Kimberly J. Williams, JD
Harris County Purchasing Agent

March 05, 2026

Commissioners Court
Harris County, Texas

RE: Job No. 230107

Members of Commissioners Court:

Please approve the attached Order(s) authorizing the County Judge to execute the attached First Amendment to the Agreement(s) for the following:

Description: Group Medical (including Prescription Drug Program and Stop Loss Coverage, Employee Assistance Program and Flexible Spending Accounts) for Harris County and Harris County Flood Control District

Vendor(s): Aetna Life Insurance Company

Amount: $428,000,000 previously approved funds for the term 01/01/2026 - 12/31/2026
0 additional funds for the term 01/01/2026 - 12/31/2026
$428,000,000

Reviewed By: • Harris County Purchasing • Human Resources and Talent

The First Amendment adds certain documents to the Agreement(s) with no increase in the total contract amount.

Sincerely,

Kimberly J. Williams

Kimberly J. Williams, JD
Purchasing Agent

JW
Attachment(s)
cc: Vendor(s)

FOR INCLUSION ON COMMISSIONERS COURT AGENDA MARCH 19, 2026

FIRST AMENDMENT TO THE ADDENDUM TO THE AGREEMENT BETWEEN HARRIS COUNTY, HARRIS COUNTY FLOOD CONTROL DISTRICT, AND AETNA LIFE INSURANCE COMPANY

THE STATE OF TEXAS §
§
COUNTY OF HARRIS §

This First Amendment to the Addendum to the Agreement is made and entered into by and between Harris County (the "County"), acting through its Human Resources and Talent (the "Department"), the Harris County Flood Control District (the "District"), and Aetna Life Insurance Company ("Contractor"). The County, the District, and the Contractor are referred to herein collectively as "Parties" and individually as a "Party." The County and District are collectively the "Insureds."

Recitals

On November 14, 2023, the County and the Contractor entered into an Addendum to an Agreement (the "Agreement") for group medical insurance coverage (the "Services") under Job No. 23/0107.

On August 14, 2025, Harris County Commissioners Court approved implementing an Employer Group Waiver Plan ("EGWP") for prescription drug coverage for Medicare retiree members.

The Parties desire to amend the Agreement for the first time ("First Amendment") to implement the EGWP, and add required documents to the Agreement and for the implementation of the EGWP.

Terms

I.

This First Amendment shall be governed by the Agreement, which is incorporated herein by reference as though fully set forth word for word. In the case of conflict, the terms of this First Amendment will control and prevail over those contained in the Agreement.

II.

The following documents are hereby incorporated into the Agreement and are attached hereto as Exhibit A:

1. Medicare Group Agreement
2. Financial Conditions Document
3. Aetna Plan and Benefit Information Document
4. Pharmacy Service and Fee Schedule to the Master Services Agreement
5. Addendum to Service and Fee Schedule: Specialty Product Pricing
6. Rate Exhibit
7. SilverScript Summary of Benefits

8. Group Employer Medicare Advantage Plan and Medicare Prescription Drug Plan Activation

Any terms in the documents in Exhibit A are subject to the negotiated terms of the Agreement, but in the case of conflict or to the extent the terms of the Agreement are not relevant to the services provided under this First Amendment, the terms of this First Amendment will control and prevail over those contained in the Agreement.

III.

All other terms and provisions of the Agreement shall remain in full force and effect as originally written. It is expressly understood and agreed that the Agreement is incorporated herein by reference.

IV.

Execution. Multiple Counterparts: This First Amendment may be executed in several counterparts. Each counterpart is deemed an original. All counterparts together constitute one and the same instrument. Each Party warrants that the undersigned is a duly authorized representative with the power to execute this First Amendment.

AETNA LIFE INSURANCE COMPANY

By: Richard A. Frommeyer
_____
Richard Frommeyer
Senior Vice President, Group Retiree, ALIC

HARRIS COUNTY

By:_____
LINA HIDALGO
COUNTY JUDGE

APPROVED AS TO FORM:
JONATHAN FOMBONNE
COUNTY ATTORNEY

By: DocuSigned by: Scott Petty BA20529EFED047E...
T. Scott Petty
Senior Assistant County Attorney
C.A. File 25GEN2919

EXHIBIT A

1. Medicare Group Agreement
2. Financial Conditions Document
3. Aetna Plan and Benefit Information Document
4. Pharmacy Service and Fee Schedule to the Master Services Agreement
5. Addendum to Service and Fee Schedule: Specialty Product Pricing
6. Rate Exhibit
7. SilverScript Summary of Benefits
8. Group Employer Medicare Advantage Plan and Medicare Prescription Drug Plan Activation

(follow behind)

AETNA MEDICARE GROUP AGREEMENT

This Group Agreement is by and between the Aetna entity or entities identified in Section 1.2 below ("Aetna") and Harris County and Harris County Flood Control District (the "Contract Holder"). This Group Agreement takes effect on February 1, 2026 (the "Effective Date") if Aetna has accepted the Contract Holder's signed Group Application and received the initial premium. This Group Agreement remains in force until terminated.

This Group Agreement consists of the combination of the following documents:

- The **Evidence of Coverage** issued to Members in connection with this Group Agreement, including the attached Schedule of Copayments/Coinsurance (the "EOC"). The EOC is issued by Aetna to Members on an annual basis. Upon request, Aetna will provide Contract Holder with a copy of the EOC.
- The most recent **rate exhibits, plan designs and financial conditions** issued by Aetna to the Contract Holder in connection with the original issuance and renewal of this Group Agreement, and, if Aetna is billing both the Contract Holder and Members a portion of the monthly premium, the **Service Agreement** between Aetna and Contract Holder that describes this split billing arrangement. These documents are collectively referred to herein as the "Financial Documents".
- This **Group Agreement**, including the attached CMS/Regulatory Requirements Addendum
- Contract Holder's **Group Application** (the "Group Application").
- Any riders, amendments, inserts or attachments issued pursuant to any of the foregoing documents.

The Group Application, EOC and Financial Documents are collectively referred to as the "Incorporated Documents."

Aetna and Contract Holder agree as follows:

Section 1. COVERAGE

1.1 **Covered Benefits.** The Financial Documents identify the fully-insured Aetna Medicare Plan(s) (the "Plan(s)") offered to the Contract Holder under this Group Agreement for the corresponding time periods and the service area(s) (the "Service Area(s)") where the Plans are offered. Aetna shall provide coverage to Members for all of the health care services and supplies that are covered by the Plan(s) (the "Covered Benefits").

1.2 **Aetna Insurer.** Aetna's Medicare Advantage PPO Plans are offered by Aetna Life Insurance Company, Coventry Health and Life Insurance Company, HealthAssurance Pennsylvania, Inc., and Coventry Health Care of Illinois, Inc. With regard to such Plans, "Aetna" means Aetna Life Insurance Company, Coventry Health and Life Insurance Company, HealthAssurance Pennsylvania, Inc., and Coventry Health Care of Illinois, Inc.

