

**CITY OF MIRAMAR
PROPOSED CITY COMMISSION AGENDA ITEM**

Meeting Date: November 5, 2025

Presenter's Name and Title: Kanika Stamp, Chief HR Officer/Director of Human Resources

Prepared By: Angelita Delrish, Deputy Director of Human Resources

Temp. Reso. Number: R8551

Item Description: Temp. Reso. #R8551 APPROVING AN EXTENSION OF THE AGREEMENT WITH AETNA LIFE INSURANCE COMPANY FOR THE PROVISION OF EMPLOYEE GROUP HEALTH INSURANCE PROGRAMS FOR CITY EMPLOYEES, DEPENDENTS AND RETIREES; ESTABLISHING ACTUARIAL EQUIVALENT RATES FOR INSURANCE PREMIUMS FOR CALENDAR YEAR 2026 TO INCLUDE 100% OF EXPECTED CLAIMS IN AN AMOUNT OF \$16,100,000 AND ADMINISTRATION AND STOP LOSS FEES IN AN AMOUNT OF \$2,400,400, ADDING A CONTINGENCY IN AN AMOUNT NOT-TO-EXCEED 7%, OR \$1,296,000 OF THE ANTICIPATED ANNUAL EXPENSES, TOTALING A NOT-TO-EXCEED AMOUNT OF \$19,796,400; AUTHORIZING THE CITY MANAGER TO EXECUTE ALL APPROPRIATE CONTRACT DOCUMENTS; AND PROVIDING FOR AN EFFECTIVE DATE. (Kanika Stamp, Chief Human Resources Officer/Director of Human Resources).

Consent ☐ Resolution ☒ Ordinance ☐ Quasi-Judicial ☐ Public Hearing ☐

Instructions for the Office of the City Clerk: None

Public Notice – As required by the Sec. ____ of the City Code and/or Sec. ____, Florida Statutes, public notice for this item was provided as follows: on ____ in a ____ ad in the ____; by the posting the property on ____ and/or by sending mailed notice to property owners within ____ feet of the property on ____
(fill in all that apply)

Special Voting Requirement – As required by Sec. ____, of the City Code and/or Sec. ____, Florida Statutes, approval of this item requires a ____ (unanimous, 4/5ths etc.) vote by the City Commission.

Fiscal Impact: Yes ☒ No ☐

REMARKS: Fiscal Impact of \$19,796,400 has been budgeted in FY 2026 Fund 501 – Health Insurance Fund.

Content:

- **Agenda Item Memo from the City Manager to City Commission**
- **Resolution TR8551**
 - **Exhibit A: Aetna Renewal Package**
- **Attachment(s)**
 - **Attachment 1: Aetna Master Agreement**
 - **Attachment 2: Health Renewal Projected Costs**



**CITY OF MIRAMAR
INTEROFFICE MEMORANDUM**

TO: Mayor, Vice Mayor, & City Commissioners

FROM: Dr. Roy L. Virgin, City Manager 

BY: Kanika Stamp, Chief HR Officer/Director of Human Resources

DATE: October 30, 2025

RE: Temp. Reso. No. 8551 approving the Agreement with Aetna Life Insurance Company for Employee Group Health Insurance for Employees, Retirees, and Dependents for Calendar Year 2026

RECOMMENDATION: The City Manager recommends approval of Temp. Reso. No. 8551 authorizing the City to enter into an extension of the Agreement for employee group health insurance for City employees, retirees, and dependents with Aetna Life Insurance Company for calendar year 2026, establishing actuarial equivalent rates for insurance premiums to include 100% of expected claims in an amount of \$16,100,000, administration and stop loss fees in an amount \$2,400,400 and adding a contingency in an amount not-to-exceed 7% or \$1,296,000 of the anticipated annual expenses, totaling an amount of \$19,796,400.

ISSUE: Pursuant to City Code, approval of the City Commission is required for expenditures in excess of \$75,000 by a single department from the same vendor in a single fiscal year and for contracts extending beyond the expiration date permitted in such contract.

BACKGROUND: On October 7, 2020, the City Commission approved Resolution No. 21-08, awarding a three-year Agreement with two, one-year renewal options to Aetna Life Insurance Company ("Aetna") for employee group health insurance for employees, retirees, and dependents. On October 18, 2023, the first renewal of the agreement was approved by Resolution No. 24-15 and on October 16, 2024, the City Commission approved Resolution No. 25-14, awarding the second of two one-year renewal options to Aetna. The contract provides health insurance on an annual basis from January 1st to December 31st of each year. The current contract expires on June 30, 2026. The extension to the agreement provides coverage through the end of calendar year 2026.

DISCUSSION: The three-year initial term of the Aetna contract expired on December 31, 2023. The employee group health insurance contract was renewed for the second term through December 31, 2025, through the adoption of Resolution No. 25-14 on October 16, 2024.

Of the multifaceted services included in Aetna's administrative services agreement package, all rates and services remain unchanged, with the exception of the stop loss fees. The extension to the agreement is a contract with no net cost increases for services. This results in no change to the costs for insurance for employees or their dependents.

ANALYSIS: Funding is budgeted in GL Account 501 Health Fund to cover administrative fees, stop-loss insurance and expected claims.

Temp. Reso. No. 8551
10/13/25
10/28/25

**CITY OF MIRAMAR
MIRAMAR, FLORIDA**

RESOLUTION NO. _____

A RESOLUTION OF THE CITY COMMISSION OF THE CITY OF MIRAMAR, FLORIDA, APPROVING THE EXTENSION OF THE AGREEMENT WITH AETNA LIFE INSURANCE COMPANY FOR THE PROVISION OF EMPLOYEE GROUP HEALTH INSURANCE PROGRAMS FOR CITY EMPLOYEES, DEPENDENTS AND RETIREES, ESTABLISHING ACTUARIAL EQUIVALENT RATES FOR INSURANCE PREMIUMS FOR CALENDAR YEAR 2026 TO INCLUDE 100% OF EXPECTED CLAIMS IN AN AMOUNT OF \$16,100,000 AND ADMINISTRATION AND STOP LOSS FEES IN AN AMOUNT OF \$2,400,400, ADDING A CONTINGENCY IN AN AMOUNT NOT-TO-EXCEED 7%, OR \$1,296,000, OF THE ANTICIPATED ANNUAL EXPENSES, TOTALING A NOT-TO-EXCEED AMOUNT OF \$19,796,400; AUTHORIZING THE CITY MANAGER TO EXECUTE ALL CONTRACT DOCUMENTS; AND PROVIDING FOR AN EFFECTIVE DATE.

WHEREAS, on October 7, 2020, the City Commission approved Resolution No. 21-08, awarding a three-year agreement with two, one-year renewal options to Aetna Life Insurance Company ("Aetna") for self-funded health insurance for employees, retirees, and dependents; and

WHEREAS, calendar year 2023 was the final year of coverage under the original agreement; and

WHEREAS, Resolution No. 24-15 was approved by the City Commission on October 18, 2023 and authorized the first renewal agreement which provided coverage from January 1, 2024 through December 31, 2024; and

Reso. No. _____

Temp. Reso. No. 8551
10/13/25
10/28/25

WHEREAS, Resolution No. 25-14 was approved by the City Commission on October 16, 2024 and authorized the second renewal agreement which provided coverage from January 1, 2025 through December 31, 2025; and

WHEREAS, pursuant to City Code, approval of the City Commission is required for expenditures in excess of \$75,000 by a single department from the same vendor in a single fiscal year and for contracts extending beyond the expiration date permitted in such contract; and

WHEREAS, the extension of the agreement will provide coverage from January 1, 2026, through December 31, 2026; and

WHEREAS, staff and Aetna have completed the negotiations for the extension of the second one-year renewal agreement, for a total amount not-to-exceed \$19,796,400; and

WHEREAS, the City Manager recommends approval of the extension of the agreement with Aetna Life Insurance Company for the provision of employee group health insurance programs for city employees, dependents and retirees for calendar year 2026 and for the establishment of actuarial equivalent rates for insurance premiums to include 100% of the expected claims in an amount of \$16,100,000; administration and stop loss fees in an amount of \$2,400,400 and adding a contingency of 7% or \$1,296,000 of the anticipated annual expenses, totaling an amount of \$19,796,400; and

Temp. Reso. No. 8551
10/13/25
10/28/25

WHEREAS, the City Commission deems it to be in the best interest of the residents and citizens of the City of Miramar to approve of the extension of the agreement with Aetna Life Insurance Company for the provision of employee group health insurance programs for city employees, dependents and retirees for calendar year 2026 and for the establishment of actuarial equivalent rates for insurance premiums to include 100% of the expected claims in an amount of \$16,100,000 and administration and stop loss fees in an amount of \$2,400,400 and adding a contingency of 7% or \$1,296,000 of the anticipated annual expenses, totaling an amount of \$19,796,400.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COMMISSION OF THE CITY OF MIRAMAR, FLORIDA AS FOLLOWS:

Section 1: That the foregoing "**WHEREAS**" clauses are ratified and confirmed as being true and correct and are made a specific part of this Resolution.

Section 2: That it approves the extension of the agreement with Aetna Life Insurance Company for the provision of employee group health insurance programs and premium rates for calendar year 2026 to include 100% of expected claims in an amount of \$16,100,000 and administration and stop loss fees in an amount of \$2,400,400 and adding a contingency in an amount not-to-exceed 7%, or \$1,296,000 of the anticipated annual expenses; totaling a not-to-exceed amount of \$19,796,400 for city employees, dependents and retirees for calendar year 2026.

Temp. Reso. No. 8551

10/13/25

10/19/25

Section 3: That the City Manager is authorized to execute all the contract documents including the agreement attached hereto as Exhibit "A," together with such non-substantive changes as are deemed acceptable to the City Manager and approved as to form and legal sufficiency by the City Attorney.

Section 4: That the appropriate City officials are authorized to do all things necessary and expedient to carry out the aims of this Resolution.

Section 5: That this resolution shall take effect immediately upon adoption.

Temp. Reso. No. 8551
10/13/25
10/28/25

PASSED AND ADOPTED this _____ day of _____, _____.

Mayor, Wayne M. Messam

Vice Mayor, Yvette Colbourne

ATTEST:

City Clerk, Denise A. Gibbs

I HEREBY CERTIFY that I have approved
this RESOLUTION as to form:

City Attorney,
Austin Pamies Norris Weeks Powell, PLLC

<u>Requested by Administration</u>	<u>Voted</u>
Commissioner Maxwell B. Chambers	_____
Commissioner Avril Cherasard	_____
Vice Mayor Yvette Colbourne	_____
Commissioner Carson Edwards	_____
Mayor Wayne M. Messam	_____

Reso. No. _____

TR 8551- EXHIBIT “A”



EXTENSION AGREEMENT FOR EMPLOYEE GROUP HEALTH INSURANCE AGREEMENT

This Agreement (the “Extension Agreement”) is entered into this ____ day of _____, 2025, between the City of Miramar (hereinafter “City”) and Aetna Life Insurance Company (hereinafter “Provider”).

RECITALS:

WHEREAS, the City awarded Request for Proposals No. 19-03-19 to the Provider for Employee Group Medical Program for an initial term of three years with the option to renew for two additional one-year terms (“Original Agreement”); and

WHEREAS, the commencement date of the initial three-year term was January 1, 2021 and expired on December 31, 2023; and

WHEREAS, on October 18, 2023, the City Commission adopted Resolution No. 24-15 and approved the first one-year renewal agreement effective January 1, 2024 to December 31, 2024; and

WHEREAS, on October 16, 2024, the City Commission adopted Resolution No. 25-14 and approved the second one-year renewal agreement effective January 1, 2025 to December 31, 2025; and

WHEREAS, the City desires to extend the Employee Group Medical Program Agreement for one additional one-year term from January 1, 2026 through December 31, 2026; and

WHEREAS, pursuant to Section 2-436(2)(d) of the City Code, no city contract shall be extended beyond the expiration date permitted in such contract without the City Commission's approval; and

WEHREAS, on _____ 2025 the City Commission adopted Resolution No. _____ and approved an additional one-year term to extend the agreement from January 1, 2026 through December 31, 2026 and authorized the City Manager to execute the appropriate extension agreement.

NOW, THEREFORE, the parties, in consideration of the mutual promises and covenants contained in this Extension Agreement, the Original Agreement together with any agreed upon changes made during the first and second renewal terms, agree as follows:

1. The foregoing Recitals are true and correct and are incorporated and made a part of this Extension Agreement.
2. The Agreement shall be extended for an additional one-year term from January 1, 2026 through December 31, 2026.
3. That the City and the Provider agrees to rates as shown in Exhibit 1 for the period of the extension.
4. All covenants, terms, and conditions contained in the Original Agreement, the First Renewal Agreement and the Second Renewal Agreement and any agreed

upon changes in this Extension Agreement, shall remain in full force and effect through this extension term.

IN WITNESS WHEREOF, the parties hereto have caused this Extension Agreement to be executed by their respective officials, duly authorized to execute same, on the dates indicated below.

THE CITY OF MIRAMAR

ATTEST:

Denise Gibbs, City Clerk

By: _____
Dr. Roy L. Virgin, City Manager

Dated: _____

Approved as to legal form and sufficiency
for the use of and reliance by the City of
Miramar only:

City Attorney
Austin Pamies Norris Weeks Powell, PLLC

AETNA LIFE INSURANCE COMPANY

By: _____

Print

Title

Date



An Aetna Renewal
Presented to

City Of Miramar

Annual Renewal Rating: January 01, 2026 through December 31, 2026
Plan Sponsor Numbers: 737553



Gabrielle Dimitrakis
MGR, Account Executive
Phone: 954-858-3139
Email: gkdimitrakis@aetna.com

Shannon Blakeslee
151 Farmington Avenue
Hartford, CT 06156
Phone: 860-273-3600
Email: BlakesleeS@aetna.cc

9/18/2025

City Of Miramar
Angelita Deirish
2300 Civic Center Place
Miramar, FL 33025

Dear Angelita:

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

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

This renewal includes the following exhibits and changes:

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

- **Fee Schedule**

Your medical fees will not change.

Additional Bundle up Discounts may be available if you purchase additional coverages with us.

- **Medical Programs and Services and Allowance**

- Your NSA claim administration fee effective January 1, 2026 will be \$94. The NSA claim administration fee will increase at each annual renewal and apply to NSA eligible claims paid on or after that renewal date. Refer to the NSA Payment Practices in our Caveats for information on our payment practices for NSA eligible claims.

- **Caveats**

For the best implementation experience, please notify your Account Team of changes to your plan design, programs and services no later than November 1, 2025. Some programs and services require additional notification prior to effective date for successful implementation. Please discuss with your Account Team for program specific implementation lead times. We will strive to implement these changes on a timely basis.

Your self-funded renewal package remains in effect until December 31, 2026.

If there are no changes impacting this renewal as outlined in your Caveats, the fees will remain in effect through December 31, 2026. This renewal package beginning with the ASC Fees is considered an amendment to your existing Agreement. Continuance of your benefit plan and payment of fees constitutes acceptance of this renewal. Please contact your Account Manager by October 1, 2025 to ensure they are able to address your questions prior to implementing your renewal.

Sincerely,

Gabrielle Dimitrakis
Mgr, Account Executive

A handwritten signature in black ink that reads "Shannon Blakeslee".

Shannon Blakeslee
Ld Dir, Underwriting

Why Aetna?

Effective Date: January 01, 2026

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

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

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

You can learn more about Aetna here:

<https://www.aetna.com/about-us.html>

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

The Aetna companies include:

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

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

www.aetna.com

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

City Of Miramar

Contact Information/Assumptions

Account Manager: Gabrielle Dimitrakis
 Email: gkdimitrakis@aetna.com
 Telephone: 954-858-3139

SIC Code: 9111
 Mem/EE Ratio: 1.89

Administrative Service Fees **Effective Date: January 01, 2026** **End Date: December 31, 2026**

		Current	Proposed	
Guarantee Period Effective Date		January 01, 2025	January 01, 2026	
Fee Basis		Mature	Mature	
Medical Fees as Billed (PEPM)*	Estimated Enrollment	Current	Proposed	% Change
OA Aetna Select	808	\$55.77	\$55.77	0.0%
Choice POS II	134	\$55.77	\$55.77	0.0%
Illustrative Composite Service Fees (PEPM)	942	\$55.77	\$55.77	0.0%
Pharmacy Rebate Prefund Program (PEPM)*		(\$55.77)	(\$55.77)	
Plan Year Service Fees	942	\$0	\$0	0.0%
Service Fee Summary (Plan Year)		Current	Proposed	% Change
Pharmacy Rebate Prefund Program*		(\$630,424)	(\$630,424)	
Illustrative Composite Total Fees (incl Discounts, Credits, Broker Comp, Other Chrgs) (PEPM)		\$0.00	\$0.00	
Total Fees (incl Discounts, Credits, Broker Comp, Other Chrgs)		\$0	\$0	0.0%

*Clarifications

- PEPM is defined as Per Employee Per Month
- Please see Programs and Services for additional information. Some services may come at additional cost to the fees shown above.
- Broker Compensation, if applicable, is subject to customer approval.
- Any Plan Year costs are based on the Estimated Enrollment and subject to change based on actual enrollment.
- If the self-funded Medical & Pharmacy proposal is placed out to bid, Aetna reserves the right to revise pricing for 01/01/26.

Prescription Drug Benefits

Our quotation assumes that prescription drug benefits are included and will be provided by Aetna.

If you terminate your prescription drug benefits with us, we will increase the ASC Service Fees and the medical trend assumption used for any applicable claim projections or guarantees. You may also be subject to additional charges to integrate data with external Pharmacy vendors. Refer to the reporting charges outlined in the Programs and Services exhibit for more information.

Pharmacy Rebate Prefund Program

We have offered an alternative to our traditional pharmacy rebate sharing agreement, referred to as Pharmacy Rebate Prefund Program. We have estimated your pharmacy rebates for the 2026 Guarantee Period. With this estimate, we are reducing your monthly medical administrative service fees as outlined above. When each quarterly rebate review is performed, any amounts collected which exceed the cumulative Pharmacy Rebate Prefund Program amount will be credited to you through the claim wire.

After the annual reconciliation, if the actual pharmacy rebates earned during the Guarantee Period are less than the Pharmacy Rebate Prefund Program amount, you agree to remit to us the difference within 30 days of the request.

We will re-evaluate our rebate estimates at each renewal. We will use the updated estimate for each renewal to provide a Pharmacy Rebate Prefund Program amount reduction to your administrative fees for that Guarantee Period.

City Of Miramar

Programs and Services – Self-Funded

Effective Date: January 01, 2026

Program Summary	OA Aetna Select
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Programs & Services Included in the Service Fee

Mature Base Service Fee	\$55.77
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General Administration	
Experienced Account Management Team	Included
Designated billing, eligibility, plan set up, underwriting	Included
Onsite Open Enrollment Meeting Preparation	Included
Open Enrollment Marketing Material (non-customized)	Included
ID Cards*	Included
Review or draft plan documents	Included
Summary of Benefits and Coverage (SBC)	Included
Claim Fiduciary Option 1	Included
Non-ERISA	Included
Claim Administration	Included
Plan Sponsor Liaison	Included
Special Investigations / Zero Tolerance Fraud Unit	Included

Network Services	
Full National Reciprocity*	Included
Custom Network - Low (up to 300 providers)	Included
Institutes of Excellence™ *	Included
Institutes of Quality® (IOQ) Network	Included
Gene-Based, Cellular and other Innovative Therapies (GCIT®) network	Included
National Medical Excellence Program®	Included
Network access	Included

Care Management	
Aetna Compassionate Care SM	Included
Aetna One® Essentials	Included
Aetna Advice	Included
Aetna Enhanced Maternity Program	Included
MedQuery®	Included
Preventive Care Considerations (Electronic)	Included
Utilization Management (Inpatient Precertification, Concurrent Review, Discharge Planning, Retrospective Review)	Included

Member Resources	
Designated Service Center	Included
Onshore Member Calls and Correspondence	Included
Member Website and Mobile Experience	Included
MindCheck SM	Included
Online Programs	Included

Wellness	
24-Hour Nurse Line: 1-800# Only	Included
Aetna Health Your Way™ Health Assessment and Digital Support	Included

Personal Health Record*	Included
Allowances	
Health Plan Allowance	Included
Reporting and Integration	
Analytic Consultation from Plan Sponsor Insights (10 Hours)	Included
ART Reports - New analytic reporting platform	Included
Aetna Health Information Advantage™ (AHIA)	Included
Monthly Financial Claim Detail Reports	Included
Monthly Banking Reports	Included
Behavioral Health	
Managed Behavioral Health	Included
Behavioral Health Condition Management Program - Standard	Included
Applied Behavior Analysis (ABA)	Included
AbleTo Network - member cost share may apply	Included
Aetna Discount Program	
at home products, fitness, hearing, LifeMart® shopping website, natural products and services, oral health care, vision, weight management	Included

Total Fees	\$55.77
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Programs & Services Included in the Claim Wire*

No Surprises Act - Fees*	
No Surprises Act (NSA) claim administration fee (per NSA eligible claim)	\$94
No Surprises Act (NSA) Independent Dispute Resolution (IDR) initial fee (per arbitration case)	Applicable fees are as set by law and passed through to the plan
No Surprises Act (NSA) Independent Dispute Resolution (IDR) arbitration expenses (per arbitration case)	Applicable fees are as set by law and passed through to the plan
Network Services	
Subrogation*	37.5% of savings
Contracted Services* (Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, Workers Compensation, DRG and Implant Audits)	37.5% of savings
Claim and Code Review Program*	37.5% of savings

National Advantage™ Program (NAP)*	We will retain 50% of savings (includes FCR, IBR)
National Advantage™ Program Cap (includes Facility Charge Review, Itemized Bill Review, and Data iSight™ when applicable)	Cap of \$100,000 per individual claim
Teladoc Health (Standard) General Medical (PEPM) *	\$0.45

Care Management

Enhanced Clinical Review Program – High Tech Imaging (PMPM)*	\$0.35
Enhanced Clinical Review Program – Diagnostic Cardiac (PMPM)*	\$0.10
Enhanced Clinical Review Program – Sleep Management (PMPM)*	\$0.05
Enhanced Clinical Review Program – Cardiac Implantable Devices (PMPM)*	\$0.05
Enhanced Clinical Review Program – Interventional Pain (PMPM)*	\$0.10
Enhanced Clinical Review Program – Hip and Knee Arthroplasties (PMPM)*	\$0.05

Additional Program Details*Claim Wire Billing, ID Cards, Subrogation, Contracted Services, Claim and Code Review**

Details can be found in our UW Disclosure document located at the following URL:

<https://www.aetna.com/content/dam/aetna/pdfs/aetna.com/legal-notice/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-05-01-2024.pdf>

No Surprises Act - Fees

The NSA claim administration fee will increase at each annual renewal and apply to NSA eligible claims paid on or after that renewal date. Refer to the NSA Payment Practices in our Caveats for information on our payment practices for NSA eligible claims.

