This Master Services Agreement by and between Aetna Life Insurance Company, a Connecticut corporation located at 151 Farmington Avenue, Hartford, Connecticut, its affiliated HMOs, if indicated in Appendix V, its other affiliates and subsidiaries (collectively "Aetna") and Douglas County Government, a Colorado corporation, located at Castle Rock, Colorado ("Customer") is effective as of January 1, 2013 ("Effective Date"). This Master Services Agreement, Statements of Available Services ("SASs") and any additional Schedules and Appendices, as so identified and agreed, shall be hereinafter collectively referred to as the "Services Agreement."

1. INTRODUCTION

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

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

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

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

2. TERM

Unless one party informs the other of its intent to allow the Services Agreement to terminate in accordance with Section 7 of this Master Services Agreement, the initial term of this Services Agreement shall be one (1) year beginning on the Effective Date (referred to as an "Agreement Period"). This Agreement will automatically renew for additional Agreement Periods (successive one-year terms) unless otherwise terminated pursuant to Section 7 of this Master Services Agreement.

3. SERVICES

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

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

5. **FIDUCIARY DUTY**

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

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

Claim fiduciary responsibility is identified in the applicable Statement of Available Services ("SAS").

6. **SERVICE FEES**

Customer shall pay Aetna the Service Fees in accordance with the Service and Fee Schedule(s). No Services other than those identified in the Service and Fee Schedule(s) are included in the Service Fees. The Services to be provided by Aetna and the Service Fees may be adjusted annually effective on the anniversary of the Effective Date (the "Contract Anniversary Date") by Aetna upon thirty (30) days prior written notice, or at other times as indicated in the Service and Fee Schedule(s).

Aetna shall provide Customer with a monthly statement indicating the Service Fees owed for that month. Customer shall pay Aetna the amount of the Service Fees no later than thirty-one (31) calendar days following the first calendar day of the month in which the Services are provided (the "Payment Due Date").

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

In circumstances where Aetna may have a contractual, claim or payment dispute with a provider, the settlement of that dispute with the provider may include a one time payment in settlement to the provider or to Aetna, or may otherwise impact future payments to providers. Aetna, in its discretion, may apportion the settlement to self-funded Customers, either as an additional service fee from, or as a credit to, Customer, as may be the case, based upon specific applicable claims, proportional membership or some other allocation methodology, after taking into account Aetna's costs including Aetna's internal costs of recovery and distribution.
All overdue amounts shall be subject to the late charges set forth in the Service and Fee Schedule(s).

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

7. TERMINATION

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

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

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

(C) Aetna Termination -

(1) Aetna may terminate the Services Agreement or any SAS attached hereto by giving to Customer at least sixty (60) days written notice stating when, after the date of such notice, such termination shall become effective.

(2) If Customer fails to respond to an initial request by Aetna, or the bank selected by Aetna, on which benefit payment checks are drawn in satisfaction of a claim for Plan benefits ("Bank"), to provide funds to the Bank for the payment of checks or other payments approved and recorded by Aetna, Aetna shall have the right to cease processing benefit payment requests and suspend other Services until the requested funds have been provided. Aetna may terminate the Services Agreement immediately upon transmission of notice to Customer by mail, facsimile transmission or other means of communication (including electronic mail) if (a) Customer fails to provide the requested funds within five (5) business days of written notice by Aetna, (b) Aetna determines that Customer will not meet its obligation to provide such funds within twenty-one (21) business days or (c) Aetna will have the right to cease processing benefit payment requests and suspend services if based upon a review by Aetna completed by October 1 of each year Customer has met or exceeded more than 10/12 of annual appropriation limit, as agreed to in Section 21 Budget and Appropriation, and fails to appropriate additional funds in an amount reasonably satisfactory to Aetna by October 31.
(3) If Customer fails to pay Service Fees by the Payment Due Date, Aetna shall have the right to suspend Services until the Service Fees have been paid. Aetna may terminate the Services Agreement immediately upon transmission of notice to Customer by mail, facsimile transmission or other means of communication (including electronic mail) if (a) Customer either fails to pay such Service Fees within five (5) business days of written notice of unpaid Service Fees by Aetna, or (b) Aetna determines that Customer will not meet its obligation to pay such Service Fees within such five (5) business days.

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

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

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

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

Plan benefit payments and related charges of any amount payable under the Plan shall be made by check drawn by Aetna payable through the Bank or by electronic funds transfer or other reasonable transfer method. Customer, by execution of the Services Agreement, expressly authorizes Aetna to issue and accept such checks on behalf of Customer for the purpose of payment of Plan benefits and other related charges. Customer agrees to provide funds through its designated bank sufficient to satisfy all Plan benefits (and which also may include Service Fees in satisfaction of the obligations of Section 3 and any late charges under the Services Agreement) and related charges upon notice from Aetna or the Bank of the amount of payments made by Aetna. Customer agrees to instruct its bank to forward an amount in Federal funds on the day of the request equal to such liability by wire transfer or such other transfer method agreed upon between Customer and Aetna. As used herein "Plan benefits" means payments under the Plan, excluding any copayments, coinsurance or deductibles required by the Plan.

Since funding is provided on a checks issued basis, outstanding benefit payment checks (checks which have not been presented for payment) will be handled, as elected by Customer, by stop payments processed at approximately 12 months from the issued date and amounts returned to Customer.

9. CUSTOMER'S RESPONSIBILITIES

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

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

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

(D) Employee Notices - Customer agrees to furnish each employee covered by the Plan written notice, satisfactory to Aetna, that Customer has complete financial liability for the payment of Plan benefits. Aetna shall not be responsible for any and all loss, damage and expense sustained as a result of any failure by Customer to give such notice.

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

10. RECORDS

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

Upon reasonable prior written request by Customer, and subject to the provisions of Sections 11 and 12, and as permitted by applicable law, the Plan-related benefit payment information contained in the Documentation shall be made available to Customer or to a third party designated by Customer, for inspection during regular business hours at the place or places of business where it is maintained by Aetna, for purposes related to the administration of the Plan. Aetna may assess a charge to recover costs in connection with documentation requests. Such Plan-related benefit payment Documentation will be kept by Aetna for seven (7) years after the year in which a claim is adjudicated, unless Aetna turns such Documentation over to Customer or a designee of Customer. In the event return or destruction is infeasible, Aetna shall extend protections required by HIPAA.
11. CONFIDENTIALITY

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

(B) Aetna Confidential Information - Any information with respect to Aetna's or any of its affiliate's fees or specific rates of payment to health care providers and any information which may allow determination of such fees or rates and any of the terms and provisions of the health care providers' agreements with Aetna or its affiliates are deemed to be Aetna Confidential Information. Unless otherwise required by law, no disclosure of any such information may be made or permitted to Customer or to any third party whatsoever, including, but not limited to, any broker, consultant, auditor, reviewer, administrator or agent unless (i) Aetna has consented in writing to such disclosure and (ii) each such recipient has executed a confidentiality agreement in form satisfactory to Aetna's counsel. In the event a legal process is initiated against Customer by a third party to gain access to such Aetna Confidential Information, Customer will notify Aetna immediately so that Aetna can determine how it wishes to protect its interests in such proceeding.

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

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

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

(A) General Guidelines - For the purpose of this Services Agreement, an "audit" is defined as performing a detailed review of health claim transactions for the purpose of assessing the accuracy of benefit determinations.

Audits must be commenced within two (2) years following the period being audited. Audits of performance guarantees must be commenced in the year following the period to which the performance guarantee results apply.

Audits must be performed at the location where Customer's claims are processed.

Aetna is not responsible for paying Customers' audit fees or the costs associated with the audit. Customer shall pay Aetna fees for any audit which, with Aetna's approval, (i) cannot be completed within a five (5) day period, (ii) contains a sample size in excess of 250 claim transactions (or with respect to a Health Fund audit, 250 Plan Participant(s)), or (iii) otherwise creates exceptional administrative demands upon Aetna. The Customer represents that it has informed its Plan Participants that Plan Participant Confidential Information may be used in connection with audits.

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

(B) Auditor Qualifications and Requirements - Customer will utilize individuals to conduct audits on its behalf who are qualified by appropriate training and experience for such work, and will perform its review in accordance with published administrative safeguards or procedures and applicable law against unauthorized use or disclosure (in the audit report or otherwise) of any individually identifiable information. Customer and such individuals will not make or retain any record of provider negotiated rates included in the audited transactions, or payment identifying information concerning treatment of drug or alcohol abuse, mental/nervous or HIV/AIDS or genetic markers, in connection with any audit. Aetna reserves the right to refuse to allow an auditor to conduct an audit if Aetna determines the auditor has a conflict of interest. Determination of the nature of a conflict of interest shall be in the sole and reasonable discretion of Aetna. A conflict of interest includes (but is not limited to) a situation in which the audit agent (a) is employed by an entity which is a competitor of Aetna; or (b) has terminated from Aetna within the past 12 months; or (c) is affiliated with a vendor subcontracted by Aetna to adjudicate claims. The auditor chosen by the Customer must be mutually agreeable to both Customer and Aetna. Auditors may not be compensated on the basis of a contingency fee or a percentage of overpayments identified, in accordance with the provisions of Section 8.207 through 8.209 of the International Federation of Accountant's (IFAC) Code of Ethics For Professional Accountants (Revised 2004).

(C) Audit Coordination - Customer will provide reasonable advance notice of its intent to audit and will complete an Audit Request Form providing information reasonably requested by Aetna. Further, Customer or its representative will provide Aetna at least four (4) weeks in advance of the desired audit date, with a complete and accurate listing of the transactions to be pulled for the audit, and with identification of the potential auditor. Notification requirements may exceed four weeks for unusual audit requests, including but not limited to audits involving large sample sizes (e.g., greater than 250 transactions). No audit may commence until the Audit Request Form is completed and executed by the Customer, the auditor, and Aetna.
(D) Identification of Audit Sample - Unless otherwise specified in Appendix II, Performance Guarantees, the sample must be based on a statistical random sampling methodology (e.g., systematic random sampling, simple random sampling, stratified random sampling.) Aetna reserves the right to review and approve the sample size, the objectives of the audit and the sampling methodology proposed by the auditors.

(E) Closing Meeting - The auditors will provide their draft audit findings to Aetna, in writing, before a final audit report is presented to Customer and auditors shall discuss their draft audit findings with Aetna at this stage of the audit process.

(F) Audit Reports - Aetna will have a right to receive the final Audit Report, before delivery to the Customer. Aetna shall have the right to include with the final Audit Report a supplementary statement containing supporting documentation and materials that Aetna considers pertinent to the audit.