Aetna Medicare Rx Plans are offered by SilverScript Insurance Company. With regard to such Plans, "Aetna" means SilverScript Insurance Company,

Section 2. TERM

2.1 **Initial Term.** The initial term of this Group Agreement (the "Initial Term") will be 11 months beginning at 12:01 a.m. on February 1, 2026 (the "Effective Date").

2.2 **Subsequent Terms.** This Group Agreement will automatically renew for subsequent twelve-month renewal terms (each a "Subsequent Term") on January 1st unless sooner terminated prior to the commencement of the Subsequent Term, pursuant to Section 5.

Section 3. PREMIUMS

3.1 **Premiums.** Aetna uses three different methods for billing premiums. A monthly premium can either be billed to the Member ("Direct Billing"), to the Contract Holder ("Contract Holder Billing") or to both the Member and the Contract Holder ("Split Billing"). In some cases, Aetna uses multiple billing methods for the same Contract Holder. The Group Application will indicate the billing method(s) that apply to the Plan(s) under this Agreement. If Contract Holder and Aetna agree to change the billing method(s) applicable to the Plan(s) after the Initial Term, the Financial Documents will indicate the billing method(s) that apply to the Plan(s) under this Agreement. In all cases, the "Premium Due Date" shall be the Effective Date and the 1st day of each succeeding calendar month.

- For Members who are subject to Direct Billing, Aetna will charge the Member a monthly premium (the "Member Premium") determined by Aetna based on the Member Premium in effect on the Premium Due Date, as stated in the Financial Documents.
- Where Contract Holder Billing is applicable, Aetna will charge the Contract Holder a monthly premium (the "Contract Holder Premium") determined by Aetna based on the Contract Holder Premium in effect on the Premium Due Date, as stated in the Financial Documents.
- Where Split Billing is applicable, Aetna will charge the Contract Holder and each Member a monthly premium (comprised of both Member Premiums and Contract Holder Premiums aggregating to a "Split Billing Premium") determined by Aetna based on the Split Billing Premium in effect on the Premium Due Date, as stated in the Financial Documents.

"Member Premium", "Contract Holder Premium" and "Split Billing Premium" are collectively referred to herein as "Premium".

Members shall pay all Member Premium and the Contract Holder shall pay all Contract Holder Premium to Aetna on or before each Premium Due Date. Membership as of each Premium Due Date will be determined by Aetna in accordance with Aetna's Member records.

Aetna may change the rates for the Member Premium, the Contract Holder Premium and the Split Billing Premium and the Covered Benefits at the beginning of any Subsequent Term. The applicable Financial Document may identify certain circumstances when Aetna may change the rates for the Contract Holder Premium or the Split Billing Premium (other than the Member Premium portion) during the Initial Term.

A Premium payment check does not constitute payment until it is honored by a bank. Aetna may return a check issued against insufficient funds without making a second deposit attempt.

Aetna may accept a partial payment of Premium without waiving the right to collect the entire amount due. If the Group Agreement terminates for any reason, the Members will continue to be held liable

for all Member Premiums due and unpaid before the termination and the Contract Holder will continue to be held liable for all Contract Holder Premiums due and unpaid before the termination.

3.2 **Membership Adjustments.** Aetna may make retroactive additions of Members at its discretion based upon Aetna's eligibility and enrollment guidelines consistent with all Mandates. Such additions are subject to the payment of all applicable Premiums.

Aetna may also make retroactive adjustments to the Contract Holder's billings for the termination of Members, but only for a maximum of 1 billing periods.

SECTION 4 ENROLLMENT/DISENROLLMENT

4.1 **Enrollment.** The Contract Holder shall offer enrollment in the Plan(s) in compliance with all applicable Mandates as follows:

- At least once during the Term, the Contract Holder shall hold an open enrollment period ("Open Enrollment Period") when all eligible individuals may enroll in the Plan(s). The Open Enrollment Period shall be held at the same time as the open enrollment period for all other group health benefit plans being offered by the Contract Holder to retirees.
- The Contract Holder shall also enable all eligible individuals to enroll in the Plan(s) within 31 days of becoming eligible to receive coverage under the Plan(s).

All eligible individuals and dependents not enrolled in the Plan(s) within the Open Enrollment Period or within 31 days of becoming eligible may be enrolled during any subsequent Open Enrollment Period. Coverage under the Plan(s) will not become effective until confirmed by Aetna. The Contract Holder shall permit Aetna representatives to meet with eligible individuals and dependents during each Open Enrollment Period.

4.2 **Eligibility.** The Contract Holder shall not change the Open Enrollment Period or any other eligibility requirements of the Plan(s) unless Aetna agrees to the change in writing.

4.3 **Enrollment/Disenrollment Processing.** The Parties shall agree in advance who shall bear responsibility for enrollment and disenrollment transactions as set forth in the Group Application. The Party bearing responsibility for enrollment/disenrollment transactions shall perform the function in accordance with all applicable Mandates, including Mandates relating to timeframes for processing and submission of such transactions. All of the enrollment and disenrollment requirements described in this Group Agreement also apply to any third party administrator retained by the Contract Holder to accept enrollment/disenrollment requests on its behalf.

Aetna will not be liable to Members for the fulfillment of any obligation before Aetna receives enrollment and eligibility information for the Member in a form satisfactory to Aetna. The Contract Holder must notify Aetna of the date in which a Member's eligibility ceases for the purpose of termination of coverage under this Group Agreement. Section 5.0 of the CMS/Regulatory Requirements Addendum includes additional details regarding enrollment and disenrollment requirements applicable to the Plan(s).

SECTION 5 TERMINATION

5.1 **Termination Without Cause.** Either Party may terminate this Group Agreement in its entirety or in any particular Service Area, without cause, by giving the other Party at least 90 days' prior written notice of when such termination will become effective. The notice shall specify the effective date of the termination, which shall be the first day of the month, and the Plan(s) and Service Areas to be terminated if not the entire Group Agreement. *(Note: Aetna requires 60 days' notice of termination to ensure sufficient time to meet the CMS requirement to provide Members with at least 21 calendar days' notice of termination.)*

5.2 **Termination by Aetna.** In addition to the termination rights set forth in Section 5.1 above, Aetna may terminate this Group Agreement as described in this Section 5.2.

5.2.1 **Termination for Non-Payment of Premium**. An individual Member's coverage under this Group Agreement may be terminated by Aetna in compliance with Mandates if all Member Premiums are not received by Aetna from that Member within 3 months following the Premium Due Date (the "Member Grace Period"). If Member Premiums owed by 10 percent or more of Members remain unpaid at the end of the applicable Member Grace Period, Aetna may terminate the Group Agreement upon 30 days' prior written notice to the Contract Holder.

If the Contract Holder has not paid all Contract Holder Premiums within 30 days following the Premium Due Date (the "Contract Holder Grace Period"), Aetna may terminate the Group Agreement immediately upon notice to Contract Holder.

