses or liabilities arising under or related to this Appendix, regardless of the form of action, shall be limited to the Access Fees actually paid to Aetna by the Customer for services rendered; provided, however, this limitation will not apply to or affect any performance standards set forth in the Services Agreement.

2. The terms and conditions of this Appendix shall remain in effect for any claims incurred prior to the termination date that are administered by Aetna after the termination date. Except as provided herein, this Appendix is subject to all of the provisions of the Services Agreement, provided, however, in the event of any conflict between this Appendix and the Services Agreement, the terms of this Appendix shall govern.

Appendix V

List of Aetna Affiliated HMOs
for
POS II, Aetna Select and SI HMO
Medical Products

Aetna has arranged to provide integrated administration of the POS II, the Aetna Select and SI HMO Product(s), through the HMOs. The HMOs include the following entities to the extent that Plan beneficiaries elect coverage under Products offered in geographic areas served by such entity. Aetna Life Insurance Company is authorized to represent the HMOs listed below for purposes of the execution and administration of this Services Agreement, including receipt of any notices to Aetna required hereunder:

Aetna Health, Inc. (CT)
Aetna Health of California Inc.
Aetna Health Inc. (ME)
Aetna Health Inc. (NY)
Aetna Health Inc. (NJ)
Aetna Health Inc. (PA)
Aetna Health Inc. (FL)
Aetna Health Inc. (GA)
Aetna Health Inc. (MI)
Aetna Health Inc. (TX)