13. RECOVERY OF OVERPAYMENTS

The parties will cooperate fully to make reasonable efforts to recover overpayments of Plan benefits. If it is determined that any payment has been made by Aetna to or on behalf of an ineligible person or if it is determined that more than the appropriate amount has been paid, Aetna shall undertake good faith efforts to recover the erroneous payment. For the purpose of this provision, “good faith efforts” constitute Aetna’s outreach to the responsible party twice via letter, phone, email or other means to attempt to recover the payment at issue. If those efforts are unsuccessful in obtaining recovery, Aetna may use an outside vendor, collection agency or attorney to pursue recovery unless Aetna directs otherwise. Except as stated in this section, Aetna has no other obligation with respect to the recovery of overpayments.

Overpayment recoveries made through third party recovery vendors, collection agencies, or attorneys are credited to Customer net of fees charged by Aetna or those entities.

Overpayments must be determined by direct proof of specific claims. Indirect or inferential methods of proof – such as statistical sampling, extrapolation of error rate to the population, etc. – may not be used to determine overpayments. In addition, application of software or other review processes that analyze claims in a manner different from the claim determination and payment procedures and standards used by Aetna may not be used to determine overpayments.

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

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

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

(B) Customer must notify the Aetna 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 Aetna shall not be deemed a waiver of the right to seek indemnification, unless the actions of Aetna have been prejudiced by the failure of the Customer to provide notice within the required time period.

Aetna may then take steps to be joined as a party to such proceeding, and Customer shall not oppose any such joinder. Whether or not such joinder takes place, Aetna 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.

Customer 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 Aetna, provided that in doing so it shall be deemed to have waived its right to indemnification, except in cases where Aetna has declined to defend against the claim.

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

(D) The indemnification obligation above shall not apply to that portion of any loss, liability, damage, expense, settlement, cost or obligation caused by any act undertaken by Aetna at the direction of Customer, or by any failure, refusal, or omission to act, directed by the Customer (other than services described in the Services Agreement).

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

15. DEFENSE OF CLAIM LITIGATION

In the event of a legal, administrative or other action arising out of the administration, processing or determination of a claim for Plan benefits, the party designated in this document as the fiduciary which rendered the decision in the appeal last exercised by the Plan Participant which is being appealed to the court ("appropriate named fiduciary") shall undertake the defense of such action at its expense and settle such action when in its reasonable judgment it appears expedient to do so. If the other party is also named as a party to such action, the appropriate named fiduciary will defend the other party PROVIDED the action relates solely and directly to actions or failure to act by the appropriate named fiduciary and there is no conflict of interest between the parties. Customer agrees to pay the amount of Plan benefits included in any judgment or settlement in such action. The other
party shall not be liable for any other part of such judgment or settlement, including but not limited
to legal expenses and punitive damages, except to the extent provided in Section 14 Indemnification
of the Master Services Agreement. Notwithstanding anything to the contrary in the Defense of
Litigation clause above, in any multi-claim provider litigation, (including arbitration), disputing
reimbursement for benefits for more than one Plan Sponsor, Customer authorizes Aetna to defend
and reasonably settle Customer’s benefit claims in such litigation. When reasonable under the
circumstances due to the uniqueness or degree of impact of a particular proposed claim settlement,
Aetna will confer with Customer prior to settlement.

16. REMEDIES

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

17. DISPUTES

The parties shall attempt in good faith to resolve any dispute arising out of or relating to this Agreement
promptly by negotiation between executives who have authority to settle the controversy and who are at a
higher level of management than the persons with direct responsibility for administration of the contract.
Any party may give the other party written notice of any dispute not resolved in the normal course of
business, including the prescribed period to cure alleged breaches of contract. Within (15) days after
delivery of the notice, the receiving party shall submit to the other a written response. The notice and the
response shall include (a) a statement of each party’s position and a summary of arguments supporting that
position, and (b) the name and title of the executive who will represent that party and of any other person
who will accompany the executive. Within (30) days after delivery of the disputing party’s notice, the
executives of both parties shall meet at a mutually convenient time and place, and thereafter as often as
they reasonably deem necessary, to attempt to resolve the dispute. All reasonable requests for information
made by one party to the other will be honored. All negotiations pursuant to this provision are confidential
and shall be treated as compromise and settlement negotiations for purposes of applicable rules of
evidence. If the dispute is not resolved by negotiation between executives, the parties shall endeavor to
settle the dispute by mediation under the then current CPR/AAA Mediation Procedure. Unless otherwise
agreed, the parties will select a mediator from CPR/AAA Panels of Mediators.

18. NON-AETNA NETWORKS

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

- Aetna does not credential, monitor or oversee the providers or the administrative procedures or
  practices of any non-Aetna networks;
- No particular discounts may, in fact, be provided or made available by any particular providers;
- Such providers may not necessarily be available, accessible or convenient;
- Any performance guarantees appearing in the Services Agreement shall not apply to services
delivered by non-Aetna providers or networks;
- Neither non-Aetna providers nor non-Aetna networks are to be considered contractors or
  subcontractors of Aetna; and
- Such providers are providers in private practice, are neither agents nor employees of Aetna, and
  are solely responsible for the health care services they deliver.
Customer further agrees that, if Aetna subsequently establishes its own contracted provider network in a geographic area where services are being provided by a non-Aetna network, Aetna may terminate the non-Aetna network contract, and begin providing services through a network that is subject to the terms and provisions of the Services Agreement. Customer acknowledges that such conversion may cause disruption, including the possibility that a particular provider in a non-Aetna network may not be included in the replacement network.

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

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

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

20. GENERAL

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

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

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

(D) Communications - Aetna and Customer shall be entitled to rely upon any communication reasonably 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 Aetna, 151 Farmington Avenue, Hartford, Connecticut 06156, Attention: Elizabeth A. Karpowich, email: KarpowichEA@Aetna.com, Phone: 303-793-2590 and Fax: 866-657-6867, (ii) in the case of the Customer, at the address shown below, or (iii) at such other address as either party
specifies for the purposes of the Services Agreement by notice in writing addressed to the other
party. Notices or communications shall be sent by mail, facsimile transmission or other means of
communication.

Address:  Douglas County Government
100 Third Street
Castle Rock, CO 80104
Attention: Terri Wilson
e-mail: Twilson1@douglas.co.us
Phone: 303-660-7413
Fax: 303-688-9306

(F) Force Majeure - Aetna shall not be liable for any failure to meet any of the obligations or
provide any of the services or benefits specified or required under the Services Agreement
including performance guarantees, where such failure to perform is due to any contingency
beyond the reasonable control of Aetna, its employees, officers or directors. Such contingencies
include, but are not limited to: acts or omissions of any person or entity not employed or
reasonably controlled by Aetna, its employees, officers or directors; acts of God; terrorism,
pandemic, fires; wars; accidents; labor disputes or shortages; governmental laws, ordinances,
rules, regulations, or the opinions rendered by any Court, whether valid or invalid.

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

(G) Miscellaneous - The Services Agreement shall be governed by and interpreted in accordance
with applicable federal law. To the extent such federal law does not govern, the Services
Agreement shall be governed by Colorado 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 the Services Agreement. This Section and
Sections 3 through 13 and 15 through 17 shall survive termination of the Services Agreement.
The provisions of Section 14 shall survive termination only to the extent stated therein. The
headings in the Services Agreement are for reference only and shall not affect the interpretation
or construction of the Services Agreement. This Services Agreement (including incorporated
attachments) 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. No modification or amendment of this Services Agreement shall be valid unless
in a writing signed by a duly authorized representative of Aetna 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. The parties incorporate the recitals (set forth in
Section 1 of this Master Services Agreement) into this Services Agreement as representations of
fact to each other.

21. BUDGET AND APPROPRIATION
Any other provision of this Services Agreement notwithstanding, pursuant to Colo. Const. Art. X, Sec. 20 and section 29-1-110, C.R.S., unless the parties mutually agree in writing to an amendment of this Services Agreement in the future, the maximum amount of funds budgeted and appropriated for this Services Agreement is thirteen million-one hundred thousand dollars ($13,100,000) for fiscal year 2013:

Total contract costs are based upon actual monthly enrollment and Per Employee Per Month factors. Contract is also subject to contingency charges for services performed resulting in savings to the plan. In the event that any combination of the estimated and anticipated or contingency charges in this Services Agreement at any time during the fiscal year appear to be on pace or for some other reason appear likely to exceed the amount budgeted and appropriated herein, the parties agree to immediately begin discussion about amending and/or terminating this Services Agreement in a manner intended to address the potential shortfall and risk to the parties. The following costs and estimates have been considered in determining the maximum amount budgeted and appropriated herein and any substantial deviation from the estimates may be grounds to open negotiations regarding an amendment to this Services Agreement. Estimated 2013 annual cost is based upon actual enrollment (employee) as of 1/1/13 and corresponding monthly charge as follows:

**Open Access Aetna Select**
- 900 employees x administrative charge of $37.94 per employee per month = $34,146/month ($409,752 annual)

**Choice POS II**
- 47 employees x administrative charge of $36.69 per employee per month = $1,724.43/month ($20,693.16 annual)

**Health Savings Account Administration**
- 47 Health Savings Accounts x $4.00 per account per month = $172/month ($2,064 annual)

**Stop Loss**
- 947 total employee x $67.59 per employee per month = $64,007.73/month ($768,092.76 annual)

**Minimum Annual Aggregate Claim Liability** (based upon actual enrollment January 2013 x 12 months) = ($1,036.32 x 947) x 12 months = $11,776,740. This specific estimated amount plus any adjustments based on actual employee enrollment throughout the fiscal year is part of the budgeted and appropriated amount but it will be collected in monthly increments from participating employees of Customer and deposited in a separate Customer account and used solely for the purpose of directly paying covered medical costs and expenses related hereto.

**Maximum Annual Aggregate Claim Liability** not to exceed actual enrollment x $1,036.32/month

Variable contract costs include but are not capped. These charges are collected through claim wires and not billed separately:

- **National Advantage™ Program (NAP):** The fee for NAP is 40% of achieved savings
- **Facility Charge Review (FCR):** The fee for the FCR program is 40% of achieved savings
- **Itemized Bill Review (IBR):** The fee for the IBR program is 40% of achieved savings
- **Claims Subrogation:** A contingency fee of 30% is collected upon recovery
- **Enhanced Clinical Review:** $45 Per Member Per Month (employees and dependents)

The charge for alternate Stockpile will be reconciled with the year-end accounting package.

- Alternate banking Stockpile method of Weekly draws (Thursday notifications/Friday pulls) at an estimated annual interest charge of $3031 to be calculated at year end. Aetna will waive up to ½ of this charge or $1,515.50, whichever is less for the first policy year.

A. In no event shall Customer be liable for payment under this Services Agreement for any amount in excess of the amount budgeted and appropriated. Customer is not under obligation to make or
agree to any future amendment or increased budget or appropriation for this Services Agreement but when appropriate will use its best efforts to approve any appropriate amendments. Any potential expenditure for this Services Agreement outside the current fiscal year is subject to future annual appropriation of funds for any such proposed expenditure.