5.2.2 CMS Contract Termination, Non-Renewal & Service Area Reductions & Product Withdrawal.

(a) **Termination of Entire Group Agreement**. This Group Agreement shall terminate effective upon any anniversary of the Effective Date if Aetna will no longer offer any Plan in any Service Areas, because: (1) CMS terminates or otherwise non-renews the Aetna's CMS Contract, or (2) Aetna terminates its CMS Contract or reduce the Service Areas referenced in Aetna's CMS Contract.

Aetna may also terminate this Group Agreement upon 90 days' prior written notice to the Contract Holder (or such shorter notice as may be permitted by Mandates, but in no event less than 30 days) if Aetna ceases to offer a product or coverage in any market in which Members reside

(b) **Partial Termination of Group Agreement**. This Group Agreement may also be terminated in part as to a particular Plan within one or more Service Areas by Aetna upon any anniversary of the Effective Date if Aetna will no longer offer that Plan in any Service Areas because: (1) CMS terminates or otherwise non-renews the applicable Aetna CMS Contract, (2) Aetna terminates the applicable CMS Contract or reduce the Service Areas referenced in the applicable CMS Contract, or (3) Aetna or Contract Holder cease to meet any Mandates applicable to offering the Plan(s), including the Service Area Extension Mandates described in the CMS/Regulatory Compliance Addendum, if applicable.

5.2.3 Additional Termination Rights. Aetna may also terminate this Group Agreement as follows:

(a) Immediately upon notice to the Contract Holder if the Contract Holder has committed fraud or any intentional misrepresentation of a material fact relevant to the coverage provided under this Group Agreement;

(b) Immediately upon notice to the Contract Holder if the Contract Holder no longer has any Member under the Plan(s) who resides in the Service Area;

(c) Upon 30 days' prior written notice to the Contract Holder if the Contract Holder (i) breaches a provision of this Group Agreement and such breach remains uncured at the end of the notice period; (ii) fails to meet Aetna's contribution or participation requirements applicable to this Group Agreement, as set forth in the applicable Financial Document; (iii) provides 30 days' written notice to Members stating that coverage under this Group Agreement will no longer be provided to Members; (iv) changes its eligibility or participation requirements without Aetna's consent; or (v) ceases to meet any Mandates applicable to offering the Plan(s), including the Service Area Extension Mandates described in the CMS/Regulatory Compliance Addendum, if applicable;

(d) Upon 60 days' prior written notice to the Contract Holder if the Contract Holder is a member of an employer-based association group, and the Contract Holder's membership in the association ceases; or

(e) Upon written notice to the Contract Holder if, as a result of the enactment of any new law or regulation, or any change in any law or regulation or any interpretation of any law or regulation: (1) the rights or obligations of Aetna under this Group Agreement would be materially affected; (2) CMS reimbursement to Aetna under the Medicare Advantage and/or Part D program would materially change; or (3) Plan benefits, design, premium/rates, coverage and/or administration would be materially impacted.

Any such termination shall be effective on the day immediately preceding the effective date of such law, regulation or interpretation; however, Aetna shall provide written notice to Contract Holder of this date.

5.3 **Effect of Termination.** No termination of this Group Agreement will relieve Aetna or the Contract Holder from any obligation incurred under this Group Agreement before the date of termination. The Parties agree that termination of the Plan, disenrollment of Members from the Plan, and transition and continuity of care and coverage for Members will be consistent and comply with Mandates. The Parties agree to work together in good faith to help ensure an orderly transition of coverage for Members. When terminated, this Group Agreement and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. In the event of termination for any reason, Members must continue to pay all Member Premiums due and unpaid before the effective date of the termination and the Contract Holder must continue to pay all Contract Holder Premiums due and unpaid before the termination, including Member Premiums and Contract Holder Premiums due during the applicable Member or Contract Holder Grace Period. Members also remain responsible for Member cost sharing and other required contributions during the Member Grace Period.

5.4 **Auto-Enrollment Upon Termination of Plan**. This Section 5.4 only applies if Contract Holder terminates this Group Agreement or any Plan is terminated in any Service Area, and Contract Holder elects to offer health insurance policies to Members through a public or private exchange in which Contract Holder participates.

If this Group Agreement is terminated or any Plan is terminated in any Service Area, certain Mandates permit Aetna to disenroll Members from the Plan and automatically enroll such Members in a comparable individual Medicare plan offered by Aetna ("Aetna Individual Medicare Plan"), unless the Member opts out or makes another health plan choice.

The Contract Holder agrees that if it establishes a Health Reimbursement Account ("HRA") and provides a subsidy for use by Members to pay health insurance premiums for individual health insurance policies, the Contract Holder will allow Members who are automatically enrolled in an Aetna Individual Medicare Plan as described in this Section 5.4 to continue to receive the same level of subsidy and use such HRA to pay the health insurance premium for the Aetna Individual Medicare Plan. The Contract Holder will not limit such Members' use of the HRA solely to health insurance policies issued through a public or private exchange in which the Contract Holder participates.

Section 6. PRIVACY AND SECURITY OF INFORMATION

6.1 **Compliance with Privacy and Security Laws.** Aetna and the Contract Holder shall each abide by all Mandates regarding the confidentiality and the safeguarding of individually identifiable health and other personal information, including the privacy and security requirements of HIPAA.

6.2 **Disclosure of Protected Health Information.** If Contract Holder determines that it needs protected health plan information ("PHI"), as defined in HIPAA, in connection with administration of the Plan, any such request shall be in accordance with 45 C.F.R. § 164.504(f) and other applicable Mandates.

Section 7. INDEPENDENT CONTRACTOR RELATIONSHIPS

7.1 **Relationship Between the Parties.** The relationship between the Parties is a contractual relationship between independent contractors. Neither Party is an agent or employee of the other in performing its obligations pursuant to this Group Agreement.

7.2 **Relationship Between Aetna and Network Providers.** The relationship between Aetna and providers contracted with Aetna to participate in the Plan(s)' provider network ("Network Providers") is a contractual relationship among independent contractors. Network Providers are not agents or employees of Aetna nor is Aetna an agent or employee of any Network Provider.

Network Providers are solely responsible for any health services rendered to their patients. Aetna makes no express or implied warranties or representations concerning the qualifications, continued participation, or quality of services of any Network Provider. A Network Provider's participation in the provider network for the Plan(s) may be terminated at any time without advance notice to the Contract Holder or Members, subject to Mandates. Network Providers provide health care diagnosis, treatment and services for Members. Aetna administers and determines Plan benefits.

Section 8. DEFINITIONS

8.1 "CMS" means the Centers for Medicare and Medicaid Services.

8.2 "CMS Contract" means the contract between Aetna and CMS under which Aetna offers the Plan(s) in the applicable time period.

8.3 "EOC" means the Evidence of Coverage, which is a document issued pursuant to this Group Agreement that outlines coverage for Members under the Plan(s). The EOC includes the Schedule of Copayments/Coinsurance and any riders or amendments.

8.4 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

8.5 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder.