No Surprises Act - IDR Fees

IDR fees are required by the NSA rules and are payable to the IDR entity. There is an initial fee to begin an arbitration, which applies to each case. There is also an additional fee for the arbitration expenses; the losing party within the dispute is liable for this fee. For batch cases, the NSA permits IDR entities to charge a different arbitration fee based on a set fee range and/or percentage of the batch fee. The fees are passed through (with no mark up by Aetna) to a customer based on the number of line items for their plan that were included in the batch case. The current NSA fees are set by federal agencies. Both the initial fee and the arbitration expense fee are subject to future adjustments by the agencies (and any such adjustments shall be applied to your plan).

Enhanced Clinical Review

This fee will only be charged based upon those members who fall into service areas where the program is available.

Full National Reciprocity

Excludes some standalone Aetna Whole Health networks. Details are available upon request.

Institutes of Excellence™ (IOE)

This program includes a steerage component by educating members on the benefits of using an IOE designated facility. However, benefit differential steerage is not supported for IOE Infertility network.

National Advantage™ Program (including the Contracted Rates, Facility Charge Review and Itemized Bill Review Components)

NAP includes a Contracted Rates component and two optional components: Facility Charge Review (FCR) and Itemized Bill Review (IBR). In addition, some plans also elect Data iSight (DiS) as their out-of-network plan rate for professional services. NAP's Contracted Rates component offers access to contracted rates for many medical claims from non-network providers (including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers) and ad hoc negotiations (when a contracted rate is not available). We retain a percentage of savings achieved through NAP, including savings achieved through FCR, IBR, and DiS, if elected. This NAP Fee is in addition to the per employee, per month administrative service fees.

Personal Health Record (PHR)

PHR requires the purchase of MedQuery®.

Teladoc Health

In addition to the administrative fees as outlined above, there is a per consultation charge which will be shared by the member and plan sponsor based on type of service provided and member's benefit plan. Specific charges are available upon request.

With standard Teladoc setup, standard welcome letters, marketing materials, and structure setup are required. If your plan deviates from the standard, Teladoc custom pricing rates will apply. See Programs and Services for included Teladoc programs.

City Of Miramar

Caveats - Self-Funded

Effective Date: January 01, 2026

For the purposes of this document, Aetna may be referred to using "we", "our" or "us" and City Of Miramar may be referred to using "you" or "your".

If fees are adjusted, the caveats below will apply and be based on the new assumptions.

Underwriting Caveats

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

If any of the changes outlined below occur, we may adjust your Guaranteed Fees. If this happens, you'll have to pay any difference between the fees collected and the new fees calculated back to the start of the Guarantee Period. If you are not notified of the change in advance, such difference will be reconciled in the annual accounting for the Guarantee Period.

If fees are adjusted, the caveats below will be based on the new assumptions.

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

Enrollment

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

Member-to-Employee Ratio

The member-to-employee ratio changes by more than 15 percent from the 1.89 ratio assumed in this quote.

Projected Processed Claim Transactions (PCT) Per Employee

The actual PCT ratio changes by more than 15 percent from the ratio assumed in this quote.

Age 65 and Over Enrollment

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

Quoted Benefits and Administration

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

National Advantage™ Program

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

Total Replacement

Any of the quoted lines of coverage are offered with an additional carrier.

Multiple Employer Welfare Arrangements (MEWAs) and Employer Association Health Plans (AHPs)

This quote was prepared based on the demographic information for eligible enrollees, including their home zip codes, in accordance with all applicable mandates. We must be notified immediately of any changes that affect plan locations due to new or changing enrollment statuses. We will evaluate regulatory requirements and may not be able to extend coverage in states which prohibit large group coverage through MEWAs and AHPs.

Assumptions

Underwriting

Agreement Provisions

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

Participation

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

Plan Design

This renewal is based on the current benefit plan designs, plus any noted deviations, subject to the terms of our Benefit Review document.

Claim Fiduciary - Option 1

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

External Review

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

Non-ERISA

For non-ERISA plan, the risk and responsibilities are different from those under ERISA plans, since the ERISA preemption and ERISA standard of performance do not apply. Our charge for non-ERISA plans must account for the additional liability risk as compared to known risks under an ERISA plan.

Member Communications

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

Wellness Incentives and Rewards

We offer several different wellness incentives and rewards programs that you may choose from to offer to your members. We, or our third-party vendors, will administer and distribute to your members any wellness incentives or rewards earned based on the programs selected under the direction and control of your plan. The wellness incentives and rewards earned through these programs may be taxable for your members. We will provide you with reporting which will identify members who have earned such wellness incentives or rewards. These reports will provide the data needed for any tax information reporting requirements that you determine are necessary.

With regard to these wellness incentives and rewards, you, as the Plan Sponsor have the following responsibilities:

- Ensure any incentives or rewards offered to your members comply with applicable law and any limitations imposed thereunder. This includes but is not limited to, the Health Insurance Portability Act (HIPAA), the Americans With Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA).
- Distribute notices and/or obtain any authorizations required by law.
- Comply with all tax information reporting requirements regarding any wellness incentives or rewards earned through these programs (cash, cash equivalent, or other tangible property) and provided by us or our third-party vendor to your members.
- Assume any and all liability for your noncompliance with any tax withholding or information reporting requirements.

You may wish to consult with your legal counsel or other advisors as to the proper tax treatment of such wellness incentives or rewards and to ensure that the incentives or rewards offered under your program comply with applicable law.

Mental Health/Substance Abuse Benefits

Our quotation assumes that mental health/substance abuse benefits are included.

Prescription Drug Benefits

Our quotation assumes that prescription drug benefits are included and will be provided by Aetna.

If you terminate your prescription drug benefits with us, we will increase your ASC medical fees and the medical trend assumption used for any applicable claim projections or guarantees. You may also be subject to additional charges to integrate data with external Pharmacy vendors. Refer to the reporting charges outlined in the Programs and Services exhibit for more information.

Pharmacy Rebate Prefund Program

We have offered an alternative to our traditional pharmacy rebate sharing agreement, referred to as Pharmacy Rebate Prefund Program. We have estimated your pharmacy rebates for the 2026 Guarantee Period. With this estimate, we are reducing your monthly medical administrative service fees as outlined in the ASC Fees exhibit. When each quarterly rebate review is performed, any amounts collected which exceed the cumulative Pharmacy Rebate Prefund Program amount will be credited to you through the claim wire.

After the annual reconciliation, if the actual pharmacy rebates earned during the Guarantee Period are less than the Pharmacy Rebate Prefund Program amount, you agree to remit to us the difference within 30 days of the request.

We will re-evaluate our rebate estimates at each renewal. We will use the updated estimate for each renewal to provide a Pharmacy Rebate Prefund Program amount reduction to your administrative fees for that Guarantee Period.

Stop Loss Reporting

Our quotation assumes stop loss coverage is provided by Aetna and therefore reporting to an external vendor is not required. If we are no longer the stop loss carrier, external reporting charges will apply.

Medical Pharmacy Rebates

Rebates for pharmacy products administered and paid through the medical benefit rather than the pharmacy benefit will be retained by Aetna as compensation for our efforts in administering this program.

Additional Products, Programs and Services

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

Billing Information

Advanced Notification of Fee Change

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

Late Payment

We reserve the right to assess a late payment charge at a 12 percent annual interest rate as follows:

- if you fail to pay plan benefit payments in accordance with the terms as outlined in your Master Service Agreement.
- if you fail to pay administrative service fees within the agreed upon extended grace period of 45 days.

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

Incurred late wire interest charges will be added to a future wire request and collected through your claim wire billing account. Incurred late fee payment interest charges will be collected through the year-end accounting process.

We reserve the right to change the extended period for paying Service Fees at any time. We'll provide you with 30 days written prior notice in the event we decide to change the arrangement. Any Service Fees due after the end of the 30-day notice period will be subject to the new arrangement. We reserve all rights to enforce Agreement remedies as to any Service Fees overdue.

Producer Compensation

The quoted fees don't include producer compensation.

Claim and Member Services

Runoff Claims Processing

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

Medical Service Center

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

Onshore Services

At your request, we have included the cost to handle the following services within the United States. If you'd like to make changes to these services, please contact your Account Manager.

- Member Calls and Correspondence

Certain ancillary services such as imaging, error correction, intake and triage for complaints, grievances and appeals, and internal application development and technical support may be handled outside of the United States, which is consistent with our standard claim determination and payment procedures.

Reporting and Data Transfer

Aetna Intellectual Property

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

Data Integration (Historical)

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

Data Integration (Ongoing)

Options and pricing for integrating claims data from an external vendor into one or more of our systems will vary depending

on the scale of your integration needs.

Data Transfer at Termination

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

Banking

We've assumed that you provide funds through a bank initiated Fedwire wire transfer for drafts issued under the self-funded arrangement assumed in this renewal.

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

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

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

Additional

Please review the additional important information found at the following URL. This information is incorporated by reference into this package and considered part of your Agreement. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriting Disclosure Document, the information in your package prevails.

<https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/legal-notice/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-05-01-2024.pdf>

Legislative and Regulatory Requirements

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

The Affordable Care Act (ACA) imposed Patient-Centered Outcome Research Trust Fund fee (PCORI) on the issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans. The fee was set to end in 2019, but it was extended for 10 years through 2029. The fee applies to policy or plan years ending on or after October 1, 2012, and before October 1, 2029.

Any taxes or fees (assessments) related to the Affordable Care Act that apply to the self-insured health plans are your obligation. The Administrative Service Fee does not include any such liability or the remittance of the fees on your behalf.

NSA Payment Practices

The No Surprises Act (NSA) applies to certain out of network claims at participating facilities when the member doesn't have a choice or is unaware the provider is out of network. The law protects plan participants by limiting cost sharing to the preferred benefit level and prohibits balance billing by out of network providers. For NSA eligible claims, we will pay the out of network provider an initial payment amount. In most cases, the initial payment will be an amount equal to the qualifying payment amount as defined in NSA regulations (generally, the median contracted rate for a specific service in a geographic area). A provider may choose to go to independent dispute resolution (IDR) if the provider does not accept our payment as payment in full. During the IDR process, you authorize us to pay more than the qualified payment amount in order to reasonably settle the matter when it appears expedient to do so.

Recovery of Overpayments

Our process of recovering overpayments attempts to recoup money in the most accurate, effective, and cost-efficient manner.

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

Pharmacy Service and Fee Schedule to the Master Services Agreement

**Effective January 01, 2024
City of Miramar**

aetna[®]

Table of Contents

<u>Pharmacy Discounts & Fees</u>	2
<u>Rebates</u>	3
<u>Terms & Conditions</u>	5
<u>Additional Disclosures</u>	8

Pharmacy Discounts & Fees

Management or administration of prescription drug benefits selected by the Customer will be performed by CaremarkPCS Health, L.L.C. and/or its affiliates (CVS Caremark), each of which is an affiliated, licensed pharmacy benefit manager.

Pricing Arrangement	Pass Through at Retail
Network	Aetna National Network
Employees	888

RETAIL			
	01/01/2024	01/01/2025	01/01/2026
Brand Discount	AWP - 19.50%	AWP - 19.60%	AWP - 19.70%
Generic Discount	AWP - 83.50%	AWP - 83.70%	AWP - 83.90%
Dispensing Fee	\$0.70 per script	\$0.70 per script	\$0.70 per script

MAIL ORDER PHARMACY/MAINTENANCE CHOICE			
Mail Benefit Type	Mandatory Maintenance Choice with Opt Out		
	01/01/2024	01/01/2025	01/01/2026
Brand Discount	AWP - 24.50%	AWP - 24.60%	AWP - 24.70%
Generic Discount	AWP - 87.50%	AWP - 87.70%	AWP - 87.90%
Dispensing Fee	\$0.00 per script	\$0.00 per script	\$0.00 per script

SPECIALTY PHARMACY			
Network	Open Specialty Network		
Product List	Aetna Specialty Product List		
	01/01/2024	01/01/2025	01/01/2026
Discount	AWP - 19.50%	AWP - 19.60%	AWP - 19.70%

ADMINISTRATIVE FEES			
	01/01/2024	01/01/2025	01/01/2026
Administrative Fee	\$2.00 PEPM	\$2.00 PEPM	\$2.00 PEPM

Rebates

REBATES			
Formulary	Aetna Standard Formulary		
Plan Design	3 Tier Qualifying		
Rebate Terms	Customer will receive the following minimum rebate guarantees:		
	01/01/2024	01/01/2025	01/01/2026
Retail	Greater of 100% or \$356.55 Per Brand Script	Greater of 100% or \$390.14 Per Brand Script	Greater of 100% or \$416.15 Per Brand Script
Mail Order/Maintenance Choice	Greater of 100% or \$879.74 Per Brand Script	Greater of 100% or \$962.52 Per Brand Script	Greater of 100% or \$1019.28 Per Brand Script
Specialty	Greater of 100% or \$3,258.44 Per Brand Script	Greater of 100% or \$3,671.29 Per Brand Script	Greater of 100% or \$4,172.93 Per Brand Script

REBATES			
Formulary	Aetna Standard Formulary		
Plan Design	3 Tier Non-Qualifying		
Rebate Terms	Customer will receive the following minimum rebate guarantees:		
	01/01/2024	01/01/2025	01/01/2026
Retail	Greater of 100% or \$342.11 Per Brand Script	Greater of 100% or \$374.34 Per Brand Script	Greater of 100% or \$399.30 Per Brand Script
Mail Order/Maintenance Choice	Greater of 100% or \$858.75 Per Brand Script	Greater of 100% or \$939.56 Per Brand Script	Greater of 100% or \$994.96 Per Brand Script
Specialty	Greater of 100% or \$3,258.44 Per Brand Script	Greater of 100% or \$3,671.29 Per Brand Script	Greater of 100% or \$4,172.93 Per Brand Script

REBATES			
Formulary	Aetna Standard Formulary		
Plan Design	2 Tier		
Rebate Terms	Customer will receive the following minimum rebate guarantees:		
	01/01/2024	01/01/2025	01/01/2026
Retail	Greater of 100% or \$342.11 Per Brand Script	Greater of 100% or \$374.34 Per Brand Script	Greater of 100% or \$399.30 Per Brand Script
Mail Order/Maintenance Choice	Greater of 100% or \$858.75 Per Brand Script	Greater of 100% or \$939.56 Per Brand Script	Greater of 100% or \$994.96 Per Brand Script
Specialty	Greater of 100% or \$3,258.44 Per Brand Script	Greater of 100% or \$3,671.29 Per Brand Script	Greater of 100% or \$4,172.93 Per Brand Script

Capitalized terms in the pricing charts above are not intended to reflect defined terms except where specifically noted in the Prescription Drug Services Schedule.

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

In the event of any inconsistencies between the terms and conditions set forth in this Pharmacy Service and Fee Schedule and the terms and conditions set forth in the Prescription Drug Services Schedule, the terms and conditions of this Pharmacy Service and Fee Schedule shall prevail.

Terms & Conditions

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

- To the extent the pricing and services outlined in this document are part of a renewal to the Customer, the pricing set forth herein is valid for 90 days from the date of such offer.
- This pricing has an effective date of January 1, 2024. In order for Aetna to implement the pricing as set forth above by the effective date, a notification of award must be given 90 days prior to effective date.
- Our renewal assumes that Aetna administers both the medical and pharmacy benefits for Customer on an integrated basis. If Customer elects to use a different vendor to provide medical benefits, then Aetna reserves the right to adjust the pricing contained in this proposal.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Participating Pharmacy shall give the Plan Participant the benefit of the lesser of (i) the Participating Pharmacy's Usual and Customary Charge, (ii) MAC (where applicable) or (iii) discounted AWP cost. Participating Pharmacy shall collect and retain from the Plan Participant at the time of dispensing the lesser of (i) the Cost Share; (ii) the Participating Pharmacy's Usual and Customary Charge, (iii) MAC (where applicable) or (iv) discounted AWP cost.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
 - Discount and Dispensing Fee guarantees are measured individually and reconciled in the aggregate; surpluses in one or more component guarantees may be used to offset shortages in other component guarantees.
 - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within one hundred eighty (180) days following the guarantee period.
 - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant Cost Share and include zero balance due claims.
 - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein:
 - Compound Prescription claims
 - Limited distribution drug (LDD) claims
 - Direct Plan Participant reimbursement / out-of-network claims
 - Coordination of Benefits (COB) or secondary payor claims
 - In-house pharmacy claims
 - Vaccines (including for COVID) and other COVID testing-related claims
 - 340B claims
 - Retail pricing guarantees include claims that reflect the Usual & Customary Retail Price.

- Single Source Generic Drugs are included in the Generic Discount guarantees.
- Only Specialty Products dispensed by a Specialty Pharmacy are included in the Specialty Pharmacy Discount guarantee listed above. Specialty Products dispensed by Participating Retail Pharmacies are not included in any Discount guarantee listed above.
- Aetna has assumed 0.00% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.
- Pricing and terms in this proposal assume the Customer has elected the Aetna Standard formulary and the Choose Generics program.
- The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members
- Open Specialty Network means that Plan Participants are required to use participating Specialty Pharmacies (no fills at retail allowed) with the exception of the HIV class which is not required to be dispensed at Participating Specialty Pharmacies.
- The Overall Effective Discount (OED) offer is conditioned on Aetna being the exclusive provider of Specialty Products through CVS Specialty Pharmacies with the exception of the HIV class and Client implementing and maintaining a generics first plan design for specialty. Aetna may amend the individual Specialty Drug discounts from time to time to manage the financial guarantee. The financial guarantee is measured and reconciled annually across all Specialty Drugs dispensed by Aetna Specialty pharmacy, including through the Specialty Connect program, with the exception of the following exclusions (in addition to the standard exclusions).
 - New to market Specialty Products
 - Limited distribution drugs

For the items noted here, the following quoted rates shall apply:

- New to market Specialty Products: AWP - 15%
- New to market limited distribution drugs: AWP - 10%

MAC: Certain dosage forms and strengths may not be included on the MAC list and shall be priced at the Specialty Product default rate.

In the event retail leakage increases by a percentage change of 10%, or more, from the effective date of the agreement, Aetna reserves the right to amend pricing.

- Our financial offer does not assume any adoption of the Transform Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.
- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein.
- Rebate guarantees may be subject to:
 - The adoption of Specialty Guideline Management (SGM) program

- Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
- The above rebate guarantees exclude:
 - Over the Counter (OTC) Claims
 - Limited distribution drug (LDD) Claims
 - Any other Claim identified as having received 340B program wholesale pricing
 - Compound Drug Claims
 - Paper or Member Submitted Claims
 - Coordination of Benefits (COB) or secondary payor Claims
 - Vaccine and vaccine administration Claims
 - COVID treatment Claims
 - Claims approved by Formulary Exception
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty rebate guarantees apply to Specialty Product claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:
 - Two-tier qualifying plan designs - will consist of an open plan design, with the first tier comprised of Generic Drugs and the second tier comprised of Brand Drugs. There are no requirements for a minimum Cost Share differential between these tiers. The plan design may need to implement formulary interventions recommended by Aetna.
 - Three-tier non-qualifying plan designs – maintain a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs.
 - Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a \$15.00 co-payment differential between preferred and non-preferred Brand Drugs, at least a \$15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).
- Rebate guarantees are measured individually by component and reconciled in the aggregate on an annual basis within 12 months following the end of the Plan year; a surplus in one or more component Rebate guarantees may be used to offset shortages in other component Rebate guarantees.

Additional Disclosures

The Customer acknowledges that the Discounts and Dispensing Fees contained in this agreement reflect a Transparent or Pass Through pricing arrangement at Retail. Transparent or Pass Through Pricing means the amount charged to the Customer and Plan Participants for network claims shall equal the amount paid to Participating Retail Pharmacy. Maintenance Choice claims dispensed at CVS/pharmacy, if applicable, are exempt from the Transparent Pricing requirements under this Agreement. The amount billed to the Customer will be equal to the amount paid to the participating pharmacies.

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

1. Greater than 15% change in total membership or Claims volume as compared to the baseline
2. Customer-initiated change to the Benefit Plan Design, or Formulary alignment. To the extent applicable, Aetna will notify Customer in advance of any proposed Equitable Adjustment
3. Product offering decisions by drug manufacturers that result in a reduction of rebates, including the introduction of a lower cost alternative product which may replace an existing rebatable brand product; an unexpected launch of an interchangeable version of a brand product; or a branded product converted to OTC status, recalled or withdrawn from the market; or a material reduction in the Wholesale Acquisition Cost (WAC); or
4. Other events triggering an Equitable Adjustment as detailed below:
 - Legal and/or regulatory changes specific to customers which negatively affects the economic value of the Agreement to a party or the parties under the Agreement, for example restrictions on preferred or limited network arrangements; policy changes impacting drug manufacturers which negatively affect the economic value of the Agreement including the ability to provide or maintain discounts or Rebates; and/or
 - An inability to access, or changes to, industry pricing information (e.g. AWP) required to support the current economic structure of the Agreement.

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

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

Rebate Payment Terms

Rebates are calculated and paid in accordance with the terms and conditions of this Agreement.

Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

Customer agrees that Aetna will offset a portion of the fees earned by Aetna under the Medical Service and Fee Schedule of the Agreement with Rebates that would otherwise be shared with Customer hereunder. There will be a reconciliation on a quarterly basis after the close of each contract quarter, at which point all remaining rebates, if any, will be distributed to the customer.