B. Whenever any costs or expenses contemplated within this Services Agreement are unknown or for any reason cannot be clearly determined at the time of execution of this Services Agreement, then whenever practicable and before any such costs are incurred or billed, Aetna will disclose any and all such costs in advance and seek Customer’s written approval or acknowledgement before such contingent amounts become an obligation herein.

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

CUSTOMER

DOUGLAS COUNTY GOVERNMENT

By: ___________________________
Name: _______________________
Title: _______________________
Date: ____________

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

By: ___________________________
Name: _______________________
Title: _______________________
Date: ____________

Financial Verification

______________________________
Cassandra Burns, Regional Director
BOARD OF COUNTY COMMISSIONERS
OF THE COUNTY OF DOUGLAS

BY: __________________________
Douglas J. DeBord, County Manager

DATE: 11/27/12

APPROVED AS TO FISCAL CONTENT:

Andrew Copland
Director of Finance
DATE: 11/19/13

APPROVED AS TO LEGAL FORM:

Lance J. Ingalls
County Attorney
DATE: 11/18/13
Insurance Requirements

1. The Consultant agrees to procure and maintain with insurers with an A- or better rating as determined by Best’s Key Rating Guide, at its own expense, the following policies of insurance:

   (a) Workers’ Compensation insurance to cover obligations imposed by applicable laws for any employee engaged in the performance of work under this Agreement, and Employers’ Liability insurance with the following limits:

<table>
<thead>
<tr>
<th>Workers’ Compensation:</th>
<th>Statutory</th>
</tr>
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<tbody>
<tr>
<td>Employers’ Liability:</td>
<td>$1,000,000</td>
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</tbody>
</table>

   (b) Commercial General Liability insurance with minimum combined single limits of ONE MILLION DOLLARS ($1,000,000) each occurrence and ONE MILLION DOLLARS ($1,000,000) aggregate. The policy will be applicable to all premises and operations. The policy will include coverage for bodily injury, broad form property damage (including completed operations), personal injury (including coverage for contractual and employee acts), blanket contractual, independent contractors, products, and completed operations. The policy will contain a severability of interests provision.

   (c) Commercial Automobile Liability insurance with minimum combined single limits for bodily injury and property damage of not less than ONE MILLION DOLLARS ($1,000,000) each occurrence with respect to each of Consultant’s owned, hired and non-owned vehicles assigned to or used in performance of the services. The policy will contain a severability of interests provision.

   (d) Professional Liability Insurance Coverage in an amount not less than One Million Dollars ($1,000,000.00), and Consultant shall maintain such coverage for at least two (2) years from the termination of this Agreement.

2. The required Commercial General Liability policy will be endorsed to include Douglas County as a Certificate Holder and name Douglas County, its officers and employees as additional insureds. Douglas County reserves the right to request and receive a certified copy of any policy and any endorsement thereto.

3. The certificates of insurance will be attached to this Agreement as evidence that policies providing the required coverages, conditions, and minimum limits are in full force and effect. The completed certificates of insurance and any notices, within 20 days of cancellation, termination, or material change will be sent to:

   Sheryl D. Monroe
   Douglas County
   Risk Management
   100 Third Street
   Castle Rock, Colorado 80104
4. The Consultant will not be relieved of any liability, claims, demands, or other obligations assumed by its failure to procure or maintain insurance, or its failure to procure or maintain insurance in sufficient amounts, durations, or types.

5. Failure on the part of the Consultant to procure or maintain policies providing the required coverages, conditions and minimum limits will constitute a material breach of contract upon which Douglas County may immediately terminate this Agreement.

6. The parties hereto understand and agree that Douglas County is relying on, and does not waive or intend to waive by any provision of this Agreement, the monetary limitations (presently $150,000 per person and $600,000 per occurrence) or any other rights, immunities, and protections provided by the Colorado Governmental Immunity Act, Sections 24-10-101 et seq., C.R.S., as from time to time amended, or otherwise available to Douglas County, its officers, or its employees.

7. The Consultant's liability to Douglas County, or any party claiming by or through the County, on account of or relating to the provision of services to the County during the period of the relationship between the Consultant and the County shall not exceed Twenty Million Dollars ($20,000,000) in the aggregate.

Approved by: [Signature]
Sheryl D. Monroe
Risk Manager
SELF FUNDED MEDICAL PLAN
STATEMENT OF AVAILABLE SERVICES – PPO BASED PRODUCTS
EFFECTIVE January 1, 2013
MASTER SERVICES AGREEMENT No. MSA-460027

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

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

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

II. Claim Fiduciary

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

III. Administration Services:

   A. Member and Claim Services:

      1. Requests for Plan benefit payments for claims shall be made to Aetna on forms or other
         appropriate means approved by Aetna. Such forms (or other appropriate means) may
         include a consent to the release of medical, claims, and administrative records and
         information to Aetna. Aetna will process and pay the claims for Plan benefits incurred
         after the Effective Date using Aetna's normal claim determination, payment and audit
         procedures and applicable cost control standards in a manner consistent with the terms
         of the Plan and the Services Agreement. With respect to any Plan Participant who makes
         a request for Plan benefits which is denied on behalf of Customer, Aetna will notify said
         Plan Participant of the denial and of said Plan Participant's right of review of the denial
         in accordance with ERISA. Any reference to "Plan benefit payments" will also include
         capitation payments, provider fees and other amounts paid to providers, but does not
         include co-payments or coinsurance amounts paid by Plan Participants or Service Fees.
2. Whenever it is determined that benefits and related charges are payable under the Plan, Aetna will issue a payment of such benefits and related charges on behalf of Customer. Funding of Plan benefits and related charges shall be made as provided in Section 8 of the Master Services Agreement.

3. Where the Plan contains a coordination of benefits clause, antiduplication clause, or provision(s) reducing benefits for injuries or illnesses caused or alleged to be caused by third parties, Aetna will administer all claims consistent with such provisions and any information concurrently in its possession as to duplicate coverage or the cause of the injury or illness. Aetna shall have no obligation to recover sums owed to the Plan by virtue of the Plan’s rights to coordinate where the claim was incurred prior to the Effective Date. Aetna has no obligation to bring actions based on subrogation or lien rights, unless Subrogation Services are included herein, in which event its obligations are governed by Article V of this Statement of Available Services.

B. Plan Sponsor Services:

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

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

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

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

   (a) 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 or quarterly or annual listing of paid benefits; and

   (d) quarterly or annual standard claim analysis reports.

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

4. Aetna shall develop and install all agreed upon administrative and record keeping systems, including the production of employee identification cards.
5. Aetna shall design and install a benefit-account structure separately by class of employees, division, subsidiary, associated company, or other classification desired by Customer.

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

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

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

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

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

10(b). Upon request of Customer, Aetna will review Customer-prepared employee Plan descriptions, subject to the Customer's final and sole authority regarding benefits and provisions in the self-insured portion of the Plan.

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

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

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

1. Utilization Management Inpatient and Outpatient Precertification:

Inpatient Precertification: A process for collecting information prior to an inpatient confinement. The precertification process permits eligibility verification/confirmation, initial determination of coverage, and communication with the physician and/or Plan Participant in advance of the provision of the procedure, service or supply at issue. Precertification also allows Aetna to identify Plan Participants for pre-service discharge planning and to identify and register Plan Participants for specialized programs such as Case Management and Disease Management.

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

2. Utilization Management Concurrent Review:

- Concurrent review encompasses those aspects of patient management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.
- Inpatient concurrent review is conducted telephonically or on-site at the facility where care is delivered.
- The concurrent review process includes:
  - Obtaining necessary information from practitioners and providers regarding the care being provided to Plan Participants;
  - Assessing the clinical condition of Plan Participants and the ongoing provision of medical services and treatments to determine benefit coverage;
  - Notifying practitioners and providers of coverage determinations in the appropriate manner and within the appropriate time frame;
  - Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting; and
  - Identifying Plan Participants for referral to covered specialty programs such as Case Management, Behavioral Health and Disease Management.

3. Utilization Management Discharge Planning:

This is an interdisciplinary process that assists Plan Participants as their medical condition changes and they transition from the inpatient setting. Discharge planning may be initiated at any stage of the Patient Management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences upon identification of post discharge needs during precertification or concurrent review. This program may include evaluation of alternate care settings and identification of care needed after discharge. The goal is to provide continuing quality of care and to avoid delay in discharge due to lack of outpatient support.
4. Utilization Management Retrospective Review:

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

5. Case Management Program:

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

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

Aetna operates two types of case management programs:

- **Complex Case Management** targets Plan Participants who have already experienced a health event and are likely to have care and benefit coordination needs after the event. The objective for Case Managers is to identify care or benefit coordination needs which lead to faster or more favorable clinical outcomes and/or reduced medical costs.

- **Proactive Case Management** targets Plan Participants, from Aetna's perspective, who are misusing, over-using or under-utilizing the health care system, leading them towards avoidable and costly health events. This program's objective is to confirm gaps in Plan Participants' care leading to their over-use, misuse, or under-use, and to work with the Plan Participant and their physician to close those gaps.

6. National Medical Excellence/Institutes of Excellence Program/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 Unit provides specialized Case Management through the use of nurse case managers, each with procedure and/or disease-specific training.
The Aetna Institutes of Excellence (IOE) transplant network was established to enhance quality standards and lower the cost of transplant care for Plan Participants. It is made up of a select group of hospitals and transplant centers that meet quality standards for the number of transplants performed and their outcomes, as well as access criteria for Plan Participants. IOE facilities have agreed to specific contractual terms and conditions and are selected and recognized by transplant type. The following criteria are applied to each facility prior to being selected for the IOE network:

- **Quality**—enhanced organ-specific credentialing and quality standards;

- **Access**—the national availability of, and need for, transplant facilities on a transplant-specific basis. Need is assessed relative to the distribution of membership and relative incidence of transplant types;

- **Cost**—provider contracts reflect lower negotiated rates.

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

Facilities selected for the network met the following criteria:

- Have significant experience in bariatric surgery, including a minimum of 125 procedures in the most recent calendar year - aligns with nationally recognized organizations.

- Have evidence-based and recognized standards for clinical outcomes, processes of care and patient safety.

- Provide ongoing follow-up programs and support for their bariatric surgery patients.

- Adhere to Aetna’s standards for Participant access to the facility and Aetna participating providers.

- Demonstrate efficiency in providing care based on overall cost of care, readmission rates and comprehensiveness of program.
7. **MedQuerySM:**

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

When available information reveals lack of compliance with a clinical risk, condition, or demographic-related recommendation for preventive care, a Preventive Care Consideration (“PCC”) is generated. The PCC is a preventive/wellness alert sent to the Member electronically via the Member’s Personal Health Record. Paper copies of a PCC, delivered via U.S. Mail, are also available as a buy up option.