8.6 "Mandates" means applicable laws, regulations and government requirements in effect during the Term of this Group Agreement including, without limitation, applicable Medicare laws, regulations and CMS requirements (including CMS manuals, memo guidance and other directives).

8.7 "Member" is a Medicare beneficiary who: (1) has enrolled in the Plan(s) and whose enrollment in the Plan(s) has been confirmed by CMS, and (2) is eligible to receive coverage under the Plan(s), subject to the terms and conditions of this Group Agreement and the EOC.

8.8 "Party, Parties" means Aetna and the Contract Holder.

8.9 "Term" means the Initial Term or any Subsequent Term.

Section 9 MISCELLANEOUS

9.1 **Delegation and Subcontracting.** Aetna may delegate functions and services under this Group Agreement to third party vendors (i.e., pharmacy, behavioral health vendors). Aetna's arrangements with third party vendors are subject to change in accordance with Mandates. Aetna shall be responsible for its third party vendors, including their compliance with Mandates and other legal requirements.

9.2 **Disease Management and Care Management Programs.** From time to time, Aetna may offer programs that are designed to improve quality of care, ensure access to Covered Benefits or coordinate care delivered to Members under the Plan(s) ("Disease and Care Management Programs"). Aetna will administer Disease and Care Management Programs consistent with any applicable Mandates. The Contract Holder acknowledges that Aetna may alter or discontinue the Disease and Care Management Program offered to Members at any time, consistent with all Mandates.

9.3 **Prior Agreements; Severability.** As of the Effective Date, this Group Agreement replaces and supersedes all other prior agreements between the Parties as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the Parties related to matters covered by this Group Agreement or the documents incorporated herein. If any provision of this

Group Agreement is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this Group Agreement shall continue in full force and effect.

9.4 **Claim Determinations and Administration of Covered Benefits.** Aetna is a fiduciary for the purpose of Section 503 of Title 1 of ERISA. Aetna has complete authority to determine whether and to what extent eligible individuals and beneficiaries are entitled to coverage and to construe any disputed or doubtful terms under this Group Agreement. Aetna shall be deemed to have properly exercised such authority unless it abuses its discretion by acting arbitrarily and capriciously. Aetna's review of claims may include the use of commercial software and other tools to take into account factors such as an individual's claims history, a provider's billing patterns, complexity of the service or treatment, amount of time and degree of skill needed and the manner of billing.

9.5 **Incontestability.** Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Contract Holder or any Member shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by Contract Holder shall be the basis for voiding this Group Agreement after it has been in force for two years from the Effective Date.

9.6 **Assignability.** No rights or benefits under this Group Agreement are assignable by Contract Holder to any other Party unless approved in advance by Aetna. Aetna may without Contract Holder's consent (but upon 30 days' written notice to Contract Holder) assign this Group Agreement to an affiliate, consistent with CMS requirements without the prior approval of the Contract Holder.

For purposes of this Section 9.6, an "affiliate" is defined as, any company that (i) controls, (ii) is controlled by or (iii) is under common control with Aetna or its parent corporation. A company shall be deemed to control a company if it has the power to direct or cause the direction of the management or policies of such company, whether through the ownership of voting securities, by contract, or otherwise.

9.7 **Waiver.** Aetna's failure to implement, or insist upon compliance with, any provision of this Group Agreement or the terms of the EOC incorporated hereunder, at any given time or times, shall not constitute a waiver of Aetna's right to implement or insist upon compliance with that provision at any other time or times.

9.8 **Conflict.** In the event of a conflict between the terms of this Group Agreement and any of the Incorporated Documents or among any of the Incorporated Documents, the order of priority shall be as the listing of incorporated documents set forth in the second paragraph of this Group Agreement. Any riders, amendments, inserts and attachments shall have the same priority as the document to which they are attached.

9.9 **Third Parties.** This Group Agreement does not give any rights or impose any obligations on third parties except as specifically provided herein.

9.10 **Non-Discrimination.** The Contract Holder shall not encourage or discourage enrollment in the Plan(s) based on health status or health risk and shall follow all applicable Mandates on non-discrimination.

9.11 **Compliance with Mandates; Amendment to Comply with Mandates.** Aetna and the Contract Holder shall comply with all Mandates applicable to the performance of their respective obligations under this Group Agreement. The Contract Holder shall comply with the applicable provisions of the CMS/Regulatory Addendum, which is designed to ensure Contract Holder's and Aetna's compliance with specific Mandates.

9.12 **Applicable Law.** This Group Agreement shall be governed and construed in accordance with applicable federal law and the applicable law, if any, of the State of Texas.

9.13 **Force Majeure.** If due to circumstances not within Aetna's reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Aetna's Network Providers or entities with whom Aetna has contracted for services under this Group Agreement, or similar causes, the provision of medical or hospital benefits or other services provided under this Group Agreement is delayed or rendered impractical, Aetna shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid Premiums held by Aetna on the date such event occurs. Aetna is required only to make a good-faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

9.14 **Use of the Aetna Name and all Symbols, Trademarks, and Service Marks.** Aetna controls the use of its name and all symbols, trademarks, and service marks presently existing or subsequently established. The Contract Holder shall not use any of them in advertising or promotional materials or in any other way without Aetna's prior written consent. The Contract Holder shall stop any and all use immediately upon Aetna's request or upon termination of this Group Agreement.

9.15 **Coordination of Benefits.** This Section 9.15 applies solely if the Contract Holder is a Member's former employer and the Member sustains a work related injury before he or she leaves employment, regardless of when symptoms become evident. In such event, the Contract Holder shall protect Aetna's interests in any workers' compensation claims or settlements with any Member by reimbursing Aetna for all paid medical expenses which have occurred as a result of the work related injury that is compensable or settled in any manner.

Upon Aetna's request, the Contract Holder shall also submit a monthly report to Aetna listing all workers' compensation cases for Members who have outstanding workers compensation claims involving the Contract Holder. The list shall contain the name of the Member, the date of loss and the diagnosis.

9.16 **Notices.** Any notice required or permitted under this Group Agreement shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the Group Application, or to any more recent address of which the sending Party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

9.17 **Amendments.** This Group Agreement may be amended as follows:

- This Group Agreement shall be deemed to be automatically amended to conform with all Mandates promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over Aetna;
- By mutual written agreement between both Parties; or
- By Aetna upon 30 days' written notice to the Contract Holder.

The Parties agree that an amendment does not require the consent of any Member or other person. Except for automatic amendments to comply with Mandates, all amendments to this Group Agreement must be approved and executed by Aetna.

9.18 **Clerical Errors.** Clerical errors or delays by Aetna in keeping or reporting data relative to coverage will not reduce or invalidate a Member's coverage. Upon discovery of an error or delay, an adjustment of Premiums shall be made. Aetna may also modify or replace a Group Agreement, EOC or other document issued in error.