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

Formulary Management

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

Other Payments

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

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

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

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

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

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

Early Termination

In the event Customer terminates Aetna's arrangement of prescription drug benefit services as described in the Prescription Drug Services Schedule and Pharmacy Service and Fee Schedule to the Agreement prior to December 31, 2026 (an "Early Termination") Aetna shall retain any earned but unpaid rebates as of the Early Termination date subject to any exception thereto provided herein.

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

Aetna's remedies as described immediately above are liquidated damages and shall not be characterized as a penalty (collectively, the "Early Termination Fee"). Unless otherwise agreed in writing by the parties, such Early Termination Fee will be due and paid in full within sixty (60) days after the termination effective date.

Late Payment Charges

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

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

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

Pharmacy Audit Rights and Limitations

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

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the Prescription Drug Services Schedule.

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

City Of Miramar

Stop Loss Financials

Effective Date: January 01, 2026

Control #737553

Policy Period: January 01, 2026 through December 31, 2026

Status: Final/Firm

Valid until: 10/27/2025

- Please refer to the Stop Loss Assumptions and Caveats for additional information.
- Stop Loss rates and factors will be billed on a Composite PEPM basis.

Quote Specifications	Current	Renewal	Option 1	Option 2
Contract Situs	Florida	Florida	Florida	Florida
Policy Period Length (months)	12	12	12	12
Total Enrollment	905	939	939	939
Producer Commission	None	None	None	None
Terminal Liability Option	No	No	No	No

Individual Stop Loss (ISL) Coverage	Current	Renewal	Option 1	Option 2
Covered Benefits	Medical/Rx	Medical/Rx	Medical/Rx	Medical/Rx
Individual Stop Loss Amount	\$250,000	\$250,000	\$275,000	\$300,000
Lasering (High Risk Claimants)	No	No	No	No
Aggregating Specific Amount	None	None	None	None
Contract Type	Paid	Paid	Paid	Paid
ISL Coinsurance %	100%	100%	100%	100%
Maximum Annual ISL Payment Amount	Unlimited	Unlimited	Unlimited	Unlimited
ISL Composite PEPM Rate	\$130.66	\$184.49	\$167.48	\$152.87
Estimated ISL Policy Period Premium	\$1,418,968	\$2,078,833	\$1,887,165	\$1,722,539
% Change in Individual Stop Loss Premium		41.2%	28.2%	17.0%

Aggregate Stop Loss (ASL) Coverage	Current	Renewal	Option 1	Option 2
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City Of Miramar

Stop Loss Financials		Effective Date: January 01, 2026		
Covered Benefits	Medical/Rx	Medical/Rx	Medical/Rx	Medical/Rx
Aggregate Stop Loss Percentage	125%	125%	125%	125%
Contract Type	Paid	Paid	Paid	Paid
Maximum Annual ASL Payment Amount	\$1,000,000	\$1,000,000	\$1,000,000	\$1,000,000
ASL Composite PEPM Rate	\$6.56	\$7.35	\$7.41	\$7.46
Estimated ASL Policy Period Premium	\$71,242	\$82,820	\$83,496	\$84,059
Projected Policy Period Total Claims	\$14,422,628	\$17,708,055	\$17,849,858	\$17,971,673
Projected Policy Period Aggregate Corridor	\$18,028,250	\$22,135,069	\$22,312,322	\$22,464,591
Aggregate Stop Loss Factor PEPM	\$1,660.06	\$1,964.42	\$1,980.15	\$1,993.66
Minimum Aggregate Stop Loss Amount	\$18,028,285	\$22,135,069	\$22,312,322	\$22,464,591

Financial Summary	Current	Renewal	Option 1	Option 2
Total ISL & ASL Composite PEPM Rate	\$137.22	\$191.84	\$174.89	\$160.33
Estimated Monthly Premium	\$124,184	\$180,138	\$164,222	\$150,550
Estimated Policy Period Stop Loss Premium	\$1,490,209	\$2,161,653	\$1,970,661	\$1,806,598
% Change in Total Stop Loss Premium		39.8%	27.5%	16.8%

This quotation is issued or underwritten by Aetna Life Insurance Company.

City Of Miramar

Stop Loss Assumptions & Caveats

Effective Date: January 01, 2026

For the purposes of this document, Aetna may be referred to using "we", "our", or "us" and City Of Miramar may be referred to using "you" or "your".

We are pleased to provide you with our renewal for Stop Loss insurance. These Assumptions and Caveats, in conjunction with the Stop Loss Financials exhibit, combine to form the entirety of this renewal. Please review them carefully and notify us immediately if any of the features do not meet your expectations or if any of our assumptions are incorrect. Changes in the features or assumptions may affect premium rates or claim factors.

Additional state-specific notices should be reviewed at this link:

<https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/legal-notice/documents/stop-loss-underwriting-disclosures-06-06-2023.pdf>

If you renew Aetna's Stop Loss coverage, you will receive your application for insurance electronically. You will access it via a link delivered by email and endorse it using electronic signature capabilities. You will also receive your policy electronically. This process requires a web browser which supports the HTTPS protocol, HTML, and cookies. You will also need to view PDF documents using software such as Adobe Reader or similar. You have the right to request that these transactions occur by regular mail using paper copies, which would require you to physically sign your application and mail it back to us. Please contact your broker and/or your Aetna Account Manager to make this request.

Stop Loss policies and applications/schedules of insurance are updated annually upon renewal. Please contact your broker and/or your Aetna Account Manager for a copy of the Stop Loss policy.

This proposal assumes you have notified us of any known applicants for gene replacement therapy.

Renewal Status

This is a final, firm offer. You must accept the rates by 10/27/2025

If you fail to accept the rates by 10/27/2025, we reserve the right to request updated underwriting data, which may alter the rates and terms of the offer.

Assumptions

- The policy period is indicated on the Stop Loss Financials. The Stop Loss policy period must agree with the self-funded plan's contract period, both of which must end on the next renewal date.
- Eligible medical claim expenses are funded on an issued basis.
- It is assumed Aetna is also the claim fiduciary for the self-funded plan(s) covered by Stop Loss. Claims approved by fiduciary override/exception are not covered by Stop Loss.
- Eligibility for Stop Loss coverage will apply as described in the self-funded benefit plan(s) and in accordance with the Stop Loss policy provisions.
- In at least one quoted option, Pre-65 and post-65 retirees, and their dependents, have been included in Stop Loss coverage.
- There must be common ownership among all participating divisions or subsidiaries for this quote to remain valid.
- Your business and/or Standard Industrial Code is 9111.

What Is Covered

- Self-funded benefit plans covered by Stop Loss are identified on the Stop Loss Financials. All other benefit plans are excluded.
- NEW! Aetna will not apply High Risk Individual Stop Loss Amounts (lasers) for FDA-approved or pipeline gene replacement therapy drugs dispensed for specific conditions. Gene replacement therapy drug claims will also not be included in the ISL

claim experience used for rating purposes at the Stop Loss renewal.

Gene replacement therapies use genetic engineering to replace or repair mutated genes, effectively treating a patient's medical condition. This new feature specifically applies to the gene replacement therapy drugs approved to treat specific disease, age, and gene expressions via one-time gene replacement treatments – or curative treatments – for previously untreatable, often fatal, conditions.

Please note the terms under which this applies:

- Existing High Risk Individual Stop Loss Amounts established for gene replacement therapy drugs are not impacted and will be maintained for the duration of the policy period.
- Existing High Risk Individual Stop Loss Amounts set up due to the member's underlying condition or other reasons will apply, but will not be increased any further specifically for gene replacement therapy drugs.
- High Risk Individual Stop Loss Amounts may apply for all other diseases or drugs, including medical costs associated with the underlying condition or medical services associated with the gene replacement therapy treatment.
- Coverage of gene replacement therapy drugs will apply as follows:
 - When a gene replacement therapy drug is administered for the indicated disease, age, and gene expression by one of Aetna's "Gene-based, Cellular, and other Innovative Therapies" (GCIT) network providers, we will consider the eligible claim expense for the gene replacement therapy drug less the ISL amount shown on the Stop Loss Financials exhibit.
- The Stop Loss Financials displays the projected policy period Aggregate Corridor, calculated as the projected total enrollment x the ASL claim factor x the number of months in the policy period.
The actual Aggregate Corridor will be updated to reflect actual monthly enrollment during the policy period.
The Aggregate Corridor is also subject to the minimum Aggregate Stop Loss Amount, which is calculated as the ASL claim factor x (the greater of the quoted enrollment or the actual enrollment in the first month of the policy period).
- Contract Type - As indicated on the Stop Loss Financials, eligible claim expenses will be covered for incurred and paid dates based on:
 - A Paid contract type - Claims paid during the policy period, regardless of the incurral date, are included under Stop Loss. However, if the prior policy period was covered by any Stop Loss policy with a run-out contract type or provision, claims paid during the prior policy's run-out period are not covered by this Stop Loss proposal.
- A Maximum Annual Aggregate Stop Loss Payment amount is included in the coverage options on the Stop Loss Financials. It reflects the maximum reimbursement we will pay for Aggregate Stop Loss coverage during the policy period.
If you elect this coverage feature, it will create a gap in coverage between your benefit plan(s) and your Stop Loss policy.
If the total eligible claim expenses funded by Aggregate Stop Loss reach the Maximum Annual Aggregate Stop Loss Payment amount during a policy period, all subsequent eligible claim expenses will be funded by you until the renewal date.

What Is Not Covered

Coverage exclusions include but are not limited to the following:

- Expenses that are not payable under the plan or in accordance with Aetna's clinical policy and established claim practices. This includes expenses that are experimental or investigational, not medically necessary, in excess of the reasonable and customary charge, or any claim exception;
- Eligible claim expenses covered by another valid Stop Loss policy, including another Aetna policy, during the same time period or run-in claims also covered by a prior policy carrier's run-out provision;
- Plan administration expenses including, but not limited to cost containment administrative fees, care management fees, and network access fees, with the exception of shared savings fees associated with our National Advantage Program (NAP);
- Assessments or surcharges applied to claims by any government body, with the exception of the MA Uncompensated Care Pool, Minnesota Care Provider Tax, or New York Health Care Reform Act surcharges;
- Incentive or risk share payments, care coordination payments, and other non-fee-for-service payments associated with any agreement with an accountable care or similar provider organization;
- Expenses for non-emergency services, treatment, or related complications provided outside the United States. This includes prescription drugs or medical supplies provided by non-U.S. based companies;
- Capitation payments excluded from Individual Stop Loss but included under Aggregate Stop Loss.

Stop Loss Reimbursement

- When Aetna is also the plan's administrator and the Stop Loss policy is in-force, eligible claims are funded by Stop Loss immediately, as they are approved for payment under the plan. This "Immediate Reimbursement" means that your cash flow is not impacted by waiting for reimbursement of claims exceeding the Stop Loss amount and claim reports are not required. Additional reconciliation is necessary when run-in or run-out is covered, or when other than a 12/12 or Paid contract type is utilized.

When Aetna is not the claims administrator, reconciliation for reimbursable amounts is performed at the end of the policy period once you provide appropriate claim details and other necessary information.

- The Monthly Budget Feature standardly applies to Aggregate Stop Loss claims as long as we are the claims administrator and the Stop Loss policy remains in-force. This feature provides cash flow protection by capping your monthly claim liability. However, when you choose to fund claims:

- through multiple primary wire lines, or
- through one primary wire line and report through one or more internal wire lines,

additional, final reconciliation is necessary after the close of the policy period.

When Aetna is not the claims administrator, reconciliation for reimbursable amounts is performed at the end of the policy period once you provide appropriate claim details and other necessary information.

Underwriting Requirements

- We reserve the right to amend or withdraw our offer to reflect the underwriting impact of any additional information we obtain or in the event you are unable to provide us any of the information we need to fully underwrite the risk.
- If you fail to meet the our underwriting requirements, including but not limited to a minimum of 51 eligible subscribers, our Stop Loss offer will be withdrawn. If failure to meet this requirement occurs after a Stop Loss policy has been issued, the policy will terminate as of the first day of the first month following the month in which the underwriting requirement was not met.
- We reserve the right to adjust the premium rate or any aggregate Stop Loss factor as of the date of any change to the underlying assumptions that impacts the risk assumed. Changes include, but are not limited to:
 - Any change of +/- 10 percent in enrollment
 - Any change to the plan document(s) that will change the risk assumed under the policy
 - Any change to this policy
 - Any addition or deletion of a unit, division, subsidiary, affiliated or associated company exceeding 10 percent of existing enrollment
 - Any change in federal or state law or regulation that impacts the policy or the coverage provided
 - Any change impacting the risk we have assumed, including but not limited to: age, gender, geography, occupation, incorrect or incomplete information provided in Disclosure statements, etc., that impacts the nature of the risk by more than 10 percent
 - Any change in claims administrator, provider network or cost containment vendor, provided we have consented to the change in writing
 - Any change in the claims administrator's claim payment system or payment practices that causes a variation of +/- 5 percent versus the most recent 12 month average claim processing time.

New units, subsidiaries, etc., will be underwritten. Claim reports may be requested. If this information is not provided, we reserve the right to require a completed and signed Disclosure and may apply AAW/DNC rules on the acquired group.

What is Leveraged Trend?

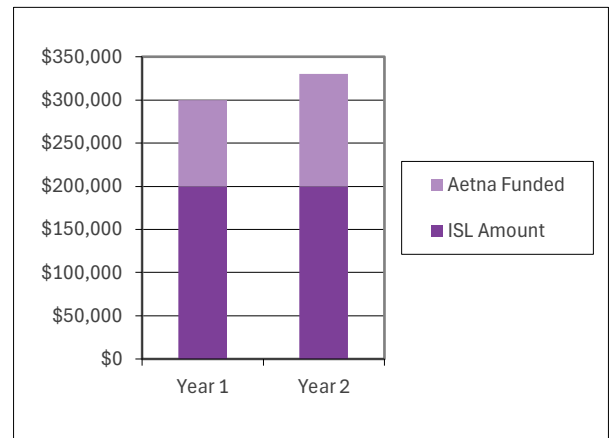
Leveraged trend is the single largest component of annual Stop Loss premium increases. Trend becomes 'leveraged' when the groups responsible for funding health care claims do not maintain the same share of potential claim liability year over year. With Stop Loss, this happens when a plan sponsor does not increase the Individual Stop Loss amount annually, resulting in a decreasing level of risk for the health plan's claim costs. Conversely, as leveraged trend causes the risk to shift to the Stop Loss carrier, premium charged to the plan sponsor is increased correspondingly.

To eliminate the leveraging impact on premium, a plan sponsor should increase its Individual Stop Loss amount by trend each year. This maintains the same proportion of risk between the plan sponsor and the carrier over time, as shown below.

Scenario 1

	Year 1	Year 2	Trend
Individual's Claim	\$300,000	\$330,000	10%
ISL Amount	\$200,000	\$200,000	0%
Aetna Funded Portion	\$100,000	\$130,000	30%

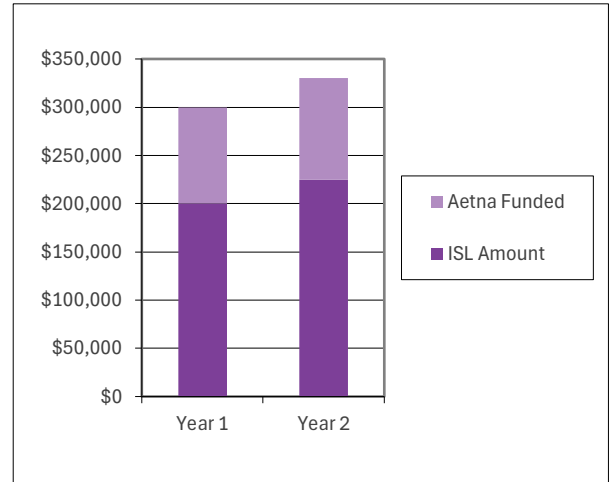
- The plan sponsor's Individual Stop Loss (ISL) amount is \$200,000 in both Year 1 and Year 2.
- At 10 percent annual health care trend, a \$300,000 claim in Year 1 increases in Year 2 to \$330,000.
- Aetna's portion, however, increases from \$100,000 in Year 1 to \$130,000 in Year 2.
- While annual claim trend is only 10 percent, leveraged trend is 30 percent. This results in a sizeable rate increase for Year 2.



Scenario 2

	Year 1	Year 2	Change
Individual's Claim	\$300,000	\$330,000	10%
ISL Amount	\$200,000	\$225,000	13%
Aetna Funded Portion	\$100,000	\$105,000	5%

- The plan sponsor's Individual Stop Loss (ISL) amount is \$200,000 in Year 1 and \$225,000 in Year 2.
- At 10 percent annual health care trend, a \$300,000 claim in Year 1 increases in Year 2 to \$330,000.
- Aetna's portion increases from \$100,000 in Year 1 to \$105,000 in Year 2.
- Because the ISL Amount increases in Year 2, leveraged trend is only 5 percent, which reduces the Year 2 rate increase.



The scenarios above are illustrative; they do not reflect actual plan sponsor experience.

Stop loss policies are insured or underwritten by Aetna Life Insurance Company.



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FULL COBRA ADMINISTRATIVE SERVICES CITY OF MIRAMAR – SCOPE OF SERVICES

EXHIBIT A

Benefits Outsource, Inc. (BOI) seamless COBRA Administrative services provide a dedicated account representative, an easy, more efficient system to input, monitor and track eligibility, as well as flexible reporting, making a simplified solution to overall COBRA administration.

Administrative services include but are not limited to; access to web-based system, generation of notices, mailings, election and termination processing, monthly billings, premium collections and accountability, detailed monthly reporting and customer service.

Initial Setup:

1. Onboarding/Client Setup - Enter plan specs provided by client into system for line of benefit (i.e. medical, dental, vision, FSA)
 - a. Coordinate requirements for file set-up and transmission of participant data.
2. Receive client data via secure channel (SFTP or Encrypted Email) in various formats.
3. Integrate participant data into Web-system.
4. Receive and send qualified beneficiary data via SFTP, in Excel or CSV format)
5. Integrate qualified beneficiary data into Web-system
6. Generate letters and forms for election; revise as deemed necessary.
7. Provide access to web-based COBRA system for staff to enter COBRA enrollment information and continuants to view information and/or optionally make payments.

Ongoing Administration:

1. Receive client data from client or carrier(s) via secure channel (SFTP or encrypted email)
2. Annually enter current plan specs into system for respective line of benefit (i.e. medical, dental, vision)
3. Prepare COBRA availability notice for QB
4. Prepare General Notice for New Hires (where applicable)
5. Mail all notices and bill enrolled COBRA continuants monthly
6. Track COBRA election timelines
7. Record and process COBRA elections
8. Notify the client and carrier(s) of COBRA eligibility (enrollment, updates, terminations)
 - a. Via Point of Contact (POC)
 - b. Via Direct Access to respective carrier portal
 - c. Via EDI file feed
8. Provide payment methods via ACH, checks, money order and credit card
9. Collect COBRA premiums and record, accordingly
10. Reconcile premium discrepancy with group or carrier
11. Send follow-up letter to COBRA continuant regarding premium underpayment, late payment, NSF
12. Send to COBRA continuant reminder notice due to:
 - Failure to make regular payment timely
 - Formal terminations of continuant's coverage; nonpayment, per request by continuant, and upon exhaustion of COBRA period (18, 29 or 36 months)
13. Provide Secondary event notification when applicable
14. Prepare Conversion notice 180 and 60 days prior to attainment of COBRA continuation

15. coverage expiration.
16. Update rates annually at point of renewal, where applicable
17. Assist client with annual Open Enrollments
18. Provide ongoing access, support and training to system for both client & participants
19. Provide QBs and COBRA continuants with a toll-free contact number for convenience
20. Local presence for members to visit, make payment and to discuss their account(s).

Monthly Reporting:

1. Provide monthly Disbursement and Enrollment Details Report with COBRA Continuants to include the following: Name, masked SSN, coverage level, paid through date, monthly premium, unpaid premium, short payment, retroactive premium, termination.
2. Adhoc reports are available upon request



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**FULL COBRA ADMINISTRATIVE SERVICES
CITY OF MIRAMAR FEE SCHEDULE**

EXHIBIT B

The fee schedule below for COBRA Administrative Services includes but are not limited to; annual web-based set-up of plans, generation of notices, mailings, enrollment election and termination processing, billings, monthly premium collection and remittance, detailed monthly reporting and customer service. Our complete COBRA package offers value-added administration and competitive pricing, combined with excellent service.

COBRA FEES: PER BENEFIT ELIGIBLE EMPLOYEE PER MONTH (PEPM) ADMINISTRATIVE SERVICES PRICING	
Plan Years	2026
Implementation Fee	Waived
Annual Recurring Fee	Waived
COBRA Administrative Services Fee	\$1.20

Rates include administrative costs related to COBRA administrative services as outlined in EXHIBIT A, Scope of Services.



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**RETIREES ADMINISTRATION
CITY OF MIRAMAR - SCOPE OF SERVICES
MEDICAL, DENTAL, VISION & LIFE INSURANCE**

EXHIBIT A

Benefits Outsource, Inc. (BOI) seamless Retirees Administrative services provide a dedicated account representative, an easy, more efficient system to input, monitor and track eligibility, as well as flexible reporting, making a simplified solution to overall Retirees administration.

Administrative services include but are not limited to; access to web-based system, generation of notices, mailings, election and termination processing, monthly billings, premium collections and accountability, detailed monthly reporting and customer service.

Initial Setup:

1. Onboarding/Client Setup - Enter plan specs provided by client into system for line of benefit
2. Coordinate requirements for file set up and transmission of participant data
3. Receive client data via secure channel (SFTP or Encrypted Email)
4. Integrate participant data into Web-system
5. Prepare direct billing notification for retirees; customize or revise as deemed necessary
6. Prepare transition notice for current and pending retirees
7. Provide access system and training (client & participants).