8. **Aetna Health ConnectionsSM Disease Management:**

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

Aetna Health ConnectionsSM Disease Management is an enhancement to Aetna’s medical/disease management spectrum and will target Plan Participants at risk for high cost who have actionable gaps in care, engage the Plan Participants at the appropriate level, and assist the Plan Participant to close gaps in care in order to avoid complications, improve clinical outcomes and demonstrate medical cost savings.

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

Through an intensive focus on prevention, early treatment and education, the Beginning RightSM 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 Plan Participants with a toll-free 24-hour/7 day health telephonic access to registered nurses experienced in providing information on a variety of health topics. The nurses can contribute to informed health care decision-making and optimal patient/provider relationships through coaching and support. The nurses cannot diagnose, prescribe treatment or give medical advice, but they can provide Plan Participants with information on a broad spectrum of health issues, including: self-care, prevention, chronic conditions and complex medical situations. Plan Participants can also access the Audio Health Library, a recorded collection of more than 2,000 health topics, available in English and Spanish. Plan Participants can register on Aetna Navigator, Aetna's member and consumer website, and access Health wise Knowledgebase, another valuable resource of information on thousands of health topics.

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

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

11. Personal Health Record:

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

Aetna offers the Aetna CareEngine®-Powered PHR (for Customers who have elected this buy-up option). The CareEngine-Powered PHR combines the basic functions of a PHR with a personalized, proactive, evidence-based messaging platform. As above, it’s pre-populated with health information from Aetna’s claims system. Members can also input personal health information themselves. An online health assessment is available to facilitate the self-reporting process. The Aetna CareEngine-Powered PHR also offers:

- Personalized messaging and alerts based on medical claims, pharmacy claims, and demographic information, and lab reports.
- Original condition-specific content developed and reviewed by doctors from the Harvard Medical School and the Aetna InteliHealth editorial team.
- Aetna’s personalized, interactive health and wellness program, Simple Steps To A Healthier Life.
- Informed Care Decisions, an online decision support tool that provides treatment information for more than 40 diseases and conditions.
12. Managed Behavioral Health:

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

- Inpatient Care Management provides phone-based utilization review of inpatient behavioral health (mental health and chemical dependency) admissions intended to contain confinements to appropriate lengths, assure medical necessity and appropriateness of care, and control costs. Inpatient Care Management provides precertification, concurrent review and discharge planning of inpatient behavioral health admissions. These services also include identification of Plan Participants for referral to specialized programs such as Behavioral Health Disease Management programs, Intensive Case Management or Medical Psychiatric Case Management.

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

13. Intensive Case Management (Behavioral Health):

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

14. Aetna Compassionate Care Program

The Aetna Compassionate Care program provides additional support to terminally ill members and their families. It removes barriers to hospice and provides more choices for end-of-life care, so that members are able to spend their time with family and friends outside a hospital setting.

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

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

The enhanced hospice benefits package includes the following:

- The option for a member to continue to seek curative care while in hospice.
- The ability to enroll in a hospice program with a 12-month terminal prognosis.
- The elimination of the current hospice day and dollar maximum plan limits.
- Respite and bereavement services are now included as part of the new enhanced hospice benefits. The hospice services provided through a hospice regularly include these services and are coordinated by the hospice agency providing care and the Aetna nurse case manager precertifying care for the member. In addition, bereavement services are also available through the Aetna EAP for plan sponsors without an EAP vendor.

Bereavement counseling shall be available both to Members upon loss of a loved one and to family and caregivers of a Member enrolled in ACCP following the death of such Member.

V. Network Access Services:

A. Aetna, by a Network Provider, will issue a payment on behalf of Customer for those services in an amount determined in accordance with the Aetna contract with the Network Provider and the Plan benefits. In addition to standard fee-for-service rates, these contracted rates with network providers may also be based on case rates, per diems, capitation arrangements and in some circumstances, include risk-adjustment mechanisms, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. Retroactive adjustments are occasionally made to Aetna's contract rates (e.g., because the federal government does not issue cost of living data in sufficient time for an adjustment to be made on a timely basis, or because contract negotiations were not completed by the end of the prior price period or due to contract dispute settlements). In all such cases, Aetna shall adjust Customer's payments accordingly. Customer's liability for all such adjustments shall survive the termination of this Services Agreement.

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

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

VI. Subrogation Services:

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

Subrogation/reimbursement language must be included in the Customer's summary plan description (SPD) and the SPD must be finalized and available to Customer's employees before subrogation/reimbursement matters can be investigated and pursued. Aetna will continue to process claims during the investigation process. Aetna will not pend or deny claims for subrogation/reimbursement purposes.
Aetna or its contracted representative shall retain a percentage of any monies collected while pursuing subrogation/reimbursement recoveries. This fee includes reasonable expenses. Reasonable expenses include but are not limited to (a) collection agency fees, (b) police and fire reports, (c) asset checks, and (d) locate reports.

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

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

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

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

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

If Customer notifies Aetna of its election to terminate the Services provided by Aetna, all claims identified for potential subrogation/reimbursement recovery prior to the date notification of such election is received, including both open subrogation files and claims still under investigation, shall be handled to conclusion by Aetna and shall be governed by the terms of this provision, unless otherwise mutually agreed. Aetna will not investigate or handle subrogation/reimbursement cases or recoveries on any matters identified after Customer’s termination date.
VII. Customer's Responsibilities

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

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

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

IX. Performance Guarantees

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

X. Fees

The following Administrative Fees are provided in conjunction with Aetna's Services relating to the self funded medical products offered under the Plan Sponsor's self funded benefits plan. All Administrative Fees from this SAS are summarized in the following Service and Fee Schedule.
The corresponding Service Fees effective for the period beginning January 1, 2013 and ending December 31, 2013 are specified below. They shall be amended for future periods, in accordance with Section 6 of the Master Services Agreement. Any reference to “Member” shall mean a Plan Participant as defined in the Master Services Agreement.

<table>
<thead>
<tr>
<th>Product</th>
<th>Per Employee* Per Month Fee -</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>*A person within classes that are specifically described in Appendix I, including employees, retirees, COBRA continues and any other persons including those of subsidiaries and affiliates of Customer who are reported, in writing, to Aetna for inclusion in the Services Agreement.</td>
</tr>
<tr>
<td>Aetna Open Access Aetna Select</td>
<td>$37.94</td>
</tr>
<tr>
<td>Aetna Choice™ POS II</td>
<td>$36.69</td>
</tr>
<tr>
<td>Health Savings Account PAPM</td>
<td>$4.00</td>
</tr>
</tbody>
</table>

Services applicable and included in above PEPM fees (except where indicated otherwise):

<table>
<thead>
<tr>
<th>Services</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. \ Administration Services</td>
<td>Included</td>
</tr>
<tr>
<td>II. Aetna Health Connections™ Services</td>
<td>Included</td>
</tr>
<tr>
<td>- Utilization Management Inpatient and Outpatient Precertification</td>
<td>Included</td>
</tr>
<tr>
<td>- Utilization Management Concurrent Review</td>
<td>Included</td>
</tr>
<tr>
<td>- Utilization Management Discharge Planning</td>
<td>Included</td>
</tr>
<tr>
<td>- Utilization Management Retrospective Review</td>
<td>Included</td>
</tr>
<tr>
<td>- Case Management Program</td>
<td>Included</td>
</tr>
<tr>
<td>- Infertility Case Management</td>
<td>Not Included</td>
</tr>
<tr>
<td>- National Medical Excellence/ Institutes of Excellence with transportation and lodging expense</td>
<td>Included</td>
</tr>
<tr>
<td>Service</td>
<td>Included/Not Included</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>MedQuery℠ with Member Messaging</td>
<td>Included</td>
</tr>
<tr>
<td>MedQuery℠ without Member Messaging</td>
<td>Not Included</td>
</tr>
<tr>
<td>Preventive Care Consideration (PCC) paper copy</td>
<td>Not Included</td>
</tr>
<tr>
<td>Aetna Health Connections℠ Disease Management</td>
<td>Included</td>
</tr>
<tr>
<td>Beginning Right℠ Maternity Program</td>
<td>Included</td>
</tr>
<tr>
<td>Informed Health Line as follows</td>
<td>Included</td>
</tr>
<tr>
<td>Nurseline 1-800# Only</td>
<td>Included</td>
</tr>
<tr>
<td>Wellness Counseling</td>
<td>Not Included</td>
</tr>
<tr>
<td>Healthy Body, Healthy Weight</td>
<td>Not Included</td>
</tr>
<tr>
<td>Healthy Insights Member Newsletter</td>
<td>Not Included</td>
</tr>
<tr>
<td>Preventive Mailings</td>
<td>Not Included</td>
</tr>
<tr>
<td>Onsite Health Screening Services</td>
<td>Not Included</td>
</tr>
<tr>
<td>Simple Steps To A Healthier Life®</td>
<td>Included</td>
</tr>
<tr>
<td>Personal Health Record CareEngine®-Powered PHR</td>
<td>Included</td>
</tr>
<tr>
<td>Focused Psychiatric Review</td>
<td>Not Included</td>
</tr>
<tr>
<td>Managed Behavioral Health</td>
<td>Included</td>
</tr>
<tr>
<td>Intensive Case Management (Behavioral Health)</td>
<td>Included</td>
</tr>
<tr>
<td>Medical/Psychiatric Case Management</td>
<td>Not Included</td>
</tr>
<tr>
<td>Depression Disease Management</td>
<td>Not Included</td>
</tr>
<tr>
<td>Anxiety Disease Management</td>
<td>Not Included</td>
</tr>
<tr>
<td>Alcohol Disease Management</td>
<td>Not Included</td>
</tr>
<tr>
<td>Radiology Benefit Management</td>
<td>Not Included</td>
</tr>
<tr>
<td>Flexible Medical Model Flex Option 1</td>
<td>Not Included</td>
</tr>
<tr>
<td>Flex Option 2</td>
<td></td>
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<tr>
<td>-------------</td>
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</tr>
<tr>
<td>Flex Option 3</td>
<td></td>
</tr>
<tr>
<td>Frequent ER Visits</td>
<td></td>
</tr>
<tr>
<td>Informed Health Line Call Backs</td>
<td></td>
</tr>
<tr>
<td>Post Partum Calls</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Non-Compliance</td>
<td></td>
</tr>
<tr>
<td>Multiple Visits to Providers</td>
<td></td>
</tr>
</tbody>
</table>

- Aetna's Compassionate Care℠ Program | Included |
- ACCP Enhanced Hospice Benefits Package | Included |
- Designated Team | Included |
- Dedicated Team | Included |
- CAT (Care Advocate Team) | Included |

**Aetna Health Connections Get Active℠ as follows:**

| Shape up competition/tracking multi-week program without pedometer | Not Included |
| Stay in Shape Year-round Program without pedometer | Not Included |

- Aetna Benefits Advisor | Not Included |
- Quit Tobacco | Not Included |
- Healthy Lifestyle Coaching | Not Included |

**Member Health Engagement Plan (MHEP):**

| Progress Bar | Not Included |
| Incentive Administration | Not Included |

**Mindfulness at Work™**

- Viniyoga™ Stress Reduction | Not Included |

### III. Network Access Services

- Network Discount Offset Arrangement | Not Included |
Aetna also may adjust Service Fees effective as of the date on which any of the following occurs.