9.19 **Misstatements.** If any fact as to the Contract Holder or a Member is found to have been misstated, an equitable adjustment of Premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

9.20 **Confidential Information**. The term "Confidential Information" includes, but is not limited to, this Group Agreement or any information of either Contract Holder or Aetna (whether oral, written, electronic, visual or fixed in any tangible medium of expression) relating to either Party's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers, contractors, costs and pricing data, trade secrets, know-how, processes, plans, designs and other information of or relating to either Party's business.

- **Confidentiality Obligations**. Aetna and Contract Holder shall not disclose or make use of any Confidential Information except as permitted under this Group Agreement without the prior written consent of the non-disclosing party, which consent may be conditioned upon the execution of a confidentiality agreement. Each Party may disclose Confidential Information of the other Party only to its employees, agents, consultants, or authorized representatives who have a need to know the Confidential Information in order to accomplish the purpose of this

Group Agreement and who (A) have been informed of the confidential and proprietary nature of the Confidential Information, and (B) with respect to agents, consultants or authorized representatives, have agreed in writing not to disclose it to others and to treat it in accordance with the requirements of this Section. Aetna or Contract Holder, as applicable, shall be responsible to the other Party for any breach of this Agreement by its respective employees, agents, consultants, or authorized representatives.

- **Permitted Disclosure of Confidential Information**. The foregoing shall not apply to such Confidential Information to the extent: (A) the information is or becomes generally available or known to the public through no fault of the receiving party; (B) the information was already known by or available to the receiving party prior to the disclosure by the other party on a non-confidential basis; (C) the information is subsequently disclosed to the receiving party by a third party who is not under any obligation of confidentiality to the disclosing party; (D) the information has already been or is hereafter independently acquired or developed by the receiving party without violating any confidentiality agreement or other similar obligation; or (E) the information is required to be disclosed pursuant to a non-appealable court order. Except in accordance with the requirements of this Section 9.20, neither Party nor its employees, agents, consultants, or authorized representatives may disclose, or permit to be disclosed, Confidential Information of the other Party as an expert witness in any proceeding, or in response to a request for information by oral questions, interrogatories, document requests, subpoena, civil investigative demand, formal or informal investigation by any government agency, judicial process or otherwise. If either Party, or any of its respective employees, agents, consultants, or authorized representatives, is requested to disclose the Confidential Information of the other Party for any of the reasons described in the preceding sentence such Party shall give prompt prior written notice to the other Party to allow the other Party to seek an appropriate protective order or modification of any requested disclosure. The receiving party agrees to cooperate with the disclosing party in any action by the disclosing party to obtain a protective order or other appropriate remedy. If the receiving party is ultimately legally compelled to disclose such Confidential Information, the receiving party shall disclose the minimum required pursuant to the court order or other legal compulsion.
- **Remedies**. Any unauthorized disclosure or use of Confidential Information would cause Aetna or Contract Holder immediate and irreparable injury or loss that may not be adequately compensated with money damages. Accordingly, if either Party fails to comply with this Section 9.20, the other Party will be entitled to specific performance including immediate issuance of a temporary restraining order or preliminary injunction enforcing this Group Agreement, and to judgment for any and all claims, liabilities, demands, damages, losses, costs or expenses of any kind, including, without limitation, reasonable attorneys' fees and expenses caused by the breach, and to any other remedies provided by law or in equity.

9.21 **Aetna Intellectual Property**. Under this Group Agreement, Contract Holder may have access to certain of Aetna's Customer reporting systems. Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing services under this Group Agreement ("Aetna IP"). Aetna will grant Contract Holder, as a plan sponsor, a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in this Group Agreement. Contract Holder agrees not to modify, create derivative product from, copy,

duplicate, decompile, dissemble, reverse-engineer or otherwise attempt to perceive the source code from which any software component of the AetnaIP is compiled or interpreted. Nothing in this Group Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent or otherwise transfer or convey, the Aetna IP to Contract Holder.

Signed as of the Effective Date.

Aetna:

By: 

Richard A. Frommeyer
Vice President

CMS/REGULATORY REQUIREMENTS ADDENDUM

The following provisions describe critical regulatory requirements that apply to all plan sponsors offering Aetna group Medicare plans, and they are included in this Group Agreement to ensure Aetna and Contract Holder's compliance with Mandates.

Section 1.0 CMS Uniform Premium Requirements.

1.1 **Medicare Advantage – Premium Requirements**. This Section 1.1 applies only if Aetna is offering a Medicare Advantage HMO or PPO Plan to Members, and Contract Holder and Members are paying any portion of the Premium for the Medicare Advantage benefit ("MA Premium").

Contract Holder will comply with the following conditions with respect to any subsidization of MA Premium and any required MA Premium contribution by the Member:

- Contract Holder may subsidize different amounts of MA Premium for different classes of Members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly).
- MA Premium contribution levels cannot vary for Members within a given class.
- Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required MA Premium payment by the Member.

1.2 **Part D – Premium and Low Income Subsidy Requirements**. This Section 1.2 applies only if Aetna is offering an Aetna Medicare Rx Plan or a Medicare Advantage HMO and/or PPO plan with Medicare prescription drug plan benefits to Members.

Contract Holder will comply with the following conditions with respect to any subsidization of that portion of Premiums paid by Contract Holder for the Medicare Prescription Drug benefit ("PD Premium") and any required PD Premium contribution by the Member:

- Contract Holder may subsidize different amounts of PD Premium for different classes of Members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Classes of Members and their dependents cannot be based on eligibility for the Low Income Subsidy ("LIS").
- PD Premium contribution levels cannot vary for Members within a given class.
- Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required PD Premium payment by the Member ("Member Contribution") so the Member in no event shall be required to pay more than the sum of: a) the standard Medicare Part D premium, net of the direct subsidy payment from CMS, and b) one hundred percent (100%) for any supplemental coverage selected by the Member.

Contract Holder shall comply with the following conditions with respect to any LIS payment received from CMS for any LIS-eligible Member:

- Any monthly LIS payment received from CMS for an LIS-eligible Member shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of the Contract Holder's PD Premium contribution. However, if the sum of the Member Contribution and Contract Holder's PD Premium is less than the LIS payment, any portion of the LIS payment will be returned to CMS by Aetna.
- If the LIS payment for any LIS-eligible Member is less than the Member Contribution required by such individual (including the Member Contribution for supplemental benefits, if any), Contract Holder shall communicate with the LIS-eligible Member about the cost of remaining enrolled in Contract Holder's Plan versus obtaining coverage as an individual under another Medicare Part D Prescription Drug plan.
- In the event that the LIS-eligible Member is due a refund of the LIS payment (i.e., there was no upfront reduction of the PD Premium by the LIS amount), such refund shall be completed by Aetna or Contract Holder, as applicable, within 45 days of the date Aetna receives the LIS payment for that Member from CMS.

Section 2.0 Records.

2.1 **Maintenance of Information & Records**. Contract Holder agrees to maintain Information and Records (as those terms are defined in Section 2.2 below) in a current, detailed, organized and comprehensive manner and in accordance with Mandates, and to maintain such Information and Records for the longer of: (i) a period of ten (10) years from the end of the final contract period for the Plan(s), (ii) the date the U.S. Department of Health and Human Services, the Comptroller General or their designees complete an audit, or (iii) the period required by Mandates.