Ongoing Administration:

1. Receive new and/or enrolled retiree updates via secure channel (SFTP or Encrypted Email)
2. Integrate participant data into web-based system.
3. Prepare direct billing notification for retirees; customize or revise as deemed necessary
4. Provide ongoing access, support and training on system for both client & members
5. Prepare and mail notice for direct billings which include:
 - a. Coupons for accompanying monthly premium payments
 - b. Payment instructions regarding ACH, credit card and check for remittance of monthly premium payments
 - c. Coverage types and benefits
6. Notify client and carrier of retiree eligibility (enrollment, updates, termination)
Via Point of Contact (POC)
Via Direct Access to respective carrier portal
Via EDI file feed
7. Record and process direct billing premium payments
8. Remit premium payments to carrier monthly
9. Reconcile premium discrepancy with carrier
10. Provide retiree notice regarding non-payment of premium and premium underpayment
11. Prepare cancellation notice due to:
Failure to make regular payment
Terminations (All terminations must be formally communicated)
12. Update premium rates in system at point of renewal
13. Send notice of rate change 60 days in advance: or when notified by client

14. Assist client with annual open enrollments
15. Upon attainment of Medicare age, provide COBRA to dependent and terminate retiree from plan
16. Provide toll-free number to members for customer service convenience
17. Local presence for members to visit, make payment and to discuss their account(s).

Monthly Reporting:

1. Provide monthly Disbursement and Enrollment Detail Report with Retirees to include the following: Name, masked SSN, coverage level, paid through date, monthly premium, unpaid premium, short payment, retroactive premium, termination.
2. Ad Hoc reports are available upon request.



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**RETIREES ADMINISTRATION
CITY OF MIRAMAR - FEE SCHEDULE
MEDICAL, DENTAL, VISION & LIFE INSURANCE**

EXHIBIT B

The fee schedule below for Retirees Administrative Services include but are not limited to; annual web-based set-up of plans, generation of notices, enrollment election and termination processing, monthly billing, premium collection and remittance, detailed monthly reporting and customer service. Our complete package offers value-added administration and competitive pricing, combined with excellent service at a reasonable cost.

RETIREES FEES: PER ENROLLED RETIREE PER MONTH ADMINISTRATIVE SERVICE PRICING	
Plan Year	2026
Implementation Fee	Waived
Annual Recurring Fee	Waived
Retirees Administrative Service Fee	\$4.00

The above rate revision is being provided to include Retiree administrative processes for medical, dental, vision and life insurance. Rates include administrative costs related to Retirees administrative services as outlined in EXHIBIT A, Scope of Services described herein.

Aetna Behavioral Health, LLC, Aetna Resources for Living, PO Box 818048, Cleveland, OH 44181-8048

September 23, 2025

City of Miramar
Attention: Angelita Delrish, Deputy Director, HR
2300 Civic Center Place
Miramar, FL 33025

Dear Angelita Delrish:

Thank you for renewing your Aetna Employee Assistance Program (EAP). At Aetna, we believe in an integrated, total health focus where an EAP and other benefits are part of a continuum of care.

Please review the enclosed Services Agreement. If you would like to propose revisions to the Aetna Behavioral Health, LLC Services Agreement, please provide a red-lined version to me. I will forward that to our attorney for review.

Otherwise, if these Agreements are acceptable to you, please sign where indicated and return the Agreements to us as directed below. Once received and fully executed on our end, I will send a copy to you for your records.

- Email: EAPAcctSupp@AETNA.com
- Fax: (800) 970-6255

To prevent possible delays or disruption to the renewal of your EAP services, please return your signed Agreements prior to the effective date of your renewal.

Please note that the enclosed Agreements supersede any and all prior or contemporaneous oral or written communications or proposals, including without limitation, your agreement with Aetna Behavioral Health, LLC.

Should you have any questions regarding these documents or any other aspects of your Employee Assistance Program, please do not hesitate to contact me. We look forward to a continued long and productive relationship between Aetna and City of Miramar.

Sincerely,

Jill Pinder
Account Executive
(860) 996-7586
Jill.Pinder@rfl.com

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

This Employee Assistance Program Services Agreement (hereinafter, the "Services Agreement") is made and entered into by and between Aetna Behavioral Health, LLC, on behalf of itself and its affiliates (hereinafter "Company") and City of Miramar (hereinafter "Customer").

WHEREAS, Customer has established an employee assistance program ("EAP") for certain eligible individuals; and

WHEREAS, Customer also desires to engage the services of Company to provide EAP services and WorkLife and other additional EAP services which are defined in this Agreement (the "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. This Services Agreement includes and incorporates by reference the attached **General Conditions Addendum, Domestic Description of EAP Services Addendum, Description of Work/Life Services Addendum, and Domestic EAP Service and Fee Schedule**, and the Business Associate Agreement entered into between Aetna Life Insurance Company, on behalf of itself and its affiliates (including Aetna Behavioral Health, LLC) and Customer, as may be amended from time to time, and is referred to herein as the "Business Associate Agreement".

Customer hereby elects to receive the Services set forth in the **Domestic EAP Service and Fee Schedule** attached hereto and made a part hereof. The corresponding Service Fees are specified in the **Domestic EAP Service and Fee Schedule** which shall be amended for future periods, in accordance with Section 3 of the **General Conditions Addendum**, to reflect the Services elected and corresponding Service Fees for such periods.

This Services Agreement (including incorporated addendums) constitutes the complete and exclusive contract between the parties and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein. Notwithstanding Section 3 of the **General Conditions Addendum**, no modification or amendment of this Services Agreement shall be valid unless contained in writing and signed by a duly authorized representative of Company and a duly authorized representative of Customer. By executing this Services Agreement, Customer acknowledges and agrees that it has reviewed all terms and conditions incorporated into this Services Agreement and intends to be legally bound by the same.

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

The initial term of this Services Agreement shall be from 1/1/2026 through 12/31/2026.

IN WITNESS WHEREOF, the parties hereto have caused this Services Agreement to be executed by their duly authorized representatives.

CITY OF MIRAMAR

AETNA BEHAVIORAL HEALTH, LLC

Signed By: _____

Signed By: _____

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

GENERAL CONDITIONS ADDENDUM

Definitions: In this General Conditions Addendum and in all attachments to this Services Agreement:

- (A) "Employee" means any person eligible to receive Services under this Services Agreement by virtue of being a current employee of Customer, and not designated a temporary employee, and employees of subsidiaries and affiliates of Customer who are reported by Customer, in writing, to Company for inclusion in this Services Agreement.
- (B) "Dependent" means the eligible family members, including domestic partners, household members, and dependents (including adult children up to age 26) of an Employee eligible to receive Services under this Services Agreement as a dependent of an Employee.
- (C) If Applicable, the term "EAP Behavioral Health Professional" may mean EAP Network Provider or EAP Staff Clinician.
- (D) If applicable, the term "EAP Network Providers" shall mean licensed behavioral health professionals, who meet all Company credentialing standards, and who are contracted by Company, as independent contractors, to provide counseling to Members.
- (E) If applicable, the term "EAP Staff Clinicians" shall mean behavioral health professionals who are licensed in the State in which they practice and who are employed by Company to provide clinical services to Members. EAP Staff Clinicians may be part of Company's EAP call center and may provide telephonic clinical services. If applicable, EAP Staff Clinicians may be located at the Customer site and provide counseling at the Customer's location.
- (F) "Members" means Employees and Dependents eligible for Services.
- (G) "Payment Due Date" shall mean the date that payment is required as set forth on the Customer's invoice. Payment Due Date will be 31 calendar days after the first calendar day of the month in which the services are provided. Payment is to be made in a form and manner as reasonably determined by Company.
- (H) The term "Service Fees" shall have the meaning set forth in Section 3 of this General Conditions Addendum.
- (I) The term "Services" shall have the meaning set forth in Section 1 of this General Conditions Addendum.

The following are the terms and conditions under which Company agrees to perform Services for Customer:

1. **Purpose.** Customer will purchase and Company will provide to Customer the Services designated in this Services Agreement and such other services Customer requests of Company and Company agrees in writing to perform, as described in the **Domestic EAP Service and Fee Schedule** and the **Description of Services Addenda** (the "Services").
2. **Term.** The initial term of this Services Agreement shall commence on the Effective Date and shall continue to the first anniversary of the Effective Date, unless terminated by either party in accordance with Section 4 of this **General Conditions Addendum**. Following the initial term, this Services Agreement shall be automatically renewed from year to year, unless terminated by either party in accordance with Section 4 of this General Conditions Addendum.
3. **Service Fees.** The Customer shall pay Company the fees according to the **Domestic EAP Service and Fee Schedule**. Company may change the EAP Services and the EAP Service Fees annually by giving the Customer 30 day's notice before the changes take effect. Change will take effect on the anniversary of the Effective Date unless otherwise indicated in the applicable **Domestic EAP Service and Fee Schedule**. Company shall provide the Customer with an invoice indicating the Service Fees owed for that month. The Customer shall pay Company the Service Fees in accordance with Payment Due Date. The Customer shall provide with their payment either a copy of the Company invoice, modified to reflect current number of employees or a copy of a pre-approved invoice which meets Company's billing requirements. The Customer shall also reimburse Company for certain additional expenses, as stated in the **Domestic EAP Service and Fee Schedule**.

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

4. Termination. This Services Agreement may be terminated by Company or the Customer as follows:

- (A) Legal Prohibition** - If any state or other jurisdiction enacts a law which prohibits the continuance of this Services Agreement, or an existing law is interpreted to prohibit the continuance of this Services Agreement, this Services Agreement shall terminate automatically as to such state or jurisdiction on the effective date of such law or interpretation; provided, however, that if only a portion of this Services Agreement is prohibited by such law, only that portion of this Services Agreement shall be affected, and this Services Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.
- (B) Customer Termination** - Customer may terminate this Services Agreement with respect to all Employees (including their Dependents) or any group of Employees included under this Services Agreement or any subsidiary or affiliate of Customer that is covered under this Services Agreement by giving Company at least **thirty-one (31) days** written notice prior to the end of the initial term or prior to the end of any given contract year within the initial term, after the date of such notice, such termination shall become effective.
- (C) Company Termination** -
 - (1) Company may terminate this Services Agreement 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) Company may terminate this Services Agreement within thirty-one (31) days of transmitting notice to Customer by mail, facsimile transmission or other means of communication (including electronic mail) if (a) Customer fails to pay Service Fees by the Payment Due Date, (b) Customer fails to provide current Employee counts to Company by each Payment Due Date, (c) Company determines that Customer will not meet its obligation to pay such Service Fees and/or provide current Employee counts by the Payment Due Date, and/or (d) Company determines that Customer is in material default, or substantial breach, of one or more of its obligations under this Services Agreement.
 - (3) Any acceptance by Company of funds or Service Fees described in paragraph 3 above, shall not constitute a waiver of Company's right to terminate this Services Agreement in accordance with this section with respect to any other failure of Customer to meet its obligations hereunder.

5. Customer's Responsibilities.

- (A) Employee Count** – If needed and where applicable, on or before the Effective Date, Customer may be requested to furnish to Company a listing of Employees (by zip code of each Employee's place of residence). Thereafter, Customer shall supply to Company, on a monthly basis by the Payment Due Date, current Employee counts in a form and manner as reasonably determined by Company. Company shall not be responsible in any manner for any delay or error in the provision of Services caused by the Customer's failure to furnish accurate Employee counts in a timely fashion. If Customer fails to provide current Employee counts with payment by the Payment Due Date, all Employee counts will be updated and reflected in the next billing and payment cycle. Company will not process Employee counts retroactively nor will Company perform any retroactive fee adjustments due to Customer submitting inaccurate Employee counts.
- (B) Fiduciary Duty** – It is understood and agreed that the Customer, as Plan Administrator, retains complete authority and responsibility for their employee health benefits plan (the "Plan"), its operations, and the benefits provided there under, including EAP (if applicable) and that Company is empowered to act on behalf of Customer in connection with the Plan only to the extent expressly stated in this Services Agreement or as agreed to in writing by Company and Customer.
- (C) Summary Plan Description (SPD)** – If Customer's EAP is part of the Plan, Customer shall provide Company with all Plan documents at least thirty (30) days prior to the Effective Date or such other date mutually agreed upon by the parties. Absent the Customer providing Company with an SPD, Company shall automatically apply its internal policies and procedures to all EAP plans, including but not limited to internal appeals and external review, as applicable. Company does not review Customer's SPD for compliance with applicable law.

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

6. **Services.** Company shall perform the Services set forth in the **Domestic EAP Service and Fee Schedule** and the **Description of Services Addenda**. Customer acknowledges that Company may utilize the services of external contractors in performing these Services. Company and Customer will discharge their obligations under this Services Agreement with that level of reasonable care which a similarly situated EAP Services provider or Plan Administrator under ERISA would exercise under similar circumstances.
7. **Records.** Customer acknowledges and agrees that Company or its affiliates or authorized agents shall have the right to use all documents, records, reports, and data, including data recorded in Company'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 accordance with applicable law and may be de-identified as to Members and Customer identity for purposes other than administration of EAP Services, at Company's discretion. Company may de-identify Documentation Records and use them for quality improvement, statistical analyses, product development and other lawful, non-Service-related purposes.
8. **Indemnification.**
- (A) Company shall indemnify and hold harmless Customer, its directors, officers, employees (acting in the course of their employment, but not as Members) for that portion of any third party loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees) caused directly by Company's willful misconduct, criminal conduct, breach of this Services Agreement, fraud, breach of fiduciary responsibility, or failure to comply with Section 6 above, related to or arising out of the Services provided under this Services Agreement.
- (B) Except as provided in (A) above, Customer shall indemnify and hold harmless Company, 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 directly by Customer's willful misconduct, criminal conduct, breach of this Services Agreement, fraud, breach of fiduciary responsibility, or failure to comply with Section 6 above, related to or arising out of this Services Agreement or Customer's role as employer; (ii) in connection with the release or transfer of member-identifiable information to Customer's third party designated by Customer, or the use or further disclosure of such information by such third party.
- (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 Company agree that, except for services provided by EAP Staff Clinicians: (i) Company does not render medical services or treatments to Members; (ii) neither Customer nor Company is responsible for the health care that is delivered by EAP Network Providers; (iii) EAP Network Providers are solely responsible for the health care they deliver to Members; (iv) EAP Network Providers are not the agents or employees of Customer or Company; 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 EAP Network Providers with respect to Members.
- (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 Company's act or omission undertaken at the

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

direction of Customer (other than Services described in this Services Agreement). The indemnification obligations under (B) above shall not apply to that portion of any loss, liability, damage, expense, settlement, cost or obligation undertaken by Customer at the direction of Company.

(F) The indemnification obligations under this Section 8 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.

9. **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.

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

11. Confidentiality.

(A) **Business Confidential Information** - Each party acknowledges that performance of this Services Agreement may involve access to and disclosure of Customer and Company 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 EAP Services, 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 Company may make lawful references to Customer in its marketing activities and in informing health care providers (including EAP Network Providers) as to the organizations and plans for which Services are to be provided.

(B) **Company Confidential Information** – Any information with respect to Company or any of its affiliate's fees or specific rates of payment to health care providers (including EAP Network Providers) and any information which may allow determination of such fees or rates any of the terms and provisions of the health care provider's agreement (including EAP Network Providers) with Company or its affiliates are deemed to be Company 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) Company has consented in writing to such disclosure and (ii) each such recipient has executed a confidentiality agreement in form satisfactory to Company's counsel.

(C) **Member Confidential Information** – In addition, each party will maintain the confidentiality of medical records, PHI, PII and confidential Member-identifiable patient information ("Member Confidential Information"), and in accordance with the terms of the Business Associate Agreement.

(D) **Upon Termination** – Upon termination of this Services Agreement, each party, upon the request of the other, will return or destroy all copies of all of the other's Business Confidential Information in its possession or control except to the extent such Confidential Information must be retained pursuant to applicable law, to the extent such Confidential Information cannot be disaggregated from the Company's databases, or except as otherwise provided under the Business Associate Agreement, provided, however,

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

that Company may retain copies of any such Business Confidential Information it deems necessary for the defense of litigation concerning the Services it provided under this Services Agreement.

(E) Customer and Company 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 Company 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 this 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.

12. Relationship of the Parties. It is understood and agreed that Company is an independent contractor with respect to all Services being performed pursuant to this Services Agreement. Company makes no guarantee and disclaims any obligation to make any specific EAP Network Providers or any particular number of EAP Network Providers available for use by Members.

13. Subcontractors. The work to be performed by Company under this 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. Company will remain liable for Services under this Services Agreement.

14. Communications. Company and Customer shall be entitled to rely upon any communication believed by them to be genuine and to have been signed or presented by the proper party or parties.

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 Company, PO Box 818048, Cleveland, OH 44181-8048, Attention: EAP Contracting, (ii) in the case of the Customer, at the address shown below, or (iii) at such other address, physical or email as either party specifies for the purposes of this Services Agreement by notice in writing addressed to the other party. Email notices or communications from Customer to Company should be directed to Customer's assigned EAP account representative.

City of Miramar
2300 Civic Center Place
Miramar, FLORIDA, 33025
amdeirish@miramarfl.gov
Attention: Angelita DeIrish

15. Force Majeure. Other than the Customer's obligation to make payments for Services provided by Company to Customer or its Members prior to the Force Majeure, neither party shall be liable for any failure to meet any of the obligations or provide any of the Services or benefits specified or required under this Services Agreement where such failure to perform is due to any contingency beyond the reasonable control of either 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 either party, its employees, officers or directors; acts of God; acts of terrorism; pandemic; fires; wars; floods; storms; earthquakes; riots; labor disputes or shortages; and governmental laws, ordinances, rules, regulations, or the opinions rendered by any court, whether valid or invalid.

16. Compliance. Customer and Company shall remain, throughout the term of this Services Agreement, in compliance with all applicable federal and state laws and regulations, including HIPAA, related to this Services Agreement and the Services to be provided hereunder. Accordingly, the parties agree to the terms of the Business Associate Agreement.

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

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

- 18. Miscellaneous.** The Services Agreement shall be governed by and interpreted in accordance with applicable federal law, including but not limited to ERISA. To the extent such federal law does not govern, this Services Agreement shall be governed by Connecticut law and the courts in such state shall have sole and exclusive jurisdiction of any dispute related hereto or arising hereunder. 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 this Services Agreement. This Section and Sections 3 through 7 and 9 through 11 shall survive termination of the Services Agreement. The provisions of Section 8 shall survive termination only to the extent stated therein. The headings in this Services Agreement are for reference only and shall not affect the interpretation or construction of this Services Agreement.

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

DOMESTIC DESCRIPTION OF EAP SERVICES ADDENDUM

Subject to the terms and conditions of this Services Agreement, the EAP Services selected by Customer and provided by Company are reflected in this **Domestic Description of EAP Services Addendum** and the **Domestic EAP Service and Fee Schedule** (as modified by Company from time to time pursuant to Section 3 of the **General Conditions Addendum**). Additional EAP Services may be provided at Customer's written request under the terms of this Services Agreement. All Services described in this EAP Services Addendum are available within the 50 U.S. states only, including Puerto Rico, U.S. Virgin Islands, and District of Columbia. International EAP Services are only available if specifically described and priced in a separate International Service and Fee Schedule.

1. **UNLIMITED TELEPHONIC ACCESS:** Unlimited telephonic access to the Company EAP call center staff, available 24 hours per day, 7 days per week, 365 days per year for purposes of assessing Member need and referring to appropriate EAP Services.
2. **SESSION MODEL:** Sessions are intended to assist with emotional, family, personal, or work-related behavioral health issues. Company offers our members the choice in how they wish to use their sessions. Company has a network of professionals who can offer services face-to-face, telephonically, or via televideo (when appropriate), or Each member is entitled, on a contract year, up to the number of sessions per problem as set forth herein in the Service and Fee Schedule (e.g., up to a set number of sessions per member per problem under the EAP Session Model), unless a State regulation requires otherwise. All sessions require prior authorization. The member must contact Company to receive referrals and authorizations for all sessions whether face-to-face, telephonic, or televideo. Marital and/or family sessions are considered one problem for the couple or family and sessions are not authorized individually for each attendee. Face-to-face, telephonic, and televideo sessions count toward the number of sessions per member per problem.
3. **EAP PROVIDER NETWORK:** A nationwide network of licensed behavioral health professionals, who meet all Company credentialing standards, and who are contracted by Company, as independent contractors, to provide counseling to Members. EAP Network Providers include, but are not limited to: social workers, licensed professional counselors, marriage and family therapists, master's level psychiatric nurses and psychologists.
4. **TRAINING AND EDUCATION:** The term "Training and Education" refers to training, provided by Company, or a Company Contracted educator to the Customer, concerning general behavioral health and work/life issues. This includes Employee Orientation Meetings and Supervisor Orientation Trainings. This training may be provided in different ways, i.e. in-person, telephonically, or web-based. Additional fees apply to web-based training over 50 participants (Participants is defined as unique phone lines calling into the webinar). Department of Transportation (DOT) services are excluded from standard Training and Education services. For specialized DOT training, see separate definition under Drug Free Workplace Services. Mental Health First Aid trainings are excluded from standard Training and Education services. For specialized Mental Health First Aid training, see separate definition under Mental Health First Aid.
5. **MANAGEMENT SERVICES:**
 - **MANAGEMENT CONSULTATION:** A telephonic resource for managers, supervisors, and human resources professionals to assist in identifying and resolving workplace issues and promoting a productive workforce. Issues may include but are not limited to employee personal and family issues, behavioral health concerns, workplace conflict, workplace crisis and other disruptions, substance abuse, threats of violence and employee performance concerns. This includes the provisions of guidance to the Customer in making voluntary referrals for employees to the EAP. EAP will coordinate with specialty providers as needed (SAP, DOT, FFD).
 - **MANDATORY REFERRALS:** Case management to assist Customer and employees in addressing significant workplace performance issues. Mandatory referrals are used to monitor compliance with the EAP Behavioral Health Professional's recommendations, wherein the EAP, with appropriate executed release of information forms, confirms the employee's participation in and compliance with the Program.
 - **DRUG FREE WORKPLACE SERVICES:** Suite of services to assist Customer in managing workplace related employee substance misuse and/or disclosure of substance abuse in the workplace. Services for general employer industries include Company EAP case management of mandatory

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

referrals related to workplace impacted substance abuse, as well as management consultation services as described above. Services for transportation related industries, such as employers who are regulated by DOT, FMCSA, FAA, FRA, FTA, PHMSA, etc., include substance abuse case management by a Substance Abuse Professional (SAP) for Department of Transportation regulation compliance. Additional service for transportation regulated employees includes DOT training to meet Drug-Free Workplace regulations regarding drug and alcohol awareness available through American Substance Abuse Professionals (ASAP) or comparable SAP provider. A variety of training formats are available, including on-site, on-line or video.