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

- 15% decrease in the number of Employees from the number assumed in Aetna's quotation of November 30, 2012, or from any subsequently reset assumptions.

<table>
<thead>
<tr>
<th>Name of Product(s)</th>
<th>Assumed Number of Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Access Aetna Select</td>
<td>894 Employees</td>
</tr>
<tr>
<td>HSA Aetna Choice POS II</td>
<td>48 Employees</td>
</tr>
</tbody>
</table>

- 15% increase in the Member to Employee ratio from the ratio assumed in Aetna's quotation of November 30, 2012, or from any subsequently reset assumptions.

<table>
<thead>
<tr>
<th>Name of Product(s)</th>
<th>Assumed Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Access Aetna Select</td>
<td>2.44 Members to 1,000 Employees</td>
</tr>
<tr>
<td>HSA Aetna Choice POS II</td>
<td>2.44 Members to 1,000 Employees</td>
</tr>
</tbody>
</table>

- 15% increase in the processed claim transactions per Employee (PCTs) ratio from the ratio assumed in Aetna's quotation of November 30, 2012, or from any subsequently reset assumptions.

<table>
<thead>
<tr>
<th>Name of Product(s)</th>
<th>Assumed PCT Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Access Aetna Select</td>
<td>25 PCTs to 15% of Employees</td>
</tr>
<tr>
<td>HSA Aetna Choice POS II</td>
<td>25 PCTs to 15% of Employees</td>
</tr>
</tbody>
</table>

### Table: Aetna Subrogation Program

<table>
<thead>
<tr>
<th>Name of Program</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Subrogation Program</td>
<td>Included</td>
</tr>
</tbody>
</table>

### Table: Group Health Certification Services

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Health Certification Services</td>
<td>Not Included</td>
</tr>
</tbody>
</table>

### Table: National Advantage Program (NAP)

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Included</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Advantage - Facility Charge Review (NAP-PCR)</td>
<td>Included</td>
<td>40% of Aggregate Savings – Fee will be included in Plan Benefit Funding Request from Bank</td>
</tr>
<tr>
<td>National Advantage - Itemized Bill Review (IBR)</td>
<td>Included</td>
<td>40% of Aggregate Savings – Fee will be included in Plan Benefit Funding Request from Bank</td>
</tr>
</tbody>
</table>

PPO Based Medical SFS 31
(2) Change in Plan - A material change in Plan is initiated by the Customer or by legislative action.

(3) Change in Claim Administration - A material change in claim payment requirements or procedures, account structure, or any other change materially affecting the manner or cost of paying benefits.

Late Payment Charges

In addition to any termination rights under the Services Agreement which may apply, if the Customer fails to provide funds on a timely basis to cover Plan benefit payments as provided in Section 8 of the Master Services Agreement, and/or fails to pay Service Fees on a timely basis as provided in Section 6 of the Master Services Agreement, Aetna will assess a late payment charge. The charge for 2013 will be as follows:

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

In addition, Aetna may assess a charge to recover its costs of collection.

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

I. Excluded and/or Superseded Provisions of Agreement:

A. Term
Unless one party informs the other of its intent to allow this SAS to terminate in accordance with the Agreement, the initial term of this SAS shall be 1 Year beginning on the Effective Date as first written above (referred to as an “Agreement Period”). This SAS will automatically renew for additional Agreement Periods (successive one-year terms) unless otherwise terminated pursuant to the Agreement. If the Agreement does not provide a termination clause, either party may terminate this SAS by giving the other party at least thirty-one (31) days written notice stating when, after the date of such notice, such termination shall become effective.

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

C. Audit Rights
The “Audit Rights” section of the Agreement is superseded by Section VII of this SAS.

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

III. Definitions:

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

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

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

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

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

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

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

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

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

"Calculated Ingredient Cost" means the lesser of:

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

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

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

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

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

"Cost Share" means that portion of the charge for a Prescription Drug or device dispensed to a Plan Participant that is the responsibility of the Plan Participant as provided in the applicable Plan, including coinsurance, copayments, deductibles and penalties, and may be a fixed amount or a percentage of an applicable amount. Cost Share will be calculated on the basis of the rates charged to Customer by Aetna for Covered Services except as required by law to be otherwise.
“Covered Services” means Prescription Drugs, Specialty Products, over-the-counter medications or other services or supplies that are covered under the terms and conditions set forth in the description of the Plan.

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

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

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

“Effective Date” means the Effective Date set forth above in the heading of the SAS.

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

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

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

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

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

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

“Mail Order Exception List” means the list of Prescription Drugs established by Aetna that includes Brand Drugs adjudicating as Generic Drugs, trademark Generic Drugs, any Generic Drug that is manufactured by one (1) manufacturer (or multiple manufacturers, for example, in the case of “authorized” Generic Drugs), and any Generic Drug that has an AWP within twenty-five percent (25%) of the AWP of the equivalent Brand Drug. The Mail Order Exception List is subject to change.
“National Drug Code” or “NDC” means a universal product identifier for human drugs. The National Drug Code Query (NDCQ) content is limited to Prescription Drugs and a few selected OTC products. The National Drug Code (NDC) Number is a unique, eleven-digit, three-segment number that identifies the labeler/vendor, product, and trade package size.

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

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

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

“Pharmacy Audits” shall have the meaning set forth in Section VII.A.1.

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

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

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

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

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

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

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

“Rebate Contract Excerpts”, if any, shall have the meaning set forth in Section VII.
“Rebate Guarantee” means the Rebate amount that Aetna guarantees Customer will receive as set forth in the Service and Fee Schedule.

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

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

“Services” shall have the meaning set forth in Section IV.A.1.

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

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

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

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

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

IV. Administration Services:

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

1. Services

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

2. Customer's Responsibilities

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

3. Exclusivity

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

B. Pharmacy Benefit Management Services

1. Pharmacy Claims Processing

a. On-Line Claims Processing. Using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the description of Plan benefits and this Statement of Available Services, Aetna will perform claims processing services for Covered Services that are provided by a Participating Pharmacy after the Effective Date, and submitted electronically to Aetna's on-line claims processing system. On-Line Claim processing services shall include confirmation of coverage, performance of drug utilization review activities pursuant to this Statement of Available Services, determination of Covered Services, and adjudication of the On-Line Claims. Aetna or Customer, as applicable, shall have ultimate and final responsibility for all decisions with respect to coverage of an On-Line Claim and the benefits allowed under the Plan as set forth in the Agreement.
b. DMR Claims Processing. If specified on the description of Plan benefits, Aetna will process DMR Claims using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the description of Plan benefits. The Plan Participant or Medicaid agency where applicable, shall be responsible for submitting DMR Claims directly to Aetna on such form(s) provided by Aetna within the timeframe specified on the description of Plan benefits. Aetna will process DMR Claims and, where appropriate, will reimburse such Plan Participant or Medicaid agency on behalf of Customer the lesser of: (i) the amount invoiced and indicated on such DMR Claim; or (ii) the amount the Plan Participant is entitled to be reimbursed for such claim pursuant to the description of Plan benefits. With respect to any Plan Participant who submits a DMR Claim which is denied on behalf of Customer, Aetna will notify said Plan Participant of the denial and of said Plan Participant's right of review of the denial in accordance with ERISA. Aetna or Customer, as applicable, shall have ultimate and final responsibility for all decisions with respect to coverage of a DMR Claim and the benefits allowed under the Plan as set forth in the Agreement.

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

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

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

d. Where the Plan contains a coordination of benefits clause or antiduplication clause, Aetna will administer all Claims consistent with such provisions and any information concurrently in its possession as to duplicate or primary coverage. Aetna shall have no obligation to recover sums owed to the Plan by virtue of the Plan's rights to coordinate where the Claim was incurred prior to the Effective Date. Aetna has no obligation to bring actions based on subrogation or lien rights.
2. Pharmacy Network Management

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

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

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

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

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

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

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

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

d. Retrospective Drug Utilization Review Services. Aetna shall implement and administer as specified in the description of Plan Benefits its standard Retrospective DUR programs with respect to On-Line Claims. Aetna’s Retrospective DUR programs are designed to help providers and Plan Participants identify circumstances where prescription drug therapy may be clinically inappropriate or other cost-effective drug alternatives may be available. Aetna’s Retrospective DUR programs are educational programs and program results may be communicated to Plan Participants, providers and plan sponsors. Aetna’s Retrospective DUR programs are administered using information submitted to and available in Aetna’s On-Line Claims system, as well as On-Line Claims information submitted by the Participating Pharmacy.
e. Aetna Rx Check Program. If purchased by Customer as indicated on the Service and Fee Schedule, Aetna shall administer the Aetna Rx Check Program. Aetna Rx Check programs use a rapid Retrospective DUR approach. Claims are systematically analyzed, often within 24 hours of adjudication, for possible physician outreach based on program algorithms. The specific outreach programs are designed to promote quality, cost-effective care in accordance with accepted clinical guidelines through mailings or telephone calls to physicians and Plan Participants.

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

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

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

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

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

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

4. Plan Participant Services and Programs

Internet services including Aetna Navigator and Aetna Pharmacy Website.
Through Aetna Navigator, Plan Participants have access to the following:

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

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

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

5. Rebate Administration

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

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

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

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

   ii. Adoption of and conformance to certain benefit plan design requirements related to the Formulary as described in Service and Fee Schedule;
iii. Distribution of the Formulary (or a summary thereof) to Plan Participants and/or physicians, as applicable; and

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

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

C. General Administration Services

1. Eligibility Transmission

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

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

2. Customer Services

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

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

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

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

Pharmacy SAS
- a monthly listing of funds requested and received for payment of Plan benefits;
- a monthly reconciliation of funds requested to Claims paid within the benefit-account structure;
- a monthly or quarterly or annual listing of paid benefits; and
- quarterly or annual standard claim analysis reports.

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

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

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

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

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

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

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

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

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

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

(ii) Upon request of Customer, Aetna will review Customer-prepared employee Plan descriptions, subject to the Customer’s final and sole authority regarding benefits and provisions in the self-insured portion of the Plan. Customer acknowledges its responsibility to review and approve all Plan descriptions and any revisions thereto and to consult Customer’s legal counsel, at its discretion, with said review and approval.