2.2 **Access to Information and Records**. Contract Holder will provide Aetna and federal, state and local governmental authorities having jurisdiction, directly or through their designated agents (collectively "Government Officials"), upon request, access to all books, records and other papers, documents, materials and other information (including, but not limited to, contracts and financial records), whether in paper or electronic format, relating to the arrangement described in this Group Agreement ('Information and Records"). Contract Holder agrees to provide Aetna and Government Officials with access to Information and Records for as long as it is maintained as provided in Section 2.1 above. Access to Information and Records will be provided within 14 calendar days of receipt of an applicable request, where practicable, and in no event later than the date required by an applicable law or regulatory authority.

2.3 **Survival**. The preceding provisions of this Section 2.0 shall survive termination of this Group Agreement regardless of the cause of termination.

Section 3.0 Medicare Secondary Payer Requirements. Records.

3.1 **Generally**. Aetna and Contract Holder agree to comply with all Medicare Secondary Payer ("MSP") Mandates that apply to Contract Holder, the Plan and Aetna ("MSP Requirements").

3.2 **MSP Requirements Applicable to Medicare Beneficiaries Diagnosed with End Stage Renal Disease ("ESRD")**. Aetna and Contract Holder agree to comply with all MSP Requirements applicable to

Contract Holder's active employees and retirees and their dependents who are Medicare beneficiaries diagnosed with ESRD ("ESRD Beneficiaries" or "ESRD Beneficiary"), including, without limitation, those MSP Requirements set forth in 42 U.S.C. § 1395y (b)(1)(C), 42 C.F.R. §§ 411.102(a), 411.161, and 411.162 and 42 C.F.R. §§ 422.106 and 422.108 ("ESRD MSP Requirements").

3.3 Contract Holder acknowledges and agrees that if an ESRD Beneficiary is eligible for or entitled to Medicare based on ESRD, the MSP Requirements require the commercial group health plan offered by Contract Holder ("GHP") to be the primary payer for the first 30 months of the ESRD Beneficiary's Medicare eligibility or entitlement ("30-month coordination period"), regardless of the number of employees employed by Contract Holder and regardless of whether the ESRD Beneficiary is a current employee or retiree.

3.4 To ensure Aetna's and Contract Holder's compliance with ESRD MSP Requirements, Contract Holder agrees to confirm to Aetna whether ESRD Beneficiaries are in their 30-month coordination period, and not seek to enroll ESRD Beneficiaries in the Plan(s) during their 30-month coordination period unless coverage under the GHP is maintained for such ESRD Beneficiaries for that period. If Contract Holder seeks to enroll an ESRD Beneficiary in a Plan, Contract Holder agrees to provide Aetna, upon request, with information or documentation to verify compliance with ESRD MSP Requirements, including any MSP reporting or other requirements established by CMS.

Section 4.0 Office of Foreign Asset Control. If coverage provided by the Group Agreement violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

Section 5.0 CMS Enrollment & Disenrollment Requirements.

5.1 To the extent that Contract Holder directly accepts enrollment and/or disenrollment requests from potential Members or Members that Contract Holder forwards to Aetna for processing and submission to CMS, Contract Holder will comply with all Mandates that relate to the handling and processing of enrollment and disenrollment requests that apply to the Plan(s). A Member's signature on an enrollment/disenrollment form must be dated prior to the requested enrollment/disenrollment effective date.

If requesting retroactive enrollment or disenrollment, Contract Holder will forward enrollment and disenrollment forms completed by potential Members or Members to Aetna no later than 90 days after the Member's enrollment or termination effective date. If there is a delay between the time a Member submits an enrollment/disenrollment request to Contract Holder and when the enrollment/disenrollment request is received by Aetna, the enrollment/disenrollment transaction may not be processed by CMS, unless Aetna requests and CMS approves a retroactive enrollment/disenrollment transaction for the Member. Aetna will determine whether to submit retroactive enrollment and disenrollment transaction requests to CMS, and will make such determinations in accordance with Mandates.

All Members must be notified that they will be enrolled in a Plan. CMS requires that this notice be provided by Aetna or Contract Holder not less than 21 calendar days prior to the effective date of the Member's enrollment in the Plan to allow Members the opportunity to evaluate other available health plan options.

5.2 The effective date of enrollments and disenrollments in the Plan(s) cannot be earlier than the date the enrollment or disenrollment request was completed by a Member. If approved by CMS, the effective date of an enrollment or disenrollment may be retroactive up to, but may not exceed, 90 days from the date that Aetna received the enrollment or disenrollment request from the Contract Holder, and the enrollment or disenrollment form must be completed and signed by the Member prior to the requested enrollment or disenrollment effective date.

5.3 CMS does not permit retroactive termination of a Member's coverage under the Plan(s) if the Member no longer meets Contract Holder's eligibility criteria to remain enrolled in the Plan(s). To meet this CMS requirement, Contract Holder will provide Aetna with advanced written notice if Contract Holder chooses to terminate a Member's coverage under the Plan based on loss of eligibility, and Contract Holder acknowledges that the Member's prospective coverage termination effective date will be determined in accordance with Mandates.

5.4 If Contract Holder elects to change Plan coverage offered to Members or to terminate a Member's coverage under the Plan(s), Contract Holder must provide written notice to such Member(s) at least 21 calendar days prior to the effective date of the change in the Member's coverage or disenrollment from the Plan(s), as applicable. This written notice must include a description of how the Member can contact Medicare to obtain information regarding other Medicare Advantage or Medicare Part D plan options that may be available to the Member. Aetna will assist Contract Holder with developing appropriate notices.

5.5 Aetna reserves the right to notify Members of the involuntary termination of their coverage under this Group Agreement for any reason.

5.6 If eligible individuals are to be enrolled and/or disenrolled in the Plan(s) electronically, the electronic forms used for this process must be approved by CMS for use by the Plan(s) and conform to all Mandates applicable to format, data fields and other required information. Aetna will work with Contract Holder to develop appropriate electronic forms.

5.7 Electronic enrollments and disenrollments will be deemed effective on the first day of the month requested, subject to compliance with any applicable Mandates.

5.8 Contract Holder will produce, at Aetna's request, the original copy of any enrollment or disenrollment form or record received by Contract Holder.

5.9 Contract Holder shall limit enrollment in the Plans to retirees who are Medicare eligible individuals and are receiving Employment-Based Retiree Coverage under a Group Health Plan sponsored by Contract Holder. Employment-Based Retiree Coverage means coverage of health care costs under a Group Health

Plan based on an individual's status as a retired participant in the plan, or as the spouse or dependent of a retired participant. A Group Health Plan means a plan defined in Section 607(1) of ERISA or any other plan described in 42 C.F.R. § 422.106(d).

Section 6.0 Notices to Members.