- **FITNESS FOR DUTY (FFD) CONSULTATION AND COORDINATION:** A Fitness for Duty Evaluation is a forensic evaluation completed by a specially trained psychologist, psychiatrist, outside the EAP, for the purpose of evaluating an employee's ability to safely perform the functions of their job, assess organizational and behavioral risk, and provide a report recommending steps needed to be taken to minimize Customer risk in returning the employee to work. Fitness for Duty Evaluations are outside the scope of EAP, and as such the EAP does not conduct Fitness for Duty Evaluations. Upon specific request, the EAP may assist Customer with locating companies or providers external to the EAP who are capable of performing FFD Evaluations. At all times the Customer is responsible for working directly with the identified FFD provider as well as directly making payment arrangements with that provider for the FFD Evaluation. All decisions, regarding returning to work, retaining or dismissing employees remain with the Customer.
- **SUBSTANCE ABUSE PROFESSIONAL (SAP) CONSULTATION AND CONTACT INFORMATION:** Upon request of Customer, for drug and alcohol cases that fall under the Department of Transportation (DOT) guidelines, Company shall provide initial and ongoing management consultation on DOT issues. Company will further provide contact information of local providers in our specialized network of qualified Substance Abuse Professionals. The Customer is responsible for choosing and working directly with the SAP, as well as performing Follow-up, Compliance and Aftercare attendance monitoring. The Customer is responsible for payment of the SAP and determines whether the employee or employer pays SAP fees as well as recommended treatment costs.
- **MENTAL HEALTH FIRST AID:** An educational program offered to Customers to help managers and employees recognize and respond to mental health issues in the workplace and in the community. The curriculum includes an overview of mental health and provides education about Anxiety, Depression, Suicide, Trauma, Psychosis, and Substance Use Disorders, along with videos, interactive exercises and practice scenarios. The 4-hour and the 6-hour virtual course can be provided at the corporate level. Whether virtual or in-person both the 6-hour in-person and 6-hour virtual courses provide all participants that complete course with Mental Health First Aid Certification for three years. The 4-hour virtual and in-person general awareness courses are available. The 4-hour course does NOT provide participants with a Mental Health First Aid Certification. In-person courses are limited to 30 participants per course. The virtual 4-hour general awareness course has a participant minimum of 15 participants and a maximum of 25 participants. The virtual 6-hour courses have a 15-participant minimum/maximum per course.

Mental Health First Aid Virtual Delivery Requirements for Participants

Virtual courses will be hosted through The National Council for Behavioral Health's Zoom webinar platform, and The National Council will provide a how-to guide for participants who have never used this platform.

- Computer – Windows or Apple desktop or laptop computer OR Mobile Device/Tablet/Surface: iOS, Android, Windows
- Phone (backup audio option) – It is highly recommended that users join the course from a tablet, laptop or desktop computer for the best experience. Phones may be used for audio support.
- Microphone and speakers – Participants whose computers do not have a microphone and/or speaker can use the dial-in option from their phone for audio.
- HD Webcam – Either built into the user's device or external.

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

- Internet Connection – We recommend an internet speed of at least 5 mbps upload/download speed. Users can test their internet speed here: <https://www.speedtest.net/>

For the virtual 4-hour general awareness course, Customer will ensure that participants review course materials prior to attending a virtual session. Course materials will be available for download via the online learning platform.

The virtual 6-hour certification course is a blended course that includes two hours of self-directed pre-work and four hours of instructor led training. Customer will ensure that there are 15 identified participants for registration that are committed to completing required online learning pre-work and attending the four hours of instructor led training. Course materials will be available for download via the online learning platform.

If registered participant(s) does not complete the required two hours of self-directed pre-work, the participant(s) will be denied access to the four hours of live facilitator led training. If a participant doesn't complete the pre-work or is not able to attend the instructor led portion of the course, participants will not be able to makeup the session or receive certification and no refund will be issued. Participants will only receive a certificate upon completion of post test and evaluation.

6. **CRITICAL INCIDENT SUPPORT (Crisis Support/Management Services/Critical Incident Stress De-Briefing (CISD) Services):** An array of services offered by the EAP that helps an organization to prepare for, prevent, or respond to traumatic events. Acts of war are excluded from on-site CISD Services.
 - **ON-SITE STANDARD CRITICAL INCIDENT SUPPORT:** On-site attendance response time in greater than three hours for hourly onsite crisis support and Critical Incident Stress De-Briefing (CISD) Services at Customer sites to help an organization prepare for, prevent, or respond to traumatic events.
 - **ON-SITE IMMEDIATE CRITICAL INCIDENT SUPPORT:** On-site attendance response time in less than three hours for hourly onsite crisis support and Critical Incident Stress De-Briefing (CISD) Services at Customer sites to help an organization prepare for, prevent, or respond to traumatic events.
7. **REDUCTION IN FORCE:** The process by which a work organization reduces its work force by eliminating jobs, such as closing subsidiaries or departments.
8. **HERE4U:** The term "Here4U Groups" refers to a one (1) hour nation-wide and virtual peer support group, provided by EAP Behavioral Health Professional to the Customer, to address the importance of mental wellbeing. The event addresses mild to moderate severity with a focus on preventative mental health care and maintenance of wellbeing. Here4U groups will be available through Company's web-based platform. Each web-based group will have a maximum participant capitation of 30 (Participant is defined as one individual connecting to webinar web-based platform). The event will provide access to digital tools through Company's core member website m. Participant will be required to register for each event on Company web-based platform. Here4U groups are designed for one (1) hour in duration and one (1) hour in duration will count as one (1) Here4U group.
9. **COMMUNICATION AND PROMOTIONAL MATERIALS:** Information provided to Employees and management about EAP Services, including, in part, how EAP Services can be accessed for consultation and assistance. The communications and promotional resources include template e-mails, letters, flyers, brochures, and/or posters for Employees and management. Company will provide communications and promotional materials, directly to the Customer for distribution to the Employee. In support of implementation and on-going communication, Company will provide a quantity up to 120% of the number of eligible Employees for flyers or brochures with perforated wallet card; a quantity up to 5% of the number of eligible Employees for posters; and a quantity of up to 20% of anticipated attendees at health fairs for flyers. Requests exceeding these quantities may incur an additional fee. Requests for a mailing, to all Employee's place of residence, will incur additional fees. Requests for materials outside of our standard templates will incur an additional fee.
10. **MANAGEMENT REPORTS:** A specific collection of data and narrative information designed to inform the Customer about the overall utilization of the program. Customer may receive reports on a quarterly

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

electronic basis. If for any 2 consecutive reporting periods there is less than 1% utilization, reporting frequency will default to annual reporting.

11. INTAKE MODEL:

- **STANDARD MODEL:** Initial intake calls answered by a member engagement specialist.

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

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

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

DESCRIPTION OF WORKLIFE SERVICES ADDENDUM

Subject to the terms and conditions of this Services Agreement, the WorkLife Services selected by Customer and provided by Company are reflected in this **Description of WorkLife Services Addendum** and the **Domestic EAP Service and Fee Schedule**, (as modified by Company from time to time pursuant to Section 3 of the **General Conditions Addendum**). Additional WorkLife Services may be provided at Customer's written request under the terms of this Services Agreement. All Services described in this Worklife Services Addendum are available within the 50 U.S. states only, including Puerto Rico, U.S. Virgin Islands, and District of Columbia. International EAP Services are only available if specifically described and priced in a separate International Service and Fee Schedule.

1. **UNLIMITED TELEPHONIC ACCESS:** Unlimited telephonic access to the call center staff, available 24 hours per day, 7 days per week, 365 days per year.
2. **CAREGIVING SERVICES:** Services that include consultation, information, education and referral services in connection with, in part, adoption, childcare, parenting, temporary back-up care, summer care, special needs, high-risk adolescents, academic services, education loans, grandparents as parent, adult care, elder care, and disaster resources. Carekits may be available upon request from individual Members within the 50 U.S. states only, other types of Carekit distribution or promotion request by Customer will incur additional fees.
3. **PERSONAL SERVICES:** Free educational materials, personalized referrals, and interactive web tools to assist with:
 - A. Health & Wellness--Children's health; women's health; men's health; seniors' health; weight loss and nutrition; fitness and exercise programs; general health; safety; stress management; information on diseases and conditions; and more.
 - B. Daily Life--Home improvement; pet care; consumer information; automotive services; relocation; travel; time management; cleaning services; and more.
4. **LEGAL SERVICES:** Services provided through the EAP that include:
 - A. **LEGAL SERVICES:**
 - a. ½ hour Initial Consultation with selected participating attorney on an unlimited number of new Legal Topics (each plan year). Certain topic areas are excluded, including employment law. Also excluded are matters that, in the attorney's opinion, lack merit. Court costs, filing fees and fines are the responsibility of the member. If members choose to continue with the participating attorney and hire that attorney on their own, they will receive 25% off of the fees for services beyond the initial consultation (excluding flat legal fees, contingency fees, and plan mediator services).
 - b. Mediation Services – Each member is entitled to one (1) initial thirty minute office or telephone consultation per separate legal matter at no cost with a participating mediator. In the event that the member wishes to retain a participating mediator after the initial consultation, they will be provided with a preferred rate reduction of 25% from the mediator's normal hourly rate. Typical matters may include divorce and child custody, contractual and consumer disputes, real estate and landlord tenant, car accidents and insurance disputes.
 - c. Simple Will Preparation: Members receive resources to complete one Simple Will.
 - d. All initial consultation (and discounted consultations) must be for legal matters related to the Employee and eligible household members.
 - e. Member web resources
5. **FINANCIAL SERVICES:** Services provided through the EAP that include:
 - A. **FINANCIAL SERVICES:**
 - a. ½ hour Initial Consultation with the selected participating financial counselor on an unlimited number of new Financial Counseling Topics each plan year.
 - b. Financial counseling topics include Budgeting, Credit, Debt, Retirement, College Planning, Buying vs. Leasing, Mortgages/Refinancing, Financial Planning, Tax Questions, Tax Preparation, IRS Matters, Tax Levies and Garnishments, Consumer Credit Counseling, and Community Services.
 - c. A discount of 25% off the tax preparation services.

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

- d. Individual Employees may have the option to purchase additional services for a monthly nominal fee.

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

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

7. MEMBER WEBSITE:

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

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

DOMESTIC EAP SERVICE AND FEE SCHEDULE

Customer hereby elects to receive Services, within the 50 U.S. states only, including Puerto Rico, U.S. Virgin Islands, and District of Columbia, as designated below. The below Service Fees shall be in effect for the first-year of this Services Agreement, beginning upon the Effective Date of this Services Agreement, and, thereafter, if this Services Agreement is extended by the parties for any additional successive one year term(s), such Service Fees may be revised for each such successive term. Notwithstanding the immediately preceding sentence, the below Service Fees shall be amended by Company, from time to time during the first year of this Services Agreement and for any future period(s) thereafter, in accordance with the terms of this Domestic EAP Service and Fee Schedule.

Services	Service Fees
EAP Session Model Unlimited Telephonic Access with Up to 3 counseling sessions with an EAP Network Provider or televideo provider, delivered via face-to-face, telephonically, televideo, per problem	\$ 1.39 PE/PM
Worklife Services, including Caregiving Services, Personal Services Legal and Financial Services Identity Theft Services	Included in the EAP Session Model PE/PM.
Intake Model Standard Model	Included in the EAP Session Model PE/PM.
Critical Incident Support/Critical Incident Stress De-Briefing (CISD) Services—Standard Services (On-site attendance response time in greater than 3 hours)	Unlimited Standard CISD Services: Unlimited Standard CISD sessions are included in the EAP Session Model PE/PM Rate. CISD Services are limited to 10 hours per incident. Immediate CISD's are subject to the fees described below. Issues concerning downsizing, mergers, acquisition activities (i.e. Reductions in Force or RIF's) or services beyond the 10 hour cap, are subject to the hourly rate of \$285.00 per hour plus travel and preparation expenses reimbursed at a flat rate of \$180.00 per counselor. CISD hours used, whether fee for service and/or within the bank of standard hours, are calculated based upon the combined total number of hours all clinicians are on-site. If Customer requests interpretation services, Customer will be billed the applicable fees.
Critical Incident Support/Critical Incident Stress De-Briefing (CISD) Services—Immediate Services (On-site attendance response time in 3 hours or less)	Fee for Service Immediate CISD Pricing: \$385.00 per hour plus travel and preparation expenses reimbursed at a flat rate of \$180.00 per counselor.

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

Services	Service Fees
	CISD hours used, whether fee for service and/or within the bank of standard hours, are calculated based upon the combined total number of hours all clinicians are on-site. If Customer requests interpretation services, Customer will be billed the applicable fees.
Critical Incident Support/Critical Incident Stress De-Briefing (CISD) Cancellation Fee	Whenever possible, Customer agrees to provide Company with 48 hours advance notice of cancellation of any requested Workplace Crisis Response Services. Failure to provide Company with 48 hours' notice of cancellation of any services: • Unlimited Standard CISD Services Cancellation Fee: Services which are excluded from the unlimited provision listed above, i.e. above the 10 hours per incident cap, immediate CISD services, downsizings, mergers, acquisition activities (i.e. Reductions in Force or RIF's) which are subject to the hourly rate, will result in a charge of \$440.00 per incident.
Reduction in Force	Fee for Service Reduction in Force Pricing: \$285.00 per hour plus travel and preparation expenses reimbursed at a flat rate of \$180.00 per counselor.
Reduction in Force Cancellation Fee	Reduction in Force Cancellation Fee: \$440.00 per incident charge for failure to provide Company with 48 hour notice of cancellation of Reduction in Force service.

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

Services	Service Fees
Training and Education	Fee for Service On-Site Training Pricing: \$250.00 per hour for the total amount of time that the educator is on site, plus a \$150.00 per hour charge for travel and preparation time. If training is not scheduled consecutively or multiple topics are scheduled, additional travel and preparation costs may apply. Fee for Service Webinar Training Pricing: \$250.00 per hour, plus a \$150.00 charge for preparation for each web-based training for up to 50 participants. For webinars with more than 50 participants, an additional charge of \$25.00 applies for each additional 25 participants up to a maximum of 200 participants. Sessions less than one (1) hour in duration will count as one (1) hour of Training and Education. If Customer requests a specific educator, or an educator with specific qualities, including but not limited to specialized certifications, experiences or language, Customer will be billed any additional incurred fees beyond the hourly fee above or have hours deducted from bank. In addition, if Customer cannot accommodate the schedule/availability of a local Company contracted educator, requiring that the services of an educator 50 miles away or greater from the Customer location is necessary, then Customer will be billed any additional incurred fees beyond the hourly fee above or have hours deducted from bank.
Training and Education Cancellation Fee	Failure to provide Company six (6) business days' notice of cancellation of a previously scheduled training program may result in a charge of: Fee for Service Training Cancellation Fee: \$375.00 per hour for services which are provided on a fee for service basis and which are subject to the hourly rate.
Mental Health First Aid Training	Please contact your Account Executive for Mental Health First Aid pricing should you require these services. Corporate Level <i>6-Hour Course In-Person (30 participant maximum)</i> - This option provides six (6) hours of standard Mental Health First Aid curriculum. Fee includes all instructor fees, travel, and customization for delivery locations within continental United States. Additional travel and expenses may apply for delivery locations in Alaska and Hawaii. <i>4-Hour Course In-Person (30 participant maximum)</i>

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

Services	Service Fees
	- This option provides four (4) hours of standard Mental Health First Aid curriculum. Fee includes all instructor fees, travel, and customization for delivery locations within continental United States. Additional travel and expenses may apply for delivery locations in Alaska and Hawaii. <i>6-Hour Course – two hours self directed preparation + four hours instructor led training Virtual (15 participant minimum and maximum)</i> - This option provides six (6) hours (2 hours self-directed pre-work + 4 hours of instructor led training) of standard Mental Health First Aid curriculum. Fee includes all instructor fees and customization. <i>4-Hour Course Virtual (Minimum of 15 participants and Maximum of 25 participants)</i> - This option provides four (4) hours of standard Mental Health First Aid curriculum. Fee includes all instructor fees and customization. Mental Health First Aid Cancellation Fee Schedule If the Customer cancels for any reason within 30 days from the training date, the Customer will be responsible for cancellation fees as follows: • 50% of the total fee 15-30 days prior to the scheduled date of training. • 100% of the total fee 0-14 days prior to the scheduled date of training. Rescheduling Fee: 25% of the total fee 0-30 days prior to the scheduled date of the training.
Here4U Events	Fee for Service Here4U Event: \$700 per event per hour. Here4U event has a maximum capitation of 30 participants (Participant is defined as one individual logging into web-based platform). Rates are viable for 1 contract year. Failure to provide Company six (6) business days' notice of cancellation of a previously scheduled Fee for Service Here4U event will result in a charge of: • Fee for Service Here4U Cancellation Fee: \$550.00 per hour for services which are provided on a fee for service basis and which are subject to the hourly rate. Requests made to reschedule an event will be treated the same as a cancellation if not providing the sufficient six business days' notice. Please speak with your Account Executive if you have any questions regarding cancellation fees.
Drug Free Workplace Services	

EMPLOYEE ASSISTANCE PROGRAM SERVICES AGREEMENT

Services	Service Fees
Substance Abuse Case Management by a Substance Abuse Professional (SAP) and/or for Department of Transportation regulation compliance	\$750.00 per case
and	and
DOT training to meet Drug-Free Workplace regulations regarding drug and alcohol awareness	DOT Alcohol and Drug-Free Workplace for Supervisors Training to meet Drug-Free Workplace regulations regarding drug and alcohol use. Additional fees may be added on to the base rate for DOT training. These fees will be assessed on a case-by-case basis and are dependent upon travel expenses and for classes that exceed 50 participants. • DOT Supervisor Training - 2 hours at \$800 DOT Alcohol and Drug-Free Workplace for Employees Awareness Training (Note: this training does not meet Drug-Free Workplace regulations regarding drug and alcohol use.) Additional fees may be added on to the base rate for DOT training. These fees will be assessed on a case-by-case basis and are dependent upon travel expenses and for classes that exceed 50 participants. • DOT Employee Training - 1 hour at \$400

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

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

Pricing



City of Miramar

Renewal Rate Period begins 01/01/2026 and is effective for 36 months, subject to the enclosed financial conditions.

1,008 employees	Current PEPM Rate	Proposed Renewal PEPM Rate Standard
1-3-Session—Consultation and resource services with up to 3 face-to-face assessment and counseling sessions per issue. Unlimited 24/7/365 Telephonic Support Services Included.	\$1.39	\$1.39
Telephonic Worklife—Comprehensive worklife consultation and referral services, specializing in child care, elder care, care for persons with disabilities, convenience services, pet care and other needs that meet challenges faced by our members each day at home and work.	Included above	Included above
EAP Models Include		
Online Worklife—Web access to information and resources to assist with child care, home health care, assisted living facilities, schools, colleges, health clubs, pet services and more.		
Unlimited Legal Consultation—Members receive 30 minute Telephonic or Face-to-Face attorney consultations for an unlimited number of issues. Typical matters may include divorce and child custody, contractual and consumer disputes, real estate and landlord tenant, car accidents and insurance disputes. Also included is a telephonic or face-to-face mediation consultation. Certain topic areas are excluded, including employment law and claims against an employer or matters that, in the attorney's opinion, lack merit. There is a 25 percent discount with attorney or mediator beyond the initial 30 minutes. Also included are a free online will for all eligible dependents and a 10 percent discount for do-it-yourself/assisted document preparation for divorce forms, estate planning forms and immigration forms, and other similar issues.		
Unlimited Financial Consultation—Members receive 30 minute Telephonic Financial Consultations for an unlimited number of issues. Telephonic Financial Consultations are provided by staff financial counselors for Budgeting, Credit, Debt, Retirement, College Funding, Buying vs. Leasing, Mortgages/Refinancing, Financial Planning, and similar issues. Telephonic Tax Consultants are provided by staff CPA and Enrolled Agents for tax questions, tax preparation and IRS matters. Telephonic tax levy/garnishment resolution is provided as well.		
ID Theft Consultation—Up to a (1) hour telephonic fraud resolution consultation for victims of Identity theft provided by a staff Certified Fraud Resolution Specialist. This includes coaching and direction on prevention and restoring credit for victims of Identity theft as well as a free Identity theft emergency response kit for victims.		
Unlimited Management Referral—Our Management Referral Unit is staffed by licensed clinicians who are specially trained in resolving workplace issues. When an employee's situation mandates a formal management referral, we can help your managers and supervisors through every step of the referral process.		
Unlimited Management Consultation—Our Account Managers, Management Resource Consultants, and Training Consultants all stay abreast of the governmental regulations and maintain a broad base of knowledge to help formulate and update corporate policies. It's like adding expert consultants to your Human Resources Department - without the added expense.		
Communications—Targeted communication materials that educate supervisors, employees and dependents on the immediate and long-term impact provided through their EAP and Worklife benefits. These include tri-fold brochures and wallet cards; managers resource updates; posters; newsletters and bulletins; web articles, videos, and links to helpful and timely subject matter every month of the year. Company will provide reasonable quantities of printed materials in support of implementation and/or on an annual basis at Customer's request at no cost. Reasonable quantities are defined as up to 120% of the number of eligible Employees for items such as flyers or brochures; a quantity up to 5% of the number of eligible Employees for items such as posters; and a quantity of up to 20% of anticipated attendees at health fairs for other promotional items. Requests exceeding these quantities may incur an additional fee.		
Unlimited Crisis Response Services—Customized and designed to meet organizational and individual needs to minimize damage and return people to previous levels of productivity as soon as possible. An unlimited number of on-site incidents up to 10 hours per incident. Unlimited Crisis Response Services available for standard services and grief counseling. Crisis Response for immediate services, reductions in force, acts of terrorism, acts of war, and catastrophic natural disaster are excluded from unlimited services.		
Digital CBT included. A unique online emotional wellness portal. It can help your employees with mild or moderate depression and anxiety. Digital CBT offers practical ways to improve emotional and overall well-being through eLearning programs, simple tools, trusted resources and daily motivation.		