Aetna shall have no responsibility or liability for the content of any of Customer’s Plan documents, regardless of the role Aetna may have played in the preparation of such documents.
If Customer requires both preparation (a) and review (b), there may be an additional charge.

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

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

V. Important Information about the Pharmacy Benefit Management Services

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

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

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

Any material plan changes impacting administration, utilization or demographics may impact Rebate projections and actual Rebates received. Aetna reserves the right to terminate or change this program prior to the end of any Agreement Period for which it is offered if: (a) there is any legal, legislative or regulatory action that materially affects or could affect the manner in which Aetna conducts its Rebate program; (b) any material manufacturer Rebate contracts with Aetna are terminated or modified in whole or in part; or (c) the Rebates actually received under any material manufacturer Rebate contract are less than the level of Rebates assumed by Aetna for the applicable Agreement Period. If there is any legal action, law or regulation that prohibits, or could prohibit, the continuance of the Rebate program, or an existing law is interpreted to prohibit the program, the program shall terminate automatically as to the state or jurisdiction of such law or regulation on the effective date of such law, regulation or interpretation.
B. Customer acknowledges that from time to time, Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates and which are paid separately to Aetna or designated third parties (e.g., mailing vendors, printers). These payments are to reimburse Aetna for the cost of various educational programs. These programs are designed to reinforce Aetna's goals of maintaining access to quality, affordable health care for Plan Participants and Customer. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates as compensation for bona fide services it performs, such as the analysis or provision of aggregated information regarding utilization of health care services and the administration of therapy or disease management programs.

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

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

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

D. Customer acknowledges that Aetna contracts with Participating Retail Pharmacies directly or through a pharmacy benefit management (“PBM”) subcontract to provide Customer and Plan Participants with access to Covered Services. The prices negotiated and paid by Aetna or PBM to Participating Retail Pharmacies vary among Participating Retail Pharmacies in Aetna's network, and can vary from one pharmacy product, plan or network to another.
Under this Statement of Available Service and Service and Fee Schedule, Customer and Aetna have negotiated and agreed upon a uniform or "lock-in" price to be paid by Customer for all claims for Covered Services dispensed by Participating Retail Pharmacies. This uniform price may exceed or be less than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services. Where the uniform price exceeds the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, Aetna realizes a positive margin. In cases where the uniform price is lower than the actual price negotiated and paid by Aetna to the Participating Retail Pharmacy or PBM for dispensing Covered Services, Aetna realizes a negative margin. Overall, lock-in pricing arrangements result in a positive margin for Aetna. Such margin is retained by Aetna in addition to any other fees, charges or other amounts agreed upon by Aetna and Customer, as compensation for the pharmacy benefit management services Aetna provides to Customer. Also, when Aetna receives payment from Customer before payment to a Participating Pharmacy or PBM, Aetna retains the benefit of the use of the funds between these payments.

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

F. Customer acknowledges that Aetna generally pays Participating Pharmacies (either directly or through PBM) for Brand Drugs whose patents have expired and their Generic Drug equivalents at a single, fixed price established by Aetna (Maximum Allowable Cost or MAC). MAC pricing is designed to help promote appropriate, cost-effective dispensing by encouraging Participating Pharmacies to dispense equivalent Generic Drugs where clinically appropriate. When a Brand Drug patent expires and one or more generic alternatives first become available, the price for the Generic Drug(s) may not be significantly less than the price for the Brand Drug. Aetna reviews the drugs to determine whether to pay Participating Pharmacies (or PBM) based on MAC or continue to pay Participating Pharmacies (or PBM) on a discounted fee-for-service basis, typically a percentage discount off of the listed Average Wholesale Price of the drug (AWP Discount). This determination is based in part on a comparison under both the MAC and AWP Discount methodologies of the relative pricing of the Brand and Generic Drugs, taking into account any Rebates Aetna may receive from Prescription Drug manufacturers in connection with the Brand Drug. If Aetna determines that under AWP Discount pricing the Brand Drug is less expensive (after taking into account manufacturer Rebates Aetna receives) than the generic alternative(s), Aetna may elect not to establish a MAC price for such Prescription Drugs and continue to pay Participating Pharmacies (or PBM) according to an AWP Discount.
In some circumstances, a decision not to establish a MAC price for a Brand Drug and its generic equivalents dispensed by Participating Pharmacies could mean that the cost of such Prescription Drugs for Customer is not reduced. In addition, there may be some circumstances where Customer could incur higher costs for a specific Generic Drug ordered through Aetna Mail Order Pharmacy than if such Generic Drug were dispensed by a Participating Retail Pharmacy. These situations may result from: (i) the terms of Aetna’s arrangements with Participating Pharmacies (or PBM); (ii) the amount of the Cost Share; (iii) reduced retail prices and/or discounts offered by Participating Pharmacies to patients; and (iv) the amount, if any, of Rebates to which Customer is entitled under the Statement of Available Services and the Service and Fee Schedule.

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

b. Closing Meeting

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

B. Additional Pharmacy Claim Audit Terms and Conditions

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

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

VIII. Financial Guarantees

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

IX. Performance Guarantees

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

II. Claim Fiduciary:

Customer and Aetna agree that with respect to applicable state law, Aetna will be the "appropriate named fiduciary" of the Plan for the purpose of reviewing denied claims under the Plan. Customer understands that the performance of fiduciary duties under applicable state law necessarily involves the exercise of discretion on Aetna's part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Therefore, and to the extent not already implied as a matter of law, Customer hereby delegates to Aetna discretionary authority to determine entitlement to benefits under the applicable Plan Documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan. It is also agreed that, as between Customer and Aetna, Aetna's decision on any claim is final and that Aetna has no other fiduciary responsibility.
Subject to the terms and conditions of the Services Agreement, the Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to Section 6 of the Master Services Agreement) will be provided by Aetna. Additional Services may be provided at Customer's written request under the terms of the Services Agreement. This Statement of Available Services ("SAS") shall supersede any previous SAS or other document describing the Services.

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

- Section 4 ("Standard of Care") is excluded and replaced by Section III of this SAS;
- Section 5 ("Fiduciary Duty") is excluded and replaced by Section IV of this SAS;
- Section 6 ("Service Fees") is excluded and replaced by Section V and Section VI of this SAS;
- Section 14 ("Indemnification") is excluded and replaced by Section VII of this SAS;
- Section 20 (B) ("Subcontractors") is amended by the addition of a new paragraph, set forth in Section VIII of this SAS;
- Section 20 (G) ("Miscellaneous") is amended by deleting "including but not limited to ERISA" from the first sentence.

The following sections of the Services Agreement do not apply with respect to the Services provided pursuant to this HSA SAS:

- Section 7(D) ("Responsibilities on Termination")
- Section 9 (A) ("Customer's Responsibilities - Eligibility")
- Section 9(B) ("Customer's Responsibilities - Initial SPD Review")
- Section 12 ("Audit")
- Section 13 ("Recovery of Overpayments")
- Section 15 ("Defense of Claim Litigation")
- Section 18 ("Non-Aetna Networks")
- Section 19 ("Health Insurance Portability and Accountability Act (HIPAA) Compliance")
II. HSA Services:

A. Enrollment Assistance

Aetna will provide Customer with a supply of HSA enrollment forms and associated employee education material. Customer will distribute these materials to eligible employees (in paper or electronic form acceptable to Aetna), collect the completed enrollment forms and retain the forms of those employees that choose to establish an HSA account ("Accountholders"). The enrollment information must be maintained for at least seven years and provided to Aetna upon Aetna’s reasonable request. In addition, Customer will distribute to each Accountholder any written or electronic notices as reasonably requested by Aetna. When paper enrollment forms are provided to Aetna by Customer, Aetna, or its subcontractors will also maintain a copy of the forms. Customer will not be required to collect or maintain employee enrollment information to the extent the employee enrolls directly with Aetna through Aetna’s web portal.

B. Enrollment Reporting

Customer will provide Aetna, in format and manner agreed by Aetna, all necessary information regarding the employees who have enrolled to become Accountholders. Customer will also notify Aetna promptly of any changes in participation or eligibility. Customer will be responsible for the accuracy of the information provided and understands that Aetna will rely on the information most recently supplied by Customer.

C. Contributions

Customer will remit contributions on behalf of the Accountholders by either an electronic funds transfer method acceptable to Aetna or by manual check to an Aetna Lockbox, with sufficient supporting information to permit Aetna to reconcile contributions to each Accountholder’s HSA. Customer will be responsible for determining and communicating to Accountholders the method(s) by which they can contribute to their HSAs through benefit election, payroll deduction or other mechanism maintained by the Customer. Customer will also secure any authorization required from Accountholders to contribute funds into their HSAs. In the event that Aetna receives a contribution on behalf of an employee who is not an Accountholder, the contribution will be returned to Customer.

D. Excess Contributions

Aetna is unable to accept contributions to an HSA in excess of the statutory maximum annual contribution limit established by law. If Customer remits a contribution for an Accountholder in excess of this amount, Aetna will return the excess amount to Customer. 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.
E. Account Administration

Aetna will administer HSA accounts in accordance with applicable law and regulations. Subject to such law and regulation, Aetna will process HSA transactions in accordance with each Accountholder’s instructions. In the event funds are deposited or withdrawn from an HSA account in error, Aetna will attempt to correct such error, provided that Aetna will not be required to take any action inconsistent with applicable law or regulations. Interpretations of law and regulation shall be made by Aetna in its sole discretion.

Availability of HSA accounts may be subject to know-your-customer and other requirements established by Aetna from time to time and Aetna may, in its sole discretion, refuse to open or continue any HSA account.

Accountholders may elect to continue their HSA accounts with Aetna after termination of the Master Services Agreement or their employment with Customer, subject to payment of applicable fees directly to Aetna.

F. Tax Reporting

Aetna will provide annual and other tax statements to Accountholders as required of HSA administrators. Customer will be responsible for recording and reporting HSA contributions made through payroll deduction as required of payroll administrators.

G. Customer Services

1. Aetna will identify an HSA service representative to work with Customers in matters related to HSA accounts.

2. Upon request by Customer and consent by Aetna, Aetna will implement amendments or modifications to Customer’s HSA offering. A charge may be assessed for implementing such amendment or modification. Customer’s administration services fees, as set forth in the Service and Fee Schedule, may be revised in connection with the implementation of any amendments or modifications.

3. At least quarterly, Aetna will provide a report containing the following information:
   a. Participation: Total number of Customer employees who have opened HSA accounts.
   b. Aggregate Deposits: Total amount deposited into Accountholder HSAs from all sources.
   c. Aggregate Withdrawals: Total amount withdrawn from Accountholder HSAs.

H. Optional Customer Services

The following services will be provided only if elected by the Customer in the Service and Fee Schedule:

1. Debit Card: Aetna will provide the capability for HSA participants to pay for HSA-eligible expenses using debit card technology, including the production of HSA debit cards and claim streamlining capabilities.
2. Reporting Support: Aetna will provide Customer with information reasonably available to Aetna to assist Customer in preparing HSA-related reports for the Internal Revenue Service and/or Department of Labor.