6.1 **Notice of Changes.** Contract Holder will provide Members with written notice describing any changes made to premiums, benefits or other terms of the Plan(s) as required under Mandates. If Contract Holder does not distribute notices as required under this Section 6.0 Aetna may, at its discretion, distribute such notices to Members.

6.2 **Notice of Termination of Coverage**. Contract Holder will notify Members of the termination of the Plan(s) in compliance with Mandates. However, Aetna reserves the right to notify Members of termination or suspension of the Plan(s) for any reason. Contract Holder will provide written notice to Members of their rights upon termination of coverage as required under Mandates.

6.3 **Member Plan Materials.** The Contract Holder shall cause any Member Plan materials that have not been approved by CMS to comply with ERISA or, in the case of a non-ERISA Plan, any applicable alternative regulatory disclosure requirements.

6.4 **Plan Reporting and Disclosure Requirements.** The Contract Holder agrees that it is responsible for any and all Plan reporting and disclosure requirements imposed by ERISA and other applicable law, including updating the Summary of Benefits and Coverage (SBC) or Summary Plan Description (SPD) and other Plan documents and issuing any necessary summaries of material modifications to reflect any changes in benefits.

Section 7.0 Service Area Extension & Network Adequacy for Plan. This Section 7.0 only applies if Aetna is offering a Medicare Advantage PPO Plan to Members who reside in an Extended Service Area (as defined below).

To enable employers/unions to offer group Medicare Advantage ("MA") plans to all of their Medicare-eligible retirees/dependents wherever they reside, CMS has established a waiver of service area requirements ("Waiver") for organizations that are approved by CMS to offer MA plans ("MAOs"). Under this Waiver, MAOs offering a group MA plan in a given Service Area, can extend coverage to an employer/union sponsor's Medicare-eligible retirees/dependents residing outside of that Service Area, even if the MAO does not offer a provider network for the group MA plan ("Provider Network") that meets CMS network adequacy requirements in that Service Area ("Extended Service Area").

Aetna and Contract Holder agree that Aetna will use this Waiver to offer the Medicare Advantage PPO Plan to Members who reside in an Extended Service Area ("MA PPO Plan"). The Parties acknowledge that Aetna must meet certain CMS requirements to offer the MA PPO Plan in an Extended Service Area, and these requirements include, but are not limited to, the following:

(1) at least 51% of retirees/dependents who are currently enrolled in Aetna MA HMO or PPO plans offered by Contract Holder must be enrolled in an Aetna MA HMO or PPO plan that offers a Provider Network that meets CMS network adequacy requirements, and

(2) all Members who reside in an Extended Service Area must receive the same Covered Benefits at the preferred in-network cost-sharing for all Covered Benefits.

The Parties agree to comply with all Mandates that apply to use of this Waiver. Further, Contract Holder acknowledges and agrees that:

(1) Members who reside in an Extended Service Area do not have access to a Provider Network that meets CMS network adequacy requirements, and

(2) health care providers and suppliers that are not contracted with Aetna to participate in the Provider Network are not required to accept the Plan and furnish Covered Benefits to Members who reside inside or outside of an Extended Service Area, except as required under Mandates. Failure to meet CMS requirements of this Waiver may result in termination of the MA PPO Plan in Extended Service Areas.

Section 8.0 **Retiree-Only Plan.** Contract Holder represents that actively working employees and their dependents are not permitted to enroll in the Plan(s) and that by offering the Plan(s) it intends to create and maintain a retiree plan that is separate from its active plan.

Section 9.0 **Public Records Acts.** The Parties acknowledge that Contract Holder is a public entity and subject to state laws governing disclosure of public records. Contract Holder agrees that the confidential and proprietary information of Aetna which is in writing and marked as confidential and proprietary, shall be afforded protection under applicable law. Prior to disclosing such confidential and proprietary information of Aetna, Contract Holder shall immediately notify Aetna of any requests for information made by a third party pursuant to applicable state statute or local ordinance and shall further provide Aetna sufficient time to claim applicable exemptions and/or designate those portions of this information that constitute proprietary information exempt from disclosure under applicable state statute or local ordinance. Contract Holder further acknowledges that it will not release any information identified by Aetna as exempt from disclosure without first providing notice to Aetna of such intent and allowing Aetna to seek judicial relief to prevent such disclosure. Contract Holder agrees not to oppose any action of Aetna to obtain a declaratory judgment or other appropriate remedy. If a court thereafter determines that Contract Holder is legally required to disclose such proprietary information, Contract Holder shall disclose the minimum required pursuant to the court order.

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Definitions

For the purpose of this document: (1) "MA" means a group Medicare Advantage MA HMO and/or PPO plan without Medicare prescription drug coverage; (2) "MAPD" means a group MA HMO and/or PPO plan with Medicare prescription drug coverage; (3) "PDP" means a group standalone Medicare prescription drug plan; and (4) "ESA" means an MA PPO plan that uses a CMS-established waiver of service area requirements to offer coverage to eligible retirees/dependents who reside in an extended service area that does not offer a provider network that meets CMS network adequacy requirements.

Effective Date

The rates and benefit plan designs provided in this proposal are effective February 1, 2026 through December 31, 2026. We will issue a new Financial Conditions with each year's renewal that will govern for that year, and contract will be amended to include the latest version when applicable.

The following conditions allow us to assess the potential financial impact and adjust premium rates, subject to applicable state and federal mandates:

- **Enrollment Assumptions** – The proposed rates assume member enrollment by plan type as outlined below:

Product	Enrolled Members
Rx 20%/25%/35%/30%	6,498

  We reserve the right to rerate or restructure our rating if: a) the total enrollment varies by more than 10 percent from the enrollment assumption used in the enclosed rating or, b) if any site's enrolled membership expressed as a percent of total enrolled membership varies by more than +/- 10 percent from that assumed when rating the case. Aetna group retiree coverage does not extend to additional employer groups unless we are able to review supplemental census information and other underwriting information for appropriate financial review.

- **Full replacement** - This proposal assumes Aetna group retiree benefits will be a full replacement of the Medicare-eligible retirees and dependents currently enrolled in the Commercial Aetna Prescription Drug Plan and future retirees from any source or other entity. This proposal further assumes that all members currently enrolled in the Humana Medicare Advantage with Part D plan will remain in said plan. If at any point in time during the period of the coverage, the above is not valid, we reserve the right to revise, modify or terminate this proposal.

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- **Legislative, Regulatory, CMS Changes, Executive Orders or Enforcement action** – Aetna reserves the right to revise or terminate all components of this proposal at any time if there are any legislative, regulatory, CMS changes, Executive Orders and/or enforcement actions that cause a change to taxes, fees, assessments, required benefits, Medicare Advantage program revenue or level of reimbursement that CMS will make to Aetna for Members, or the manner and/or cost of providing MAPD Plan medical benefits, including, but not limited to:

    - any changes in methodology used to calculate CMS funding for the MAPD plans;

    - any changes to the Pharmacy program, including, but not limited to, any current proposals or legislation that have not yet been finalized; and/or

    - implementation of the Risk Adjustment Data Validation Audit (RADV) rule as published on January 30, 2023, and any related regulatory guidance

- **Plan eligibility for PDP** -This proposal assumes all members are retired and enrolled in Medicare Part A and/or Part B. You represent that actively working employees and their dependents are not permitted to enroll in your group standalone Medicare prescription drug plan(s) ("Plan(s)"), and that by offering the Plan(s) you intend to create and maintain a retiree plan that is separate from your active plan.