Fee For Service Options	Price
Crisis Response Services—Customized and designed to meet organizational and individual needs to minimize damage and return people to previous levels of productivity as soon as possible. Crisis Response Services are available for standard crisis services, immediate services, reductions in force, grief, acts of terrorism, and catastrophic natural disasters. Crisis Response Services are excluded for acts of war. Fee for service pricing beyond the unlimited services included above.	\$285 Per Hour - Standard Service \$385 Per Hour - Immediate Service
TRAINING AND EDUCATION: The term "Training and Education" refers to training, provided by Aetna, or an Aetna Contracted educator to the Customer, concerning general behavioral health and work/life issues. This includes Employee Orientation Meetings and Supervisor Orientation Trainings. This training may be provided in different ways, i.e. in-person, telephonically, or web-based delivery. For webinars with more than 50 participants, an additional charge of \$25.00 applies for each additional 25 participants up to a maximum of 200 participants. Department of Transportation (DOT) services are excluded from standard Training and Education services. For specialized DOT training, see separate definition under Drug Free Workplace Services.	\$300 Per Hour
Crisis Response Services travel and prep fee.	\$180 per Counselor
Training and Education services travel and prep fee. (If training is not scheduled consecutively or multiple topics are scheduled, additional travel and preparation costs may apply.)	\$150 per Counselor
Cancellation Fees: Crisis Response Services: Whenever possible, Customer agrees to provide Company with 48 hours advance notice of cancellation of any requested Workplace Crisis Response Services. Failure to provide Company with 48 hours' notice of cancellation of any services may result in a charge as summarized to the right. • Fee for Service CISD Cancellation Fee: Services which are provided on a fee for service basis and which are subject to the hourly rate will result in a charge of \$440.00 per incident. • Bank of Standard CISD and Training Hours Cancellation Fee: Services which are included in the bank of capitated hours described above, will result in the deduction of a number of hours from the bank, equal to the number of cancelled hours. • Unlimited Standard CISD Hours Cancellation Fee: Services which are excluded from the unlimited provision listed above, i.e. above the 10 hours per incident cap, immediate CISD services, downsizings, organizational changes, catastrophic natural disasters, and terrorism which are subject to the hourly rate will result in a charge of \$440.00 per incident. Training and Education: Failure to provide Company six (6) business days' notice of cancellation of a previously scheduled Training may result in a charge as summarized to the right: Bank of Training and Education Cancellation Fee: Services which are included in the bank of capitated hours described above, will result in the deduction of a number of hours from the bank, equal to the number of cancelled hours. Fee for Service Training Cancellation Fee: Services which are provided on a fee for service basis and which are subject to the hourly rate will result in a charge of \$375 per hour.	\$440 per incident for CISD \$375 per hour for Training services which are provided on a fee for service basis and which are subject to the hourly rate.
DOT Alcohol and Drug-Free Workplace for Supervisors Training to meet Drug-Free Workplace regulations regarding drug and alcohol use. Additional fees may be added on to the base rate for DOT training. These fees will be assessed on a case-by-case basis and are dependent upon travel expenses and for classes that exceed 50 participants. • DOT Supervisor Training - 2 hours at \$800 DOT Alcohol and Drug-Free Workplace for Employees Awareness Training (Note: this training does not meet Drug-Free Workplace regulations regarding drug and alcohol use.) Additional fees may be added on to the base rate for DOT training. These fees will be assessed on a case-by-case basis and are dependent upon travel expenses and for classes that exceed 50 participants. • DOT Employee Training - 1 hour at \$400	
Substance Abuse Professional (SAP) Services—The EAP shall provide initial and ongoing management consultation and referral for drug and alcohol cases that fall under the Department of Transportation (DOT) guidelines. We will refer the employee to a qualified SAP to conduct initial assessment and provide additional services as required. Services can include treatment recommendations, referral to an education/treatment program, compliance monitoring, SAP re-evaluation, and follow-up testing recommendations once the employee has been cleared to return to work.	\$750 per case

EAP Pricing Assumptions

A one-year minimum contract.

All employees and their dependents/household members are eligible for services.

Sessions counted on a per issue basis rather than a per year basis (Depending on the model purchased, members have access to as many as three or five face-to-face counseling sessions per issue per year—not three or five total sessions per annum.)

Rates are good for 60 days.

36 month rate guarantee.

Rates are dependent on employee population within 20% (+/-) of that quoted.

Quoted rates include coverage for the 50 US states only. Please inquire about rates in outlying territories.

From enrollment to daily savings, ALEX helps your members avoid costly benefits mistakes.

At the heart of ALEX is Benefits Counselor -- a personalized, virtual experience that improves benefits awareness by walking members through your major medical, vision, dental, voluntary benefits, and retirement plans. With ALEX, members have a human-based, engaging experience with just enough of a sense of humor to keep them interested - helping them overcome natural biases, make smarter decisions, and understand financial implications of picking a plan.

Once your members finish talking to ALEX, they'll have a recommendation for the best possible benefits choices for them and their families, understanding opportunities to save money along the way. ALEX identifies many of the common benefits pitfalls and steers members towards the right plans and decisions for them—based on their own personal health and finances. Far from a one-size-fits-all benefits decision tool, ALEX learns your members' family needs, chronic conditions, and more to deliver tailored advice all year round.

ALEX Annual Comprehensive Pricing	
Plan Sponsor	CITY OF MIRAMAR
Medical Eligible	1,202
ALEX Product Component	Essentials
ALEX Benefits Counselor and Go License	Included
2025/2026 Unique Plan Sponsor URL	Included
Decision Support and/or Education on: • Medical (Networks, Deductibles, HRA/HSA/FSA, OOPM, Preventive Care, Covered Procedures, Rx, individual Medicare education) • Health Funds (FSA/HSA guidance, Limited, Dependent Care, & Commuter FSAs) • Retirement • Dental • Vision • Life • AD&D • Disability • Voluntary Benefit Bundle including Accident, Critical Illness, and Hospital Indemnity • EAP • Pharmacy Savings • Three "More Benefits" text-only modules	Included
Jellyvision Implementation and Account Management	Included
Customer Success and Marketing Support	Included
Real Time Analytics Dashboard	Included
Employee Survey Verbatim Results	Included
Benefits Sneak Peek Videos (2) -- Open Enrollment + New Hire engagement	Included
ALEX Homepage	Not Included
ALEX Chat	Not Included
Smart Tips Videos (15)	Not Included
Total Proposed Fee - ANNUAL FEE	\$19,751

Billing of Fees

ALEX fees are claim wire billed to the plan sponsor on a one time basis once the tool(s) are launched, unless otherwise specified.

NOTE: Medical Eligible is the number of employees eligible for your company sponsored medical benefits across all insurance carriers. An adjustment to the final pricing will be made if there is an increase or decrease in the medical eligible employees of:

15 percent if you have less than 29,999 medical eligible employees

5 percent if you have more than 30,000 medical eligible employees

- **Benefits Counselor and Go** – Educate and engage employees on multiple benefits topics, from major medical to voluntary benefits – while ensuring employees avoid costly enrollment missteps.
- **Benefits Sneak Peek** – Give employees bite-sized servings of benefits plan information to get them thinking about their choices ahead of times.
- **Smart Tips Videos** – Give employees access to video tips that help them take full advantage of their benefits and educate them on benefits best practices.
- **Chat** – Provide instant answers to employees' top benefits questions with ALEX's smart, interactive chatbot that also promotes cost-savings tools.



City of Miramar
Inspira Financial Annual Renewal
January 1, 2026 – December 31, 2026

The upcoming plan year promises to be an exciting time, as we continue to implement system enhancements and update processes in our pursuit to provide exceptional customer service. A **rate pass** has been granted for all services that are currently being administered.

As you review this renewal package detailing our standard and optional services, please keep in mind our ability to offer additional services for a fee.

Please communicate immediately if you are considering canceling or terminating any services.

- Review the HSA renewal reminders and preparation tips within this package (HSA Renewal Readiness). Remember to terminate employees not staying in the plan for the new year. This can include members who opt out of an HDHP during open enrollment.
- If your plan includes debit cards, note that our debit card is good for five years after the issue date. A new card does not need to be issued each year.
- To ensure timely delivery of debit cards, please provide new elections 30 days prior to the start of the new plan year.

We look forward to another successful year, and providing the highest level of customer service possible.

Thank you,

Polly Snelgrove
Senior Account Manager

HSA Renewal Readiness

In an effort to improve the timeliness and quality of Health Savings Account (HSA) enrollment and contribution reporting, we would like provide you with some reminders for the upcoming year.

Contribution Year

HSA contributions are based on tax year. **Please update the Tax Year field on deposit files when reporting new-year contributions.**

File Reporting

Eligibility Files – Inspira Financial must receive new enrollments 30 days in advance of the new plan year, in order for employees to receive their debit cards prior to the plan start date. **If new enrollments are not received in time for the accounts to open on the first day of the new plan year**, those accountholders cannot reimburse themselves for claims incurred between the first day of the year and the date the account opens. Per IRS regulations, qualified medical expenses must be incurred on or after the date the HSA is established.

- Add new HSA enrollees to your eligibility file. You'll also do this when there is a rehired employee returning to the HSA plan.
- Existing employees staying in HSA for the new plan year do not need to be re-enrolled. Their status effective dates can remain the same.
- Terminate employees not staying in the HSA plan for the new year as per your file layout specifications. This can include employees who opt out of a High Deductible Health Plan (HDHP) during open enrollment.

Note: If the employee is staying in the HSA but moving to another division, do not report the employee as a termination. Please work with your Account Manager to transition the employee within the HSA plan.

Recoupment of Funds – On June 25, 2008, the Internal Revenue Service (IRS) issued [Notice 2008-59](#). This notice provided guidance on HSAs. This guidance allows for a plan sponsor to recoup funds in only two circumstances:

- An employee was never eligible for an HSA
- The contribution exceeds the statutory annual maximum

Negative Contributions – A plan sponsor cannot send a negative HSA contribution on a file. For assistance with any potential funding reversals, please reach out to your Account Manager for a full review of IRS regulations surrounding reversals.

Customer Identification Process (CIP)

The USA PATRIOT Act requires that any individual who enrolls in an HSA must pass the CIP before the account can open.

When an employee does not initially pass CIP, the account is set to a Failed Vetting status (i.e., not yet open). The employee will receive a letter from Inspira advising what is required to satisfy the CIP requirements. If the employee does not respond after three letters (90 days), Inspira will return all funds you have sent on behalf of that employee. Your Account Manager will send you a notification when this occurs.

- **ACH Debit:** Funds are pushed back to your corporate bank account on file.

- **ACH Credit or Fed Wire:** Funds are posted to your cash balance at Inspira to be taken as future credit.

Daily updates of the CIP report are available on the Employer Admin Site.

Debit Card / Welcome Package

Inspira sends a Welcome package to new accountholders upon passing CIP, which also contains their debit card.

Taxes

All HSA accountholders are required to complete IRS Form 8889 (Health Savings Account) as part of their federal income tax reporting. For help with Form 8889 and its instructions, please visit www.irs.gov. Inspira will provide the following tax documents:

- **Form 1099-SA** is used to report account distributions (payments) and the Fair Market Value (FMV) as of December 31 of the previous year. This form is issued by the end of January.
- **Form 5498-SA** is used to report contributions to the HSA, and the finalized Fair Market Value (FMV) as of December 31 of the previous year. This form is generally issued by the end of May, because accountholders are able to make corrections or additional contributions until Tax Day.

Inspira will mail the Form 1099-SA by January 31 of the following year and the Form 5498-SA by May 31 of the following year.

Accountholders should keep all receipts of purchases in case they are audited by the IRS.

The debit card has some merchant restrictions on purchases. If the accountholder uses HSA funds for non-qualified expenses, they will have to pay income taxes and a 20% tax penalty on that amount.

Statutory Contribution Max for 2026

Accountholders can contribute up to the statutory limit, regardless of the health plan deductible amount.

HDHP Minimum Deductible Amount	
Individual	\$1,700
Family	\$3,400
HDHP Maximum Out-Of-Pocket Amount	
Individual	\$8,500
Family	\$17,000
HSA Statutory Contribution Maximum	
Individual	\$4,400
Family	\$8,750
HSA Catch-Up Contribution	
For individuals 55 or older, until enrolled in Medicare	+\$1,000

- Eligible accountholders who are age 55 and older can make a catch-up contribution to their HSA. As long as they do not yet have Medicare coverage, they can contribute an additional \$1,000.
- If each spouse is eligible to make a catch-up contribution, they must make the additional contribution to their own HSA.
- Some employees may have enrolled in the HDHP after January 1 (i.e., new hire, status change). If those employees are still eligible on December 1, they may contribute to the HSA as if they were eligible for the full year. With this Last-Month Rule, the employees must remain eligible from December 1 through the end of the next year. This is the “testing period.” If an employee does not keep their eligibility during the testing period, the contributions for the months they were not actually eligible are subject to income taxes and penalties. Employees in this situation should speak with a tax advisor.

Please do not hesitate to contact your Account Manager with any questions or concerns.

Inspira Financial Health Savings Account

City of Miramar

January 1, 2026 – December 31, 2026

	Fee
Implementation Fee	\$0.00
*Annual Fee	\$0.00
**Monthly Fee	
Monthly Administration Fee Per Member	\$2.35
Minimum Monthly Billing	\$0.00 per employer per month

Optional Service Fees	
Types of Communication Assistance	
Onsite Enrollment Meeting Support Less than 500 eligible or more than one meeting for groups with 500 plus eligible 500-5,000 eligibles 5,001+ eligibles	\$500.00 per event One free day based on availability, then \$500/day for each additional day As negotiated
Customized Website (with or without single sign on from another site) Lead time: 90 days Cut-off for January 1 business is September 15	\$150 per hour Statement of Work required.
Single Sign On (SSO) to <u>Generic</u> Inspira Member Website (assumes Inspira standard for web service call) Lead time: 60 days	No charge
Customized Member Flyers (revisions to generic member flyers) Lead time: 5 weeks	\$1,000 per flyer Includes two rounds of edits, plus printing and shipping costs, if needed.
Customized Member Letters Lead time: 5 weeks *System-generated • HSA Vetting Communications • Vetting success confirmation email* • Vetting failure letter - first letter • Vetting failure letter - second letter • Vetting failure letter - final letter	\$1,500 per letter, plus mailing costs. Includes two rounds of edits.
Co-Branded Debit Card Lead time: 5 weeks Cut-off for January 1 business is October 15	\$500 for front logo. Custom URL/phone on the back of the card is an additional \$500. Rush request and/or requests after 10/15 for 1/1 fulfillment is an additional \$150 per hour. Minimum of three hours charged. \$10 per card for plan sponsor requested re-issues due to plan changes.

Customized Welcome Flyers to Accompany Inspira Card Lead time: 5 weeks Cut-off for January 1 business is October 15 Rush requests and/or requests after October 15 for January 1 fulfillment is an additional \$150/hour (minimum of three hours charged) *Quantity determined based on number of Members. Upon restocking, quantity may be re-evaluated	\$3,000 flat fee Includes two rounds of edits, plus recurring printed/fulfillment fees. Minimum order is 10k. <table> <tr> <td>Quantity*</td><td>Price Per Thousand</td></tr> <tr> <td>10,000 to 24,000</td><td>\$250 / M</td></tr> <tr> <td>25,000 to 50,000</td><td>\$150 / M</td></tr> <tr> <td>51,000 +</td><td>\$100 / M</td></tr> </table>	Quantity*	Price Per Thousand	10,000 to 24,000	\$250 / M	25,000 to 50,000	\$150 / M	51,000 +	\$100 / M
Quantity*	Price Per Thousand								
10,000 to 24,000	\$250 / M								
25,000 to 50,000	\$150 / M								
51,000 +	\$100 / M								
Customized PowerPoint Lead time: 6 to 8 weeks	Cost based on Statement of Work (required) Includes three rounds of edits. Typically includes up to 20 slides, up to five minutes of content, and three rounds of script/voiceover reviews.								
Development of Customized Communications (brocures, flyers, email campaigns) Lead time: Varies based on type of communication	Cost based on Statement of Work (required), plus printing and shipping costs if applicable.								
Miscellaneous Fees									
Customized Reporting	\$150.00 per hour, Statement of Work required.								
Rejected / NSF Customer Funding ACH Transactions	\$50.00 per occurrence of any plan sponsor funding ACH pull that is rejected.								
Non-discrimination testing	TBD based on testing requirements.								
*Annual fee includes upon written request: - Standard enrollment materials, limited to the number of eligible employees - Electronic sample of a Plan Document and Summary Plan Description - Fee shall remain unchanged during the initial term of the Agreement; thereafter fees are subject to change every twelve (12) months.									

Inspira Product Offerings

At Inspira, we make it simple to plan, save, and pay for personal well-being

With more than 30 years of experience dedicated to the healthcare industry, you can count on Inspira to bring consultative expertise to your health benefits program. We serve the unique needs of more than 3,200 clients, and our 92% retention rate demonstrates our ability to deliver service excellence to plan sponsors and members.

As you carefully weigh your options, we know you have your employees' best interests in mind, as well as the financial health of your organization.

Inspira understands your needs are unique, with distinct priorities and goals. Our full-service suite offers your company flexibility, while our transformative portfolio is focused on empowering individuals on the path to personal well-being – all while increasing their purchasing power.



FSA | 1987



Members contribute pre-tax dollars from paychecks to Medical/Limited Medical, Adoption, and Dependent Care FSA.

COBRA | 1995



Our well-trained team will help reduce your company's risk for this complex set of regulations.

Direct Billing | 1998



Direct Billing offers our plan sponsors a solution to bill individuals no longer on payroll who need a billing solution.

Commuter | 2001



Our online solution helps save money on eligible transit and parking expenses for members' commute to and from work.

HRA | 2003



The HRA is an account funded by the plan sponsor. Members use these funds to pay for eligible healthcare expenses.

Tuition | 2004



Tuition accounts are extremely flexible, allowing our plan sponsors to determine eligibility requirements.

HSA | 2006



Our HSA is designed to help pay for current eligible healthcare costs and save for future healthcare expenses.

Wellness | 2020



Lifestyle spending accounts allow plan sponsors to offer well-being dollars to employees.

Emergency savings fund | 2023



Save for the unexpected with automated paycheck deductions, the option for employer contributions, and simple, anytime sign-up.

MASTER SERVICES AGREEMENT
MSA- 737553

This master services agreement ("**Agreement**") between **AETNA LIFE INSURANCE COMPANY**, located at 151 Farmington Avenue, Hartford, Connecticut ("**Aetna**"), and **CITY OF MIRAMAR**, a Florida corporation, located at 2300 Civic Center Place, Miramar, Florida 33025 ("**Customer**") is effective as of January 1, 2021 ("**Effective Date**").

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

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

The parties therefore agree as follows:

1. TERM

The initial term of this Agreement will be three years beginning on the Effective Date. This Agreement may be renewed for two (2) additional one (1) year periods unless otherwise terminated pursuant to section 17 (Termination). The initial and each successive one year renewal shall be considered an "**Agreement Period**". The schedules may provide for different start and end dates for certain Services.

In addition to any renewal, the Customer's Chief Procurement Officer may authorize up to a ninety-day (90-day) extension of this Agreement in accordance with the terms and conditions of this Agreement; and the Customer's City Manager or his/her designee is authorized to extend this Agreement for operational purposes only, for a maximum of one hundred eighty (180) days in accordance with the terms and conditions of this Agreement. Any further extensions of such Agreement require the mutual approval of the City Commission and Aetna.

2. SERVICES

Aetna shall provide the Services described in the attached schedules.

3. STANDARD OF CARE

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

4. SERVICE FEES

The Customer shall pay Aetna the fees according to the Service and Fee Schedule(s) ("**Service Fees**"). Aetna may change the Services and the Service Fees annually by giving the Customer 30 days' notice before the

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

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

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

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

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

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

6. FIDUCIARY DUTY

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

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

Claim fiduciary responsibility is identified in the applicable Schedule.

7. CUSTOMER'S RESPONSIBILITIES

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

be kept by Aetna for a minimum of seven years, unless Aetna turns such documentation over to the Customer or a designee of the Customer.

9. CONFIDENTIALITY

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

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

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

- (A) **Plan Participant Information** - Each party will maintain the confidentiality of Plan Participant-identifiable information, in accordance with applicable law and, as appropriate, the terms of the HIPAA business associate agreement associated with this Agreement. The Customer may identify, in writing, certain Customer employees or third parties, who the Plan has authorized to receive Plan Participant-identifiable information from Aetna in connection with Plan administration. Subject to more restrictive state and federal law, Aetna will disclose Plan Participant-identifiable information to the Customer designated employees or third parties. In the case of a third party, Aetna may require execution by the third party of a non-disclosure agreement reasonably acceptable to Aetna. The Customer agrees that it will only request disclosure of PHI to a third party or to designated employees if: (i) it has amended its Plan documents, in accordance with 45 CFR 164.314(b) and 164.504(f)(2), so as to allow the Customer designated employees or third parties to receive PHI, has certified such to the Plan in accordance with 45 CFR 164.504(f)(2)(ii), and will provide a copy of such certification to Aetna upon request; and (ii) the Plan has determined, through its own policies and procedures and in compliance with HIPAA, that the PHI that it requests from Aetna is the minimum information necessary for the purpose for which it was requested.
- (B) **Upon Termination** - Upon termination of the Agreement, each party, upon the request of the other, will return or destroy all copies of all of the other's Business Confidential Information in its possession or control except to the extent such Business Confidential Information must be retained pursuant to applicable law or cannot be disaggregated from Aetna's databases. Aetna may retain copies of any such Business Confidential Information it deems necessary for the defense of litigation concerning the Services it provided under this Agreement, for use in the processing of runoff claims for Plan benefits, and for regulatory purposes.

respect to those overpayments. The Customer shall reasonably cooperate with Aetna in recovering all overpayments of Plan benefits.