3. Customized Documentation: Aetna will prepare or review (as elected by Customer) customized HSA documents for Customer's employees.

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

4. Aetna will arrange for the custom printing of Customer's HSA forms and documents, with all costs borne by Customer.

5. Aetna will arrange for access by Accountholders to a standard slate of investment options, as determined by Aetna, with respect to their HSA accounts.

III. Standard of Care

   Aetna will discharge its obligations under this SAS in accordance with the standard of care of an ordinary HSA administrator.

IV. HSA Administrative Fees

   The fees payable by Customer for the Services provided under this SAS are specified in the Service and Fee Schedule. The HSA Administrative Fees may be adjusted by Aetna upon at least thirty-one (31) calendar days prior written notice to Customer. Aetna may charge certain additional fees ("Service Fees") directly to Accountholders, and may adjust these Service Fees from time to time as described in Aetna's Accountholder agreement, disclosures or other Accountholder communications. Aetna may deduct these fees directly from Accountholder HSAs.

V. Billing and Payment

   Aetna will provide Customer on a monthly basis a statement showing the HSA Administrative Fees due for each month. HSA Administrative Fees are due and payable no later than thirty-one (31) calendar days following the first calendar day of the month for which HSA administrative services are provided (the "Payment Due Date"). HSA Administration Fees not paid by Customer when due may, at Aetna’s sole discretion, be charged against Accountholders. All overdue amounts shall be subject to the late charges set forth in the Fee Schedule. In determining applicable HSA Administrative Fees Aetna will be entitled to rely on current enrollment information provided by Customer.

VI. Indemnification

   A. Aetna shall indemnify and hold harmless Customer, its directors, officers, employees (acting in the course of their employment, but not as Accountholders) and agents for that portion of any loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees) which was caused solely and directly by Aetna's willful misconduct, criminal conduct, breach of the Services Agreement, or fraud related to or arising out of the Services provided under the Services Agreement.
B. Customer must notify Aetna within 30 days in writing of any actual or threatened action, suit or proceeding to which it claims such indemnification applies. Failure to so notify Aetna shall not be deemed a waiver of the right to seek indemnification, unless the actions of Aetna have been prejudiced by the failure of the other party to provide notice within the required time period.

Aetna may then take steps to be joined as a party to such proceeding, and Customer shall not oppose any such joinder. Whether or not such joinder takes place, Aetna 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.

Customer 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 Aetna, provided that in doing so it shall be deemed to have waived its right to indemnification except in cases where Aetna has declined to defend against the claim.

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

D. The indemnification obligation above shall not apply to that portion of any loss, liability, damage, expense, settlement, cost or obligation caused by Aetna’s act or omission undertaken at the direction of Customer (other than services described in the Services Agreement).

VII. Other

20 (B) (Continued) - Aetna may change subcontractors at any time without notice to Customer. Aetna or its subcontractors may refuse to accept an otherwise eligible employee as an Accountholder and/or close the HSA of an existing Accountholder pursuant to terms established by Aetna from time to time. Accountholders who cease to be affiliated with Customer (e.g., former employees) may elect to maintain their HSAs subject to terms and conditions and payment of account fees established by Aetna.

VIII. HSA Administrative Fees

The following Administrative Fees are provided in conjunction with Aetna’s Services relating to the HSA. All Administrative Fees from this SAS are summarized in the following Service and Fee Schedule.
SERVICE AND FEE SCHEDULE

Customer hereby elects to receive the Services designated below. The corresponding Administrative Fees effective for the period beginning January 1, 2013 and ending December 31, 2013 are specified below. They shall be amended for future periods, in accordance with Section 6 of the Master Services Agreement.

<table>
<thead>
<tr>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSA Administrative Fee</td>
<td>$4.00 Per Accountholder Per Month</td>
</tr>
</tbody>
</table>

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

1. If, for any Service, there is a 15% change in the number of employees participating in the health care savings account from the number assumed in Aetna’s quotation of November 30, 2012 or from any subsequently reset assumptions;

2. Change in Plan – A material change in the Plan is initiated by the Customer or by legislative action;

3. Change in Administration – A material change in claim payment requirements or procedures, account structure or any other change materially affecting the manner or cost of paying benefits.

Late Payment Charges

In addition to any termination rights under the Services Agreement which may apply, if Customer fails to pay Service Fees on a timely basis as provided in Item VI above, Aetna will assess a late payment charge. The late payment of Administrative Fees charge for 2013 is 12% annual rate.

In addition, Aetna may assess a charge to recover its cost of collection.

The late payment charge percentage specified above is subject to change annually.
Appendix I - Health Coverage

PLAN OF BENEFITS
PAYABLE UNDER
MASTER SERVICES AGREEMENT No. MSA-466027
EFFECTIVE January 1, 2013

An Agreement between

Aetna Life Insurance Company

and

Douglas County Government
("Customer")

Appendix Contents

This Appendix consists of the provisions found in the document(s) listed below.

The Document(s) included in this Appendix are as follows:

<table>
<thead>
<tr>
<th>Identification</th>
<th>Issue Date</th>
<th>Effective Date</th>
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<tbody>
<tr>
<td>Cert. Base: 1</td>
<td>March 19, 2013</td>
<td>Choice POS II</td>
</tr>
<tr>
<td>SOB: 1A</td>
<td>March 19, 2013</td>
<td>(Aetna Choice POS II)</td>
</tr>
<tr>
<td>Cert. Base: 2</td>
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</tr>
<tr>
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<tr>
<td></td>
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<td>Open Access Aetna Select Plan</td>
</tr>
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</table>
Appendix II

PERFORMANCE GUARANTEES
FOR
MASTER SERVICES AGREEMENT No. MSA-466027
EFFECTIVE January 1, 2013

An agreement between

Aetna Life Insurance Company ("Aetna")

and

Douglas County Government
(Customer)

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

THIS APPENDIX to the Master Services Agreement No. MSA-466027 between Aetna and Customer (the “Services Agreement”) is incorporated by reference therein. Customer represents that it has the authority to execute, and hereby executes, this Appendix III for and on behalf of the Plan Sponsor’s health benefit plan for which Aetna provides plan administration services (“the Plan” for the purposes of this Appendix III).

In conformity with the regulations at 45 C.F.R. Parts 160-164 (the “Privacy and Security Rules”), Aetna will under the following conditions and provisions have access to, maintain, transmit, create and/or receive certain Protected Health Information:

1. Definitions. The following terms shall have the meaning set forth below:
   (a) ARRA. “ARRA” means the American Recovery and Reinvestment Act of 2009.
   (c) Designated Record Set. “Designated Record Set” has the meaning assigned to such term in 45 C.F.R. 164.501.
   (d) Discovery. “Discovery” shall mean the first day on which a Breach is known to Aetna (including any person, other than the individual committing the breach, that is an employee, officer, or other agent of Aetna), or should reasonably have been known to Aetna, to have occurred.
   (e) Electronic Health Record. “Electronic Health Record” means an electronic record of health-related information on an individual that is created, gathered, managed and consulted by authorized health care clinicians and staff.
   (f) Electronic Protected Health Information. “Electronic Protected Health Information” means information that comes within paragraphs 1(i) or 1(ii) of the definition of “Protected Health Information”, as defined in 45 C.F.R. 160.103.
   (g) Individual. “Individual” shall have the same meaning as the term “individual” in 45 C.F.R. 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. 164.502 (g).
   (h) Protected Health Information. “Protected Health Information” shall have the same meaning as the term “Protected Health Information”, as defined by 45 C.F.R. 160.103, limited to the information created or received by Aetna from or on behalf of Customer.
   (i) Required By Law. “Required By Law” shall have the same meaning as the term “required by law” in 45 C.F.R. 164.103.
   (j) Secretary. “Secretary” shall mean the Secretary of the Department of Health and Human Services or his designee.
   (k) Breach. “Breach” means the unauthorized acquisition, access, use or disclosure of Protected Health Information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information. Breach does not include:
      (i) any unintentional acquisition, access, or use of Protected Health Information by an employee or individual acting under the authority of Aetna if:
         (I) such acquisition, access or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual, respectively, with Aetna; and
         (II) such information is not further acquired, accessed, used or disclosed by any person; or
(ii) any inadvertent disclosure from an individual who is otherwise authorized to access Protected Health Information at a facility operated by Aetna to another similarly situated individual at the same facility; and

(iii) any such information received as a result of such disclosure is not further acquired, accessed, used or disclosed without authorization by any person.

(f) **Security Incident**. "Security Incident" has the meaning assigned to such term in 45 C.F.R. 164.304.

(m) **Standard Transactions**. "Standard Transactions" means the electronic health care transactions for which HIPAA standards have been established, as set forth in 45 C.F.R. Parts 160-162.

(n) **Unsecured Protected Health Information**. "Unsecured Protected Health Information" means Protected Health Information that is not secured through the use of a technology or methodology specified by guidance issued by the Secretary from time to time.

2. **Obligations and Activities of Aetna**

(a) Aetna agrees to not use or disclose Protected Health Information other than as permitted or required by this Appendix or as Required By Law.

(b) Aetna agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Appendix.

(c) Aetna agrees to mitigate, to the extent practicable, any harmful effect that is known to Aetna of a use or disclosure of Protected Health Information by Aetna in violation of the requirements of this Appendix.

(d) Aetna agrees to report to Customer any Security Incident of the Protected Health Information not allowed by this Appendix of which it becomes aware, except that, for purposes of the Security Incident reporting requirement, the term "Security Incident" shall not include inconsequential incidents that occur on a daily basis, such as scans, "pings" or other unsuccessful attempts to penetrate computer networks or servers containing electronic PHI maintained by Aetna.

(e) Aetna agrees to report to Customer any Breach of Unsecured Protected Health Information without unreasonable delay and in no case later than sixty (60) calendar days after Discovery of a Breach. Such notice shall include the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Aetna, to have been, accessed, acquired, or disclosed in connection with such Breach. In addition, Aetna shall provide any additional information reasonably requested by Customer for purposes of investigating the Breach. Aetna's notification of a Breach under this section shall comply in all respects with each applicable provision of Section 13400 of Subtitle D (Privacy) of ARRA and related guidance issued by the Secretary from time to time.

(f) Aetna agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Aetna on behalf of Customer, agrees to the same restrictions and conditions that apply through this Appendix to Aetna with respect to such information.

(g) Aetna agrees to provide access, at the request of Customer, and in the time and manner designated by Customer, to Protected Health Information in a Designated Record Set, to Customer or, as directed by Customer, to an Individual in order to meet the requirements under 45 C.F.R. 164.524.