- **Employer contribution requirements** - This proposal assumes a minimum employer contribution level of 50% of the group premium for the Pharmacy plan. If the actual employer contribution differs from this assumed percentage, the PDP rates and/or the plan offering are subject to revision.

Medicare Part D

This proposal assumes that our current experience-rating renewal methodology for groups with at least 400 subscribers will continue to be the accepted and approved methodology for future renewals. If this is not the case, this proposal will be reviewed and may require revision.

Aetna reserves the right to terminate this proposal, change the Pharmacy Plan premium or restructure the Part D plan design or formulary at any time if there are any legislative, regulatory or CMS changes, Executive Orders and/or enforcement actions that cause a change to taxes, fees, assessments, required benefits, Part D program revenue or level of reimbursement that CMS will make to Aetna for Members, or the manner and/or cost of providing Part D benefits, including, but not limited to:

- elimination of safe harbor protection under the federal Anti-Kickback Statute (AKS) for drug manufacturer rebates or other price concessions,
- establishment of new safe harbor protection under the AKS for certain point-of-sale reductions in drug pricing,
- changes to the drug manufacturer discount program,
- changes to federal Part D subsidies, including changes to catastrophic reinsurance,
- drugs selected for Drug Price Negotiation and Maximum Fair Prices,

This proposal excludes any additional income-related Medicare Part D premium payments required of Medicare-eligible Members in order for the Member to be eligible for the Part D product.

Aetna reserves the right to revise this proposal if there is a change to Aetna's pharmacy benefit manager and/or pharmacy network for this calendar year.

Aetna reserves the right to communicate with Members regarding opportunities to reduce out of pocket prescription drug costs.

On July 29, 2024, CMS announced a voluntary 3-year Part D premium stabilization demonstration (demonstration) for standalone Medicare prescription drug plans (PDPs). Aetna notified CMS in August 2025 of its intent to participate in this demonstration for CY 2026 (1/1/2026 effective date). The PDP rates provided for the 2026 plan year reflect Aetna's participation in the demonstration as currently established by CMS. Aetna reserves the right to adjust the PDP rates if CMS terminates, delays or adjusts the demonstration. Aetna also reserves the right to adjust the PDP rates if CMS does not allow Aetna to participate in the demonstration, or Aetna declines to participate in or withdraws from the demonstration due to CMS adjustments to the demonstration or delays in implementation in the demonstration.

Aetna may be required to submit data to CMS and/or the Department of Health & Human Services (HHS) that assists with evaluation of the impacts of the demonstration on the stabilization of PDP premiums. Therefore, if your members make PDP premium payments to you, please ensure that you continue to maintain data that demonstrates your compliance with CMS' Part D premium subsidization requirements, as you may be required to provide access to such data in the future.

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Medicare Part D Formulary

The supplemental premium rates are limited to prescription drugs covered by the quoted formulary. Aetna reserves the right to adjust the level of the proposal increase per any request for formulary coverage expansion. Unless specifically addressed in this document, all previously provided Financial Conditions also apply to this proposal.

- **Rate and benefit approval** -This proposal is subject to Centers for Medicare and Medicaid Services ("CMS") annual filing approval for the Medicare Advantage and Medicare prescription drug contracts, applications, and service areas for calendar year 2026. Filed benefits, including cost sharing amounts and premiums, are subject to regulatory approval(s), where applicable, and are effective February 1, 2026 through December 31, 2026.

- **Timely premium payments** - If a premium payment is not paid in full on or before the premium due date, a late payment charge of one and one-half percent of the total amount due per month may be added to the amount due, beginning with the premium due date. We also have the right to assess late premium payment and costs of collection of any unpaid premiums or fees, including reasonable attorney's fees and cost of suit.

- **End stage renal disease** - This section applies to Aetna's group MA, MAPD and PDPs (collectively, "Aetna Group Medicare Plans"). We assume that you don't enroll retirees and their dependents who are Medicare beneficiaries diagnosed with End Stage Renal Disease ("ESRD Beneficiaries") in the Aetna Group Medicare Plans during their 30-month coordination period, unless the ESRD beneficiaries maintain coverage under your commercial group health plan as the primary payer during their 30-month coordination period and the Aetna Group Medicare Plan is the secondary payer.

  We will only offer Aetna Group Medicare Plans to ESRD Beneficiaries in a manner that is consistent and complies with applicable laws, rules, and regulations, including, but not limited to, 42 C.F.R. § 422.50(a)(2) and other Medicare Advantage and Medicare Secondary Payer ("MSP") laws, rules and regulations and Centers for Medicare and Medicaid Services ("CMS") instructions ("MSP Requirements"). If an ESRD Beneficiary is eligible for or entitled to Medicare based on End Stage Renal Disease, federal law requires your commercial group health plan ("GHP") to be the primary payer for the first thirty months of the ESRD Beneficiary's Medicare eligibility or entitlement ("30-month coordination period"), regardless of the number of employees and regardless of whether the ESRD Beneficiary is a current employee or retiree. Therefore, you must confirm whether ESRD Beneficiaries are in their 30-month coordination period, and not enroll ESRD Beneficiaries in our Aetna Group Medicare Plan during their 30-month coordination period unless coverage under the GHP is maintained for such ESRD Beneficiaries for that period.

Aetna's understanding of the 21st Century Cures Act is that MSP Requirements continue to apply to ESRD Beneficiaries. This means that ESRD Beneficiaries will continue to have the option of enrolling in an Aetna Group Medicare Plan after they complete their 30-month coordination period, as permitted under MSP requirements. If CMS or any other federal agency with jurisdiction later indicates that MSP Requirements relating to ESRD Beneficiaries have changed as a result of the 21st Century Cures Act or any other applicable law, rule or regulation, Aetna reserves the right to revise or restructure the rates in this proposal.

- **Mail Order refill data transfer**- You must provide a Mail Order pharmacy open refill data file for electronic transfer of prescriptions to Aetna. The file must be received by November 1, 2025. Aetna does not charge a fee for incoming open refill files.

- **Additional products and services-** We will bill you for the cost of special services that are not included or assumed in the pricing. For example, you'll be subject to additional charges for customized communication materials. Costs will depend on the actual services performed and are determined at the time the service is requested.

Inaccurate or incomplete information – We're relying on information from you and your representatives in establishing the rates and terms of this proposal. If any of this information is inaccurate or incomplete and has a material impact on the cost of the programs, we reserve the right to adjust our rates and terms.

Proprietary and Confidential – This proposal contains trade secrets and commercial and financial information that Aetna deems proprietary and confidential and cannot be