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

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

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

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

12. INDEMNIFICATION

- (A)** Aetna shall indemnify the Customer, its affiliates and their respective directors, officers, and employees (only as employees, not as Plan Participants) for that portion of any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees) ("**Losses**") caused directly by (i) any material breach of this Agreement by Aetna, including a failure to comply with the standard of care in section 3; (ii) Aetna's negligence, willful misconduct, fraud, or breach of fiduciary responsibility; or (iii) Aetna's infringement of any U.S. intellectual property right of a third party, arising out of the Services provided under this Agreement.
- (B)** The Customer shall indemnify Aetna, its affiliates and their respective directors, officers, and employees for that portion of any Losses caused directly by (i) any material breach of this Agreement by the Customer including a failure to comply with the standard of care in section 3; (ii) the Customer's negligence, willful misconduct, fraud, or breach of fiduciary responsibility; (iii) the release or transfer of Plan Participant-identifiable information to the Customer or its designee, or the use or further disclosure of such information by the Customer or such designee; or (iv) in connection with the design or administration of the Plan by the Customer or any acts or omissions of the Customer as an employer or Plan Sponsor.

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

14. REMEDIES

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

15. BINDING ARBITRATION OF CERTAIN DISPUTES

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

16. COMPLIANCE WITH LAWS

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

17. TERMINATION

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

(A) **Termination by the Customer** – The Customer may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving Aetna at least 30 days' prior written notice of when such termination will become effective.

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

(1) Aetna may terminate this Agreement, or the Services provided under one or more schedules, for any reason, by giving the Customer at least 30 days' prior written notice of when such termination will become effective.

IP"). Aetna has granted the Customer a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in this Agreement. Customer agrees not to modify, create derivative product from, copy, duplicate, decompile, disassemble, reverse engineer or otherwise attempt to perceive the source code from which any software component of the Aetna IP is compiled or interpreted. Nothing in this Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent or otherwise transfer or convey, the Aetna IP to the Customer.

- (C) **Notice** - Notices from Aetna to the Customer under this agreement are valid when delivered, in writing, to the Customer's email address provided at the time this contract was entered into (or such subsequent email address as the Customer has provided to Aetna by notice). Notices from the customer to Aetna are valid when delivered, in writing, to the Customer's Aetna account representative.
- (D) **Force Majeure** – With the exception of the Customer's obligation to fund benefit payments and Service Fees, neither party shall be deemed to have breached this Agreement, or be held liable for any failure or delay in the performance of any portion of its obligations under this Agreement, including performance guarantees if applicable, if prevented from doing so by a cause or causes beyond the reasonable control of the party. Such causes include, but are not limited to: acts of God; acts of terrorism; pandemic; fires; wars; floods; storms; earthquakes; riots; labor disputes or shortages; and governmental laws, ordinances, rules, regulations, or the opinions rendered by any court, whether valid or invalid.
- (E) **Governing Law** - The Agreement shall be governed by and interpreted in accordance with applicable federal law. To the extent such federal law does not govern, the Agreement shall be governed by Florida law.
- (F) **Financial Sanctions** – If Plan benefits or reimbursements provided under this Agreement violate, or will violate any economic or trade sanctions, such Plan benefits or reimbursements are immediately considered invalid. Aetna cannot make payments for claims or Services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written office of Foreign Assets Control (OFAC) license.
- (G) **Waiver** - No delay or failure of either party in exercising any right under this Agreement shall be deemed to constitute a waiver of that right.
- (H) **Third Party Beneficiaries** - There are no intended third party beneficiaries of this Agreement.
- (I) **Severability** – If any provision of this Agreement or the application of any such provision to any person or circumstance shall be held invalid, illegal or unenforceable in any respect by a court of competent jurisdiction, such invalidity, illegality or unenforceability shall not affect any other provision of this Agreement and all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect.

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

CITY OF MIRAMAR

Aetna Life Insurance Company

By: _____

Name: _____

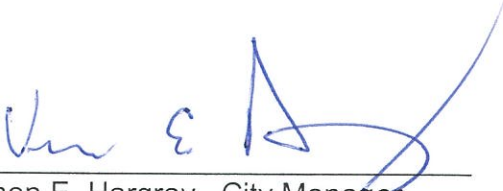
Title: _____

Karen S. Lynch
By: _____

Name: Karen S. Lynch

Title: President, Aetna Life Insurance
Company

CITY OF MIRAMAR, FLORIDA

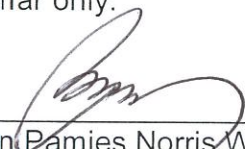
By: 

Vernon E. Hargray, City Manager

ATTEST:


Denise A Gibbs, City Clerk

Approved as to form and legal sufficiency
for the use of and reliance by the City of
Miramar only:

By 

Austin Pamies Norris Weeks Powell, PLLC
City Attorney

(TYPE DEPARTMENT, INITIALS OF THE TYPIST, NAME OF THE AGREEMENT)

2. MEMBER SERVICES:

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

3. PLAN SPONSOR SERVICES:

- (A) Aetna shall assign an experienced Account Management Team to the Customer's account. This team will be available to assist the Customer in connection with the Services provided under the Agreement.
- (B) Aetna shall design and install a benefit-account structure separately by class of employees, division, subsidiary, associated company, or other classification reasonably requested by the Customer.
- (C) Aetna shall assist the Customer in connection with the design of the Customer's Plan, including actuarial and underwriting support reasonably requested by the Customer, provided that the Customer shall have ultimate responsibility for the content of the Plan and compliance with law in connection therewith.
- (D) Aetna shall make employee identification cards available to Plan Participants. Upon request, Aetna will arrange for the custom printing of identification cards, with all costs borne by the Customer.
- (E) Upon request of the Customer, Aetna shall provide the Customer with information reasonably available to Aetna relating to the administration of the Plans which is necessary for the Customer to prepare reports that are required to be filed with the United States Internal Revenue Service and Department of Labor.
- (F) Aetna shall provide the following reports to the Customer for no additional charge:
 - (1) Monthly/Quarterly/Annual Reports - Aetna shall prepare the following reports in accordance with the benefit-account structure for use by the Customer in the financial management and administrative control of the Plan benefits:
 - (a) a monthly listing of funds requested and received for payment of Plan benefits;
 - (b) a monthly reconciliation of funds requested to claims paid within the benefit-account structure;
 - (c) a monthly listing of paid benefits;
 - (d) online access to monthly, quarterly and annual standard claim analysis reports; and
 - (e) if applicable, monthly, quarterly, or annual HealthFund product reports for customers with at least 100 enrolled lives in each HealthFund to be used for the financial evaluation and management of each HealthFund plan.
 - (2) Annual Accounting Reports - Aetna shall prepare standard annual accounting reports detailing product specific financial and plan information including enrollment fees and/or rates for each Agreement Period.

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

- (C) Retroactive adjustments are occasionally made to Aetna's contract rates. Retroactive adjustments may occur, for example, when the federal government does not issue cost of living data in sufficient time for an adjustment to be made on a timely basis, or because contract negotiations were not completed by the end of the prior price period or due to contract dispute settlements. In all cases, Aetna shall adjust the Customer's payments accordingly. The Customer's liability for all such adjustments shall survive the termination of the Agreement.
- (D) Aetna may contract with vendors who in turn are responsible for contracting with the providers who perform the health care services, and potentially for certain other services related to those providers such as claims processing, credentialing, and utilization management. Under some of these arrangements, the vendor bills Aetna directly for those services by its network of providers at the vendor's contracted rate with Aetna, and Aetna pays the vendor for those services. In certain cases, the amount billed by the vendor to Aetna, paid pursuant to the plan, includes an administrative fee for delegated services by the vendor. As a result, the amount the vendor pays to the health care provider through the vendor's contract with the provider may be different than the amount paid pursuant to the Plan because the allowed amount under the Plan will be Aetna's contracted rate with the vendor, and not the contracted amount between the vendor and the health care provider.
- (E) Aetna reserves the right to set a minimum plan benefit design structure for in-area network claims to which the Customer must comply in order to access a particular Aetna network.
- (F) Aetna shall maintain an online directory containing information regarding Network Providers. Upon request and for an additional charge, Aetna shall provide the Customer with paper copies of physician directories.
- (G) Aetna makes no guarantee and disclaims any obligation to make any specific health care providers or any particular number of health care providers available for use by Plan Participants or that any level of discounts or savings will be afforded to or realized by the Customer, the Plan or Plan Participants.
- (H) Customer agrees to comply with all of the applicable terms of Aetna's network provider contracts.

5. NON-DIRECT NETWORKS

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

**MEDICAL AND HSA
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT- 737553
EFFECTIVE January 1, 2021**

The Service Fees and Services effective for the period beginning January 1, 2021 and ending December 31, 2021 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

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

	Aetna Choice POS II	Open Access Aetna Select
Programs & Services		
Mature Base Service Fee	\$25.00	\$25.00
Implementation, Account Management & Plan Administration		
Designated Account Management Team	Included	Included
Designated Implementation Manager	Included	Included
Onsite Open Enrollment Meeting Preparation	Included	Included
Open Enrollment Marketing Material (Standard) Onsite Meeting Preparation	Included	Included
Standard ID Cards	Included	Included
Summary of Benefits and Coverage (SBC)	Included	Included
Claim Fiduciary Option 1	Included	Included
Network Services		
Institutes of Quality [®] (IOQ) Program	Included	Included
National Medical Excellence Program [®] - Transplant Coordination	Included	Included
Care Management		
Aetna Compassionate Care SM Program	Included	Included
Aetna Health Connections SM - Disease Management	Included	Included
MedQuery [®] Member Messaging	Included	Included
Personal Health Record	Included	Included
Utilization Management	Included	Included
Aetna Maternity Program	Included	Included
Transitional Care Management	Included	Included
Member Resources		
Member Website and Mobile Experience	Included	Included
MindCheck SM	Included	Included
Wellness		

Coordination of Benefits and other contracted services	Up to 37.5% of recovered amounts will be retained.	Up to 37.5% of recovered amounts will be retained.
Third Party Claim and Code Review Program	Up to 37.5% of recovered amounts will be retained.	Up to 37.5% of recovered amounts will be retained.

The following standard programs/services are also included:

Care Management 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
▪ Aetna's Compassionate Care SM Program	Included
▪ ACCP Enhanced Hospice Benefits Package	Included
▪ National Medical Excellence/ Institutes of Excellence	Included
▪ Informed Health Line Nurseline 1-800# Only	Included
▪ Simple Steps To A Healthier Life [®]	Included
▪ RedBrick Compass TM	Included
Behavioral Health Services	
▪ Managed Behavioral Health	Included
▪ Behavioral Health Condition Management	Included
Technology/Web Tools	
▪ Online Provider Directory	Included
▪ Secure Member Portal	Included
▪ Health Decision Support (Basic)	Included
Aetna Subrogation Program	Included, 37.50 % of recovered amount will be retained

Monthly administration fee per
member per month (PMPM)

\$2.35

- Debit card included
- Contract period — three years
- Pricing quotations expire 90 days after the initial proposal publication date

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

Optional Services	Fee
PayFlex Enrollment Meeting Support • Less than 500 eligible employees or more than 1 meeting • 500-5,000 eligible employees • 5,000 + eligible employees	• \$500 per event, based on availability • 1 free day based on availability, then \$500 per day for each additional day • 2 free meetings based on availability, \$500 per day for each additional day
Single Sign On (SSO) to <u>generic</u> PayFlex member website (Assumes PayFlex standard for web service call) Lead-time: 60 days	No Charge
Customized Member Flyers and quick reference guides (QRGs) (Revisions to generic member flyers) Lead-time: 5 weeks	\$1,000 per flyer Plus printing and shipping costs if needed. Includes two rounds of edits.
Customized Member communication Lead time: 5 weeks • HSA Vetting Communications ○ Vetting success confirmation e-mail* ○ Vetting failure letter – first letter ○ Vetting failure letter – second letter ○ Vetting failure letter – final letter *System-generated	Costs based on Statement of Work Plus printing and shipping costs if needed. Includes two rounds of edits.
Co-Branded Debit Card Lead-time: 5 weeks Cut-off for 1/1 business is 10/15	\$750.00

Claim Payment
A material change in claims payment requirements or procedures, account structure, or any other change materially affecting the manner or cost of paying benefits (whether initiated by you or by legislative or regulatory action).
Contract Provisions
The final benefit provisions, account structure, claim payment requirements or services change from those proposed.
Customized Banking
You require the need for a customized banking agreement and additional wire lines (administrative fees only).
Enrollment
There is a 10.0% percent decrease in the number of enrolled participants in aggregate from our enrollment assumptions or from any subsequent reset enrollment.
Legislative Impact
Legislation, regulation or requests of government authorities result in material changes to plan benefits, we reserve the right to collect any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.
Maximum Account Structure
If maximum account structure per product exceeds the number of units illustrated in the table below. Account structure determines the reporting format. During the installation process, we will work with the Plan Sponsor to finalize the account structure and determine which report formats will be most meaningful. Maximum total account structure includes Experience Rating Groups (ERGs), controls, suffixes, billing and claim accounts.
Total Employees (Aetna Select, Choice POS II) Maximum Total Structure Per Product
Less than 1000 60
Member/Subscriber Ratio
The member-to-employee ratio increases by more than 10% . We have assumed a member-to-employee ratio of: 1.94 for the Choice POS II
NAP
If the National Advantage™ Program (NAP), Facility Charge Review (FCR) or Itemized Bill Review (IBR) programs are changed or terminated.
Plan Change
A material change in the plan of benefits is initiated by the Plan Sponsor or by legislative or regulatory action.
Financial Guarantees
If one or more of the circumstances identified above occurs, then the additional financial guarantees between us including, but not limited to, discount guarantees, rebate guarantees and claim-based performance guarantees may also be modified or terminated in accordance with the financial conditions contained in those documents.
Quoted Benefits
A material change in the plan of benefits offered, or a change in claim payment requirements or procedures, or a change in state premium taxes or assessments, or any other changes affecting the manner or cost of providing coverage that is required because of legislative or regulatory action.

Value-Based Contracting

A. Introduction to Value-Based Contracting

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

- a. Provider earns \$100,000 performance-based compensation for the 12-month period January to December;
 - b. All plan sponsors, combined incurred \$8,500,000 in claims with the provider for the 12-month period January to December;
 - c. Plan sponsor incurred \$150,000 in claims with the provider for the 12-month period January to December;
 - d. Plan sponsor's share of claims costs is $(\$150,000/\$8,500,000) = 1.7647\%$. Formula: (Plan sponsor incurred claims/All plan sponsors incurred claims);
 - e. Plan sponsor's share of the \$100,000 performance-based compensation is $1.7647\% * \$100,000 = \$1,764.70$, which would be processed as a claim through ordinary self-funded banking channels.
2. Patient Centered Medical Home and Accountable Care Organization. Percentage of member months:
Achieving agreed upon clinical and efficiency goals as measured by performance year end to performance year baseline or an industry standard.
- a. Provider earns \$100,000 performance-based compensation for the 12-month period January to December;
 - b. All plan sponsors, combined had 100,500 member months with the provider for the 12-month period January to December;
 - c. Plan sponsor had 9,500 member months(for 850 unique members) attributed to the provider for the 12-month period January to December;
 - d. Plan sponsor's share of the member months is $(9,500/100,500) = 9.4527\%$. Formula: (Plan sponsor member months/All plan sponsors months);
 - e. Plan sponsor's share of the \$100,000 performance-based compensation is $(9.4527\% * \$100,000) = \$9,452.73$, which would be processed as a claim through ordinary self-funded banking channels.
3. Patient Centered Medical Home and Accountable Care Organization. Number of Members:
In addition to Example 2 above, a quarterly Accountable Care Payment (ACP) may be made to the provider to fund activities necessary to meet the financial and clinical objectives. These are paid quarterly either during, or after the end of each quarter. The financial impact is considered in the total financial package negotiated with the provider.
- a. We determine the attributed patients for the provider for the quarter April through June;
 - b. Plan sponsor had 850 members attributed to the provider for the quarter April through June;
 - c. ACP and FFS payments are incorporated into the final analysis of provider performance against the medical claims target;
 - d. We apply the agreed upon rate to the attributed patients; i.e. \$2.00 per-member, per-month (PMPM) = \$6.00 per quarter per member, to determine funding to the provider;

**PRESCRIPTION DRUG
SERVICE AND FEE SCHEDULE
TO THE MASTER SERVICES AGREEMENT- 737553
EFFECTIVE January 1, 2021**

The Service Fees and Services effective for the period beginning January 1, 2021 and ending December 31, 2023 are specified below. They shall be amended for future periods, in accordance with section 4 of the Agreement. Any reference to "Member" shall mean a Plan Participant as defined in the Agreement.

RETAIL			
	01/01/2021	01/01/2022	01/01/2023
Brand Discount	AWP - 18.10%	AWP - 18.20%	AWP - 18.30%
Generic Discount	AWP - 80.20%	AWP - 80.40%	AWP - 80.60%
Dispensing Fee	\$1.10 per script	\$1.10 per script	\$1.10 per script

MAIL ORDER PHARMACY/MAINTENANCE CHOICE			
Mail Benefit Type	Mandatory Maintenance Choice with Opt Out		
	01/01/2021	01/01/2022	01/01/2023
Brand Discount	AWP - 24.10%	AWP - 24.20%	AWP - 24.30%
Generic Discount	AWP - 82.60%	AWP - 82.80%	AWP - 83.00%
Dispensing Fee	\$0.00 per script	\$0.00 per script	\$0.00 per script

AETNA SPECIALTY PHARMACY			
Network	Aetna Specialty Network		
Price List	Preferred Plus		
	01/01/2021	01/01/2022	01/01/2023
Discount	AWP – 18.00%	AWP – 18.10%	AWP – 18.20%

REBATES			
Formulary	Aetna Standard Formulary		
Plan Design	2 Tier		
Rebate Terms	Customer will receive the following guaranteed rebates:		
	01/01/2021	01/01/2022	01/01/2023
Retail	\$115.82 Per Brand Script	\$130.46 Per Brand Script	\$130.46 Per Brand Script
Mail Order	\$394.28 Per Brand Script	\$450.41 Per Brand Script	\$450.41 Per Brand Script
Specialty Non-Hepatitis C	\$1,407.02 Per Brand Script	\$1,655.44 Per Brand Script	\$1,655.44 Per Brand Script
Specialty Hepatitis C	\$7,778.23 Per Brand Script	\$7,778.23 Per Brand Script	\$7,778.23 Per Brand Script

- Biosimilar Drug Claims.
- The following are priced as stated below:
 - New to market Specialty Products will be priced at AWP - 15% or MAC, if applicable
 - New to market limited distribution drugs will be priced at AWP - 10%.
- Our financial offer does not assume any adoption of the Livongo Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.
- Rebate guarantees may be subject to:
 - The adoption of Specialty Guideline Management (SGM) program.
 - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
- The above rebate guarantees exclude:
 - Over the Counter (OTC) Claims
 - Exclusive Distribution and limited distribution drug (LDD) Claims
 - 340B Claims
 - Compound Drug Claims
 - Paper or Member Submitted Claims
 - Coordination of Benefits (COB) or secondary payor Claims
 - Vaccine and vaccine administration Claims
 - Biosimilar Claims
 - Claims approved by Formulary Exception
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty rebate guarantees apply to Specialty Product claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:
 - Two-tier qualifying plan designs - will consist of an open plan design, with the first tier comprised of Generic Drugs and the second tier comprised of Brand Drugs. There are no requirements for a minimum Cost Share differential between these tiers. The plan design may need to implement formulary interventions recommended by Aetna.
 - Three-tier non-qualifying plan designs – maintain a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs.
 - Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a \$15.00 co-payment differential between preferred and non-preferred Brand Drugs, at least a \$15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).
- We are providing a separate rebate guarantee for the specialty brand drug claims within the Hepatitis C therapeutic class. Rebate guarantees are conditioned upon Harvoni, Epclusa, and Vosevi as the preferred formulary drugs for Hepatitis C treatment with at least 95% drug claim share, all other drugs are excluded or non-preferred, coverage is provided for all fibrosis scores (F0/F1-F4), utilization management criteria aligns with drug labeling, and Customer is not utilizing starter or split fill programs.
- Plan design and benefits must be finalized 60 days prior to the effective date to support mailing of impacted members moving to Aetna's Standard Formulary. Less than 45 day notice of acceptance of the Aetna Standard formulary renewal quote may require implementation of a temporary benefit design until benefits are ready. This will not interrupt claims adjudication and service to members.

Additional Disclosures

Formulary Management

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

Other Payments

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

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

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

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

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

Early Termination

**MEDICAL AND HSA SERVICES SCHEDULE
TO THE MASTER SERVICES AGREEMENT- 737553
EFFECTIVE January 1, 2021**

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

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

I. CLAIM FIDUCIARY

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

II. EXTERNAL REVIEW

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

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

of alternate care settings and identification of care needed after discharge. The goal is to provide continuing quality of care and to avoid delay in discharge due to lack of outpatient support.

d. Retrospective Review:

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

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

2. Case Management Programs:

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

Aetna targets two types of case management opportunities:

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

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

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

4. Specialty Case Management Programs:

- **Aetna Compassionate CareSM Program ("ACCP")** - The Aetna Compassionate Care Program provides additional support to terminally ill Plan Participants and their families. It removes barriers to hospice and provides more choices for end-of-life care so that the Plan Participant is able to spend time with family and friends outside a hospital setting.
- **ACCP Enhanced Hospice Benefits Package** - The enhanced hospice benefits package includes the following:
 - The option for a Plan Participant to continue to seek curative care while in hospice
 - The ability to enroll in a hospice program with a 12-month terminal prognosis
 - The elimination of the current hospice day and dollar maximum plan limits
 - Respite and bereavement services are included as part of the enhanced hospice benefits. The hospice services provided through a hospice regularly include these services and are coordinated by the hospice agency providing care and the Aetna nurse case manager who precertifies care for the Plan Participant. In addition, bereavement services are available through the Aetna Employee Assistance Program ("EAP") for Customers without an EAP vendor.
 - Bereavement counseling shall be available to Plan Participants upon loss of a loved one, and to family and caregivers of a Plan Participant enrolled in ACCP following the death of such Plan Participant.
- **Infertility Case Management:** - Aetna operates two types of infertility programs:
 - **Basic Infertility Program** coordinates covered diagnostic services and treatment of the underlying medical causes of infertility, helps Plan Participants understand complex infertility treatments and helps control treatment costs through care coordination and patient education.
 - **Infertility Case Management Program** provides education and information resources for Plan Participants who are experiencing infertility. Depending on the plan selected, the program may guide eligible Plan Participants to a select network of infertility providers for covered or non-covered services. If the services are covered, Aetna's Infertility Case Management Unit issues any appropriate authorizations required under the Plan.