(h) Aetna agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Customer directs or agrees to pursuant to 45 C.F.R. 164.526 at the request of Customer or an Individual, and in the time and manner designated by Customer.
Aetna agrees to make (i) internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information received from, or created or received by Aetna on behalf of, Customer, and (ii) policies, procedures, and documentation relating to the safeguarding of Electronic Protected Health Information available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Customer's compliance with the Privacy and Security Rules.

Aetna agrees to document such disclosures of Protected Health Information as would be required for Customer to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

Aetna agrees to provide to Customer the information collected in accordance with this Section to permit Customer to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528. In addition, with respect to information contained in an Electronic Health Record, Aetna shall document, and maintain such documentation for three (3) years from date of disclosure, such disclosures as would be required for Customer to respond to a request by an Individual for an accounting of disclosures of information contained in an Electronic Health Record, as required by Section 13405(c) of Subtitle D (Privacy) of ARRA and related regulations issued by the Secretary from time to time.

With respect to Electronic Protected Health Information, Aetna shall implement and comply with the administrative safeguards set forth at 45 C.F.R. 164.308, the physical safeguards set forth at 45 C.F.R. 310, the technical safeguards set forth at 45 C.F.R. 164.312, and the policies and procedures set forth at 45 C.F.R. 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Customer. Aetna acknowledges that, effective the later of the Effective Date of this Appendix or February 17, 2010, (i) the foregoing safeguards, policies and procedures requirements shall apply to Aetna in the same manner that such requirements apply to Customer, and (ii) Aetna shall be subject to the civil and criminal enforcement provisions set forth at 42 U.S.C. 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with the safeguards, policies and procedures requirements and any guidance issued by the Secretary from time to time with respect to such requirements.

With respect to Electronic Protected Health Information, Aetna shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate safeguards to protect it.

If Aetna conducts any Standard Transactions on behalf of Customer, Aetna shall comply with the applicable requirements of 45 C.F.R. Parts 160-162.

Aetna acknowledges that, effective the later of the Effective Date of this Appendix or February 17, 2010, it shall be subject to the civil and criminal enforcement provisions set forth at 42 U.S.C. 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with any of the use and disclosure requirements of this Appendix and any guidance issued by the Secretary from time to time with respect to such use and disclosure requirements.

3. Permitted Uses and Disclosures by Aetna
3.1 General Use and Disclosure
Except as otherwise provided in this Appendix, Aetna may use or disclose Protected Health Information to perform its obligations under the Services Agreement, provided that such use or disclosure would not violate the Privacy and Security Rules if done by Customer or the minimum necessary policies and procedures of Customer.
3.2 Specific Use and Disclosure Provisions

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

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

(c) Aetna shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an individual without Customer’s prior written approval and notice from Customer that it has obtained from the individual, in accordance with 45 C.F.R. 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by Aetna. The foregoing shall not apply to Customer’s payments to Aetna for services delivered by Aetna to Customer.

(d) Except as otherwise provided in this Appendix, Aetna may use Protected Health Information to provide data aggregation services to Customer as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).

(e) Aetna may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. 164.502(j)(1).

4. Obligations of Customer

4.1 Provisions for Customer to Inform Aetna of Privacy Practices and Restrictions

(a) Customer shall notify Aetna of any limitation(s) in its notice of privacy practices of Customer in accordance with 45 C.F.R. § 164.520, to the extent that such limitation(s) may affect Aetna’s use or disclosure of Protected Health Information.

(b) Customer shall provide Aetna with any changes in, or revocation of permission by Individual to use or disclose Protected Health Information, to the extent that such changes affect Aetna’s uses or disclosures of Protected Health Information.

(c) Customer agrees that it will not furnish or impose by arrangements with third parties or other Covered Entities or Business Associates special limits or restrictions to the uses and disclosures of its PHI that may impact in any manner the use and disclosure of PHI by Aetna under the Services Agreement and this Appendix, including, but not limited to, restrictions on the use and/or disclosure of PHI as provided for in 45 C.F.R. 164.522.

4.2 Permissible Requests by Customer

Customer shall not request Aetna to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy and Security Rules if done by Customer.

5. Term and Termination

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

(b) Termination for Cause. Without limiting the termination rights of the parties pursuant to the Services Agreement and upon either party’s knowledge of a material breach by the other party, the non-breaching party shall either:
i. Provide an opportunity for the breaching party to cure the breach or end the violation, or terminate the Services Agreement, if the breaching party does not cure the breach or end the violation within the time specified by the non-breaching party;
ii. Immediately terminate the Services Agreement, if cure of such breach is not possible;
iii. If neither termination nor cure is feasible, the non-breaching party shall report the violation to the Secretary.

(c) Effect of Termination

The parties mutually agree that it is essential for Protected Health Information to be maintained after the expiration of the Services Agreement for regulatory and other business reasons. The parties further agree that it would be infeasible for Customer to maintain such records because Customer lacks the necessary system and expertise. Accordingly, Customer hereby appoints Aetna as its custodian for the safe keeping of any record containing Protected Health Information that Aetna may determine it is appropriate to retain. Notwithstanding the expiration of the Services Agreement, Aetna shall extend the protections of this Appendix to such Protected Health Information, and limit further use or disclosure of the Protected Health Information to those purposes that make the return or destruction of the Protected Health Information infeasible.

6. Miscellaneous

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

(b) Amendment. The Parties agree to take such action to amend this Agreement from time to time as is necessary for Customer and Aetna to comply with the requirements of the HIPAA Privacy Rule, the HIPAA Security Rule, the HITECH Act, and HIPAA, as amended.

(c) Survival. The respective rights and obligations of Aetna under Section 5(c) of this Appendix shall survive the termination of this Appendix.

(d) Interpretation. Any ambiguity in this Appendix shall be resolved in favor of a meaning that permits Customer to comply with the Privacy and Security Rules.

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

(f) Governing Law. This Appendix shall be governed by and construed in accordance with the same internal laws as that of the Services Agreement.

The parties hereto have executed this Appendix with the execution of the Services Agreement.
APPENDIX IV

SIMPLE STEPS TO A HEALTHIER LIFE
FEATURES AND SYSTEM REQUIREMENTS

I. **Base Features:**

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

**Employer Features:**

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

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

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

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

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

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


**User Features:**

- Online Health Risk Assessment (the “HRA”) — the User completes an online health risk assessment (the “HRA”) that is a set of health-related questions. The HRA evaluates the answers, provided by the User, based on a series of clinical risk factors that are used to determine if the User is at risk for one or more medical conditions. The User will receive a summary report, identifying the at-risk conditions, as well as other health-related areas the User may need to focus on.
Health Action Plan - in addition to the summary report, the User will receive a health action plan that is generated based upon the User's completed HRA. The health action plan provides information on certain ways to achieve better health.

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

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

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

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

II. User System Requirements

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

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

- Online Access Requirement: use of a computer system to connect to Aetna's system hosting the Life Program via the Internet using a standard Web browser.
APPENDIX IV.1
NATIONAL ADVANTAGE PROGRAM

The National Advantage Program ("NAP") is an Appendix to Master Services Agreement No. MSA-466027 between Aetna and Customer (as identified herein) and is incorporated into the Services Agreement by reference.

I. National Advantage Program

A. Summary

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

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

B. Claim Submission/Payment Process

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

II. National Advantage Program – Facility Charge Review

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

A. Summary

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

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

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

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

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

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

III. National Advantage Program – Itemized Bill Review

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

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

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

A. Customer Charges For Provider Payments

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

B. Access Fees

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

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

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

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

C. Member Information Regarding National Advantage Program

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

D. Definitions

As used herein:

“Access Fee” means the amount(s) to be paid by Customer to Aetna for access to the savings provided under NAP.

“Ad-Hoc Rate” means the rate which was negotiated for a specific claim in the absence of a pre-negotiated contracted rate with a Provider.
“Aggregate Savings” means the difference between (i) the amount which would have been due or otherwise paid to Providers for Covered Services without the benefit of NAP, and (ii) the amount due Providers for Covered Services as a result of NAP.

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

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

“Plan” means the portion of Customer’s employee welfare benefit plan, which provides medical benefits to Members as administered by Aetna.

“Providers” means those physicians, hospitals and other health care providers whose services are available at a savings under NAP.

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

E. Customer Acknowledgements

Customer acknowledges that:

1. The NAP listing of Providers includes Providers that are (i) participating by virtue of direct contracts with Aetna and its affiliates, and (ii) participating by virtue of Aetna’s contracts with unaffiliated third parties that have contracts with Providers, and provide Aetna with access to these contracted rates for the purpose of NAP.

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

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

4. The following claim situations may not be eligible for NAP:
   - Claims involving Medicare when Aetna is the secondary payer
   - Claims involving coordination of benefits (COB) when Aetna is the secondary payer.
   - Claims that have already been paid directly by the Member.
F. General Provisions

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

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

List of Aetna Affiliated HMOs

for
POS II, Aetna Select and SI HMO
Medical Products

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

- Aetna Health, Inc. (CT)
- Aetna Health of California Inc.
- Aetna Health Inc. (ME)
- Aetna Health Inc. (NY)
- Aetna Health Inc. (NJ)
- Aetna Health Inc. (PA)
- Aetna Health Inc. (FL)
- Aetna Health Inc. (GA)
- Aetna Health Inc. (MI)
- Aetna Health Inc. (TX)
November 15, 2012

Douglas County
Terri Wilson
100 3rd St
Castle Rock, CO 80104

ADMINISTRATIVE SERVICES AGREEMENT NO. / ASC POLICYHOLDER NO. – 456027

Dear Ms. Wilson:

This letter agreement between Douglas County (hereinafter "Customer") and Aetna Life Insurance Company (hereinafter "Aetna") will amend the above captioned Administrative Services Agreement (Agreement) once finalized. The Performance Guarantees attached to this letter agreement replace any Performance Guarantees in the Agreement for the Guarantee Period 01/01/2013 through 12/31/2013 (hereinafter "Guarantee Period"), effective 01/01/2013.

Aetna is committed to providing quality administrative services to Customer, and we would like to emphasize our degree of commitment through the attached Performance Guarantees.

The attached Performance Guarantee agreement describes the Performance Guarantees in detail. Please sign this letter agreement and return it to us by 11/30/2012, indicating your acceptance of the Guarantees. If this letter is not signed and returned by 11/30/2012, it is assumed that Customer is in agreement with the Performance Guarantee offerings, Performance Objectives, and amounts at risk if the Performance Objectives are not met.

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IN WITNESS WHEREOF, AETNA has signed this amendment to become effective 01/01/2013.

Signed by Aetna on 11/15/2012

Jimmy Ng
Senior Underwriting Consultant

Signed by Douglas County on November 19, 2012

[Signature]

G. Benefits Administrator / HR Liaison

07/27/2012
www.aetna.com

Performance Guarantee Letter