5. National Medical Excellence Program®/Institutes of Excellence™ /Institutes of Quality®:

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

- **The Aetna Institutes of Excellence (IOE) transplant network** was established to enhance quality standards and lower the cost of transplant care for Plan Participants. It is made up of a select group

is commonly derived from claims data collected during plan administration activities. Health information may be supplemented with information entered by the Plan Participant.

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

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

9. Aetna Maternity Program:

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

10. Informed Health® Line:

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

The range of available service components options include:

- **Nurse Information line 1-800# Only.** This includes toll-free telephone access to the Informed Health Line.
- **Service Plus.** (optional additional purchase) Includes toll-free access to the Informed Health Line; introductory program announcement letter, reminder postcards mailed directly to Employee's homes; and semi-annual activity utilization report.
- **Service Green** (optional additional purchase) IHL Service Green is an environmentally friendly version of the Service Plus option. It provides the same level of service and availability as Service Plus but instead of mailing postcards and reminders, email is used.

administration through gift cards and credits to Employee's Health Reimbursement Arrangements (HRAs) and Health Incentive Credit (HIC) accounts.

14. Get ActiveSM Program:

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

15. Aetna Informed Rewards

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

16. Enhanced Clinical Review:

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

17. Aetna Oncology SolutionsSM:

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

18. Lifestyle and Condition Coaching:

- ActiveChallenge program (buy-up option)

20. Aetna One® Advocate:

Aetna One® Advocate is a high-touch, high-tech customer service model that combines data driven processes with the expertise of highly-trained advocates. The data that Aetna has about each Plan Participant such as medical claims, lab values, pharmacy data, precertification requests and provider relationships is combined with information from Plan Participants regarding their preferred method of communication (i.e. phone calls, emails, text messages), and the Plan Participant is paired up with an advocate team. Advocate teams may include concierge-level benefits specialists, nurses, wellbeing professionals, and provider network experts, and are all cross-trained to provide support from benefit questions to complex care management. Advocates also work directly with other internal resources or programs, external vendors and network providers to support Plan Participant and their families.

V. BEHAVIORAL HEALTH SERVICES

1. Managed Behavioral Health:

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

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

2. Behavioral Health Condition Management

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

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

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

VII. OTHER SERVICES

1. Teladoc:

Teladoc is a vendor that provides access to providers who are under contract with Teladoc, to provide consultations for non-urgent care needs by telephone. The providers made available through the Teladoc program are independent contractors and are neither employees nor agents of Teladoc or Aetna.

2. ALEX® Benefits Advisor:

ALEX Benefits Advisor ("ABA") is an interactive, online decision support tool designed to assist employees in making their benefits elections during open enrollment. A virtual host ("ALEX") begins the session by learning about the employee so that he can tailor his approach and content to the needs of the individual. ALEX uses plain language to ask questions about topics such as family status, dependents, health care needs, lifestyle, financial status and risk tolerance – all the while avoiding insurance jargon often associated with choosing a benefits plan. The online and mobile-friendly experience includes audio, on-screen text and animations to ensure an engaging, personalized interaction.

3. Aetna Concierge:

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

reasonable attorney's fees) resulting from the inclusion of such third party vendor information on identification cards.

10. Subrogation Services:

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

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

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

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

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

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

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

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

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

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

will be priced based on the Recognized Charge. Even with FCR, if a provider refuses to agree to a negotiated rate, claims may be priced at billed charges in certain circumstances.

C. Itemized Bill Review (“IBR”) Component

IBR applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna’s contracted rate with the provider uses a “percentage of billed charges” methodology. Aetna refers to these as “IBR Claims.”

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

D. Terms and Conditions

(i) NAP Fees

- (a) The Customer’s fees for the NAP program are charged as a percentage of the Savings achieved for a claim paid under NAP (“NAP Fee”), as described in the Service and Fee Schedule. For purposes of calculating the NAP Fee, the following definitions shall apply:
 - “Savings” means the difference between (i) the Reference Price, and (ii) the NAP priced amount.
 - “Reference Price” means (i) for Involuntary Out-of-Network Claims, the amount billed by the provider for the covered service; (ii) for Voluntary Out-of-Network Claims, the benefit level set forth under the Plan; and (iii) for in-network facility services where Itemized Bill Review applies, the rate for the facility service prior to removal of any non-payable charges identified as part of the claim review.
- (b) The Customer will not owe any NAP Fees with respect to amounts that are the financial responsibility of Aetna, such as when Aetna writes stop loss insurance and the individual or aggregate limit, as applicable, is reached.
- (c) If Aetna pays more than the Reference Price, the Savings will be defined as zero.
- (d) NAP Fees will be credited back to the Customer for any Savings subsequently reduced or eliminated for which the Customer has already paid a NAP Fee.
- (e) Aetna will provide a quarterly report of Savings and NAP Fees. NAP Fees may be included with claims in other reports.

(ii) Plan Participant Information Regarding NAP

The Customer shall inform Plan Participants of the availability of NAP Providers. Further, the Customer’s Summary Plan Description specifying coverage for out-of-network health services must conform to Aetna requirements. Aetna shall provide information regarding NAP

HSA ADMINISTRATION

This section applies specifically to the Health Savings Accounts (“HSA”) administered by Aetna on behalf of the Customer. Any reference to “Aetna” in this section shall mean “PayFlex Systems USA, Inc.”, an affiliate of Aetna Life Insurance Company.

Any references in the Agreement to the “Plan Participant” shall mean the “Accountholder”, as defined below, when used in conjunction with HSA Administration.

I. CUSTOMER’S RESPONSIBILITIES

1. The Customer shall:
 - a. provide Aetna with the necessary information of the employees that choose to establish an HSA (“Accountholders”) at least thirty (30) calendar days prior to commencement of the applicable Plan year, and thereafter promptly notify Aetna of all changes or corrections, including, but not limited to, termination, changes in status, or the addition of new Accountholders;
 - b. distribute the HSA materials provided by Aetna, or its own HSA employee education materials acceptable to Aetna, to eligible employees;
 - c. distribute to each Accountholder any written or electronic notices as reasonably required by Aetna; and
 - d. ensure the high deductible health plan (HDHP) it offers or makes available to employees satisfies the applicable requirements of Section 223 of the Code. Aetna is under no obligation to confirm or verify that any HDHP satisfies the requirements of Section 223 of the Code, nor shall Aetna be responsible for eligibility and benefit claims determinations with respect to any HDHP, whether sponsored by the Customer or otherwise, unless otherwise set forth in the Agreement.
2. The Customer acknowledges and agrees that Aetna shall not be liable for any action it has taken (or failed to take) on behalf of the Customer or an Accountholder prior to Aetna’s receipt of such information from the Customer.
3. The Customer will not provide any information concerning the available HSA investment options other than that information provided to the Customer by Aetna and specifically approved by Aetna, in each instance, for the Customer’s provision to Accountholders.
4. The Customer shall be responsible for wage reporting and any other tax or other reporting or disclosure requirements applicable to it under federal, state or local law.
5. The Customer will be responsible for recording and reporting HSA contributions made through payroll deduction as required. The Customer will provide Aetna with all data on Accountholders and contributions, including payroll deduction and the Customer contributions (if applicable). The Customer is responsible for reviewing and approving such information, including transmissions of contribution information. The Customer shall cooperate with Aetna to reconcile accounts in the event of any discrepancies between the contribution file and the actual funds transmitted and received by Aetna. The Customer will be responsible for providing any disclosure to, and obtaining any consent

3. Aetna will make available and grant access to a website portal which would allow the Customer to verify whether an HSA has been opened for its eligible employees and to view and transmit certain program data including payroll contribution information.
4. Aetna shall provide debit cards to all HSA Accountholders. Card use is bound by and subject to the terms and conditions of the "Card Association Rules" as described in the Cardholder Agreement provided to each Accountholder upon card issuance.
5. Aetna's responsibility with respect to any HSA tax reporting requirements shall be solely in connection with reporting applicable information to Accountholders and any governmental entity as required by law. Aetna will provide annual and other tax statements to Accountholders as required of HSA administrators. Aetna makes no commitment or guarantee that any amounts paid to or for the benefit of an Accountholder will be, or continue to be, excludable from the Accountholder's gross income for federal, state or local tax purposes. Such determination is the obligation of each Accountholder.
6. Aetna shall provide the Customer with reports to facilitate payroll reconciliation and account status determination. Custom reports may be provided subject to feasibility and data availability, and shall be subject to a reasonable additional cost mutually agreed to by the parties in writing. The Customer shall be billed for programming time in accordance with Aetna's then-current rates unless otherwise agreed to in writing by the parties.
7. Aetna shall credit deposits to each individual Accountholder account based on deposits reported to Aetna by the Customer. Once the deposit is made Aetna may not be able to reverse the transaction. Under no circumstances will Aetna be liable for any loss or expense arising as a result of the Customer's adjustment to payroll contributions. Aetna is unable to accept contributions to an HSA in excess of the statutory maximum annual contribution limit established by law. Aetna will not consider any other factors in determining this limitation (e.g., the actual deductible of the Accountholder's health plan or the number of months that the Accountholder is eligible to make HSA contributions). Accountholders will be solely responsible for any tax or other consequences related to HSA contributions in excess of limits applicable to their particular circumstances.
8. Aetna will arrange for access by Accountholders to a standard slate of investment options, as determined by Aetna, with respect to their HSA.

III. ADDITIONAL ADMINISTRATION INFORMATION

1. Compliance with Law.

Aetna shall not perform any substantiation or verification, for qualification as a medical expense or other compliance with law, on any transaction posted to an HSA. HSAs are completely self-directed by the Accountholder and Aetna is not responsible for ensuring compliance with applicable law.

2. Contributions.

- a. Funding for HSAs is on a deposit basis and takes the form of an ACH debit that Aetna initiates against the Customer's designated account on each day that HSA deposits are reported by the

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

5. Communications.

Any notices related to the HSA administration should be directed to PayFlex Systems USA, Inc., 10802 Farnam Drive, Suite 100, Omaha, Nebraska, 68154, Attention: Contracts.

6. Subcontractors.

Aetna may subcontract HSA administration services at any time without notice to the Customer.

7. Health Savings Account Advantage.

If selected by the Customer as indicated on the Service and Fee Schedule, Aetna shall provide the Health Savings Account Advantage program. The program will provide support to Plan Participants in three areas - patient advocacy, health care navigation, and surgery cost savings – in an effort to help reduce their out-of-pocket expenses. These services will be provided to Plan Participants who have out-of-pocket health care expenses from a single medical event at a hospital, emergency clinic or surgical center. Such out-of-pocket expenses must meet or exceed the out-of-pocket threshold, as shown on the Service and Fee Schedule, after discounts and benefits have been applied.

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

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

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

IV. DEFINITIONS

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

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

“Average Wholesale Price” or “AWP” means the “average wholesale price” for a standard package size of a Prescription Drug for the date filled from the most current pricing information provided by Medi-Span. CVS/Caremark, Aetna’s PBM subcontractor (“PBM”, uses a single data reporting source for determining Client’s AWP pricing. The standard package size applicable to a mail service pharmacy and specialty pharmacy shall mean the actual 11-digit NDC of the package size used to fulfill the quantity dispensed. The standard package size applicable to a Retail Participating Pharmacy shall be the actual package size dispensed from a Retail Participating Pharmacy as reported by such Retail Participating Pharmacy to PBM. PBM shall not dispense repackaged products that have been assigned a new NDC number.

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

“Benefit Plan Design” means the terms, scope and conditions for Prescription Drug or device benefits under a Plan, including Formularies, exclusions, days or supply limitations, prior authorization or similar requirements, applicable Cost Share, benefit maximums and any other features or specifications as may be included in Plan documents, as communicated by the Customer to Aetna in accordance with any implementation procedures described herein. The Customer shall disclose to Plan Participants any

applicable amount. Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services except as required by law to be otherwise.

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

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

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

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

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

“Generic Drug” means a Prescription Drug, that is therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient(s) and approved by the FDA or a drug that is lawfully marketed as a DESI drug. Generic Drugs shall include all drugs with an approved ANDA (unless otherwise indicated in the Medi-Span indicators file), single source generics drugs, multi-source generic drugs, products involved in patent litigation, house (or “authorized) generic drugs and generic drugs that may only be available in limited supply, and are determined in accordance with the Medi-Span Master Drug Database (Medi-Span) indicators, and their associated files, unless a change in the indicator will lower the price for Customer or Customer agrees that the change is acceptable, in helping to determine the classification of drugs (e.g., prescription vs. over the counter, brand vs. generic, single-source vs. multi-source, maintenance medication) for purposes of this Agreement. Aetna shall adhere to the “once a generic, always a generic” policy, meaning, that Plan Participants will pay a generic Cost Share for all Generic Drugs (single-source and multi-source generics).

“House or Authorized Generic Drug” means a Brand Drug submitted with a Dispense As Written (DAW) code 5 in place of its generic equivalent and where the pharmacy is reimbursed at a Generic Drug rate, including MAC, as applicable. For reconciliation of the mail Generic Drug discount

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

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

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

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

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

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

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

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

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

determination of Covered Services, and adjudication of the On-Line Claims.

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

b. Pharmacy Network Management

- (i) Participating Retail Pharmacies. Any additions or deletions to the network of Participating Retail Pharmacies shall be made in Aetna's sole discretion. Aetna shall provide notice to the Customer of any deletions that have a material adverse impact on Plan Participants' access to Participating Retail Pharmacies. Aetna shall direct each Participating Retail Pharmacy to (a) verify the Plan Participant's eligibility using Aetna's on-line claims system, and (b) charge and collect the applicable Cost Share from Plan Participants for each Covered Service. Aetna will adjudicate On-Line Claims for Covered Services from Participating Retail Pharmacies using the negotiated rates that Aetna has in place with the applicable Participating Retail Pharmacy.
 - Aetna shall require each Participating Retail Pharmacy to comply with Aetna's applicable network participation requirements. Aetna does not direct or otherwise exercise any control over the professional judgment exercised by any pharmacist dispensing prescriptions or providing pharmacy services. Participating Retail Pharmacies are independent contractors of Aetna and Aetna shall have no liability to the Customer, any Plan Participant or any other person or entity for any act or omission of a Participating Retail Pharmacy or its agents, employees or representatives.
 - Aetna shall adjudicate each On-Line Claim for services rendered by a Participating Retail Pharmacy at the applicable Discount and Dispensing Fee negotiated between Aetna and the Customer. For the avoidance of doubt, the Benefit Cost paid by the Customer in connection with On-Line Claims for services rendered by Participating Retail Pharmacies may or may not be equal to the Discount and Dispensing Fees negotiated between Aetna and such pharmacies. This is considered "traditional" or "lock in" pricing.
- (ii) Mail Order Pharmacy. Aetna shall make available information regarding how Plan Participants may access and use the Mail Order Pharmacy on its internet website and via its member services call center. The Mail Order Pharmacy shall verify the Plan Participant's eligibility using Aetna's on-line claims system, and

and that Aetna has granted the Customer the right to use one of its Formulary options during the term of the Agreement solely in connection with the plan, and to distribute or make the Formulary available to members. As such, the Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the plan. The Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a result of factors, including but not limited to, market conditions, clinical information, cost, rebates and other factors. The Customer agrees that any proposed additions and/or deletions to the Formulary will be adopted by the Customer as a matter of the plan sponsor's plan design, and that the Customer has the right to elect to not implement any such addition or deletion, which such election shall be considered a Customer change to the Formulary **subject to Aetna's ability to operationally administer such election and, if so, Aetna's reservation of right to make appropriate and equitable financial changes resulting therefrom.** The Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

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

- (vi) Disease Management Educational Program. If purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule, Aetna shall administer the Disease Management Educational Program. The Disease Management Educational Program is available to customers who purchase Aetna managed prescription drug benefit management services, but not Aetna medical benefit plan services. The program consists of Plan Participant identification and outreach based on active Claims analysis for targeted risk conditions, such as asthma and diabetes. Upon identification, Plan Participants will receive a welcome kit introducing the program, complete with important information including educational materials and resources. The Customer may choose either the Asthma or Diabetes program or a combination of the two programs.
- (vii) Aetna Rx Step®. If included as indicated on the Prescription Drug Service and Fee Schedule, Aetna Rx Step steers Plan Participants to preferred products within 13 key drug classes that have significant savings opportunities. The Customer will have the option to select all of the 13 of these drug classes, or just choose which of the 13 they want. The goal is to help keep members safe and save money, when possible.
- (viii) Aetna Rx Healthy Outcomes. If purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule, Aetna Rx Healthy Outcomes is designed to promote drug adherence and sustained positive health outcomes for Plan Participants who survive an Acute Myocardial Infarction (heart attack), Coronary Artery Stent Placement or Acute coronary syndrome.
- (ix) Aetna Healthy ActionsSM Rx Savings. If purchased by the Customer as indicated on the Prescription Drug Service and Fee Schedule, the Aetna Healthy Actions Rx Savings program helps to reduce a Plan Participant's cost share for certain prescription drugs and can include outreach to Plan Participants and prescribing doctor to help promote adherence. It targets drugs for which compliance has been found to be most critical to realize cost savings for Plan Participants and plan sponsors. The targeted drugs treat certain chronic conditions such as diabetes, hypertension, and asthma.
- (x) Choose Generics Program. If purchased by the Customer as indicated on the Pharmacy Fee Schedule, the Choose Generics Program is an option that encourages Plan Participants to receive Brand Drugs rather than their generic equivalent. Under this program, Plan Participants can choose to obtain the Brand Drug at a higher than normal cost (subject to the exceptions described in the paragraph immediately below). Such higher cost will be equal to the Cost Share for the Brand Drug plus the difference in the cost between the Brand Drug and its generic equivalent. The cost differential is not applied to the Plan Participant's deductible.

customers for whom Aetna provides pharmacy benefit management services. PBM may share these Rebates with Aetna. Subject to the terms and conditions set forth in this Schedule, including without limitation, Aetna may pay to the Customer, Rebates based on the utilization by Plan Participants of rebateable Prescription Drugs administered and paid through the Plan Participant's pharmacy benefits.

- (ii) If the Customer is eligible to receive Rebates under this Schedule, the Customer acknowledges and agrees that Aetna shall retain the interest (if any) on, or the time value of, any Rebates received by Aetna prior to Aetna's payment of such Rebates to the Customer in accordance with this Schedule. Aetna may delay payment of Rebates to the Customer to allow for final adjustments or reconciliation of Service Fees or other amounts owed by the Customer upon termination of this Schedule.
- (iii) If the Customer is eligible to receive a portion of Rebates under this Schedule, the Customer acknowledges and agrees that such eligibility under paragraphs a. and b. above shall be subject to the Customer's and its affiliates', representatives' and agents' compliance with the terms of this Schedule, including without limitation, the following requirements:
 - Election of, and compliance with, Aetna's Formulary;
 - Adoption of and conformance to certain benefit plan design requirements related to the Formulary as described in Prescription Drug Service and Fee Schedule; and
 - Compliance with other generally applicable requirements for participation in Aetna's rebate program, as communicated by Aetna to the Customer from time to time.

The Customer further acknowledges and agrees that if it is eligible to receive a portion of Rebates under this Schedule, such eligibility shall be subject to the condition that the Customer, its affiliates, representatives and agents do not contract directly or indirectly with any other person or entity for discounts, utilization limits, Rebates or other financial incentives on pharmaceutical products or formulary programs for Claims processed by Aetna pursuant to this Agreement, without the prior written consent of Aetna. Without limiting Aetna's right to other remedies, failure by the Customer to obtain Aetna's prior written consent in accordance with the immediately preceding sentence shall constitute a material breach of the Agreement, entitling Aetna to (a) suspend payment of Rebates hereunder and to renegotiate the terms and conditions of this Agreement, and/or (b) immediately withhold any Rebates earned by, but not yet paid to, the Customer as necessary to prevent duplicative Rebates on such drugs.

are designed to reinforce Aetna's goals of maintaining access to quality, affordable health care for Plan Participants and the Customer. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Rebates. These payments are generally for one of three purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data, (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and Plan Participants about clinical guidelines, disease management and other effective therapies, or (iii) to compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder. These payments are not considered as Rebates and are not included in rebate sharing arrangements with plan sponsors, including without limitation, Customer

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

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

In Plans with Cost Share tiers, use of Formulary Prescription Drugs generally will result in lower costs to Plan Participants. However, where the Plan utilizes a Cost Share calculated on a percentage basis, there could be some circumstances in which a Formulary Prescription Drug would cost the Plan Participant more than a non-Formulary Prescription Drug because: (i) the negotiated Participating Pharmacy payment rate for the Formulary Prescription Drug 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.

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

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

VII. AUDIT RIGHTS

1. General Pharmacy Audit Terms and Conditions

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

- b. Additional Terms and Conditions

- (i) Auditor Qualifications and Requirements specific to Pharmacy Audits

All Pharmacy Audits shall be performed solely by third party auditors meeting the qualifications and requirements of the Agreement, this Schedule and the Prescription Drug Service and Fee Schedule. In addition the requirements set forth in section 11, Audit Rights of the Agreement, the auditor chosen by the Customer must be mutually agreeable to both the Customer and Aetna. Auditors may not be compensated on the basis of a contingency fee or a percentage of overpayments identified, in accordance with the provisions of Section 8.207

commencement of such audit, the Customer and auditor shall enter into a rebate audit confidentiality agreement acceptable to Aetna.

b. Pharmacy Claim Audits

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

HEALTH PROJECTED COST EFFECTIVE JANUARY 2026	
Administration & Stop Loss Fees	\$ 2,400,400.00
HMO Claims	\$ 11,000,000.00
PPO Claims	\$ 2,100,000.00
HDHP Claims	\$ 3,000,000.00
7% Contingency	\$ 1,296,000.00
Not-to-Exceed	\$ 19,796,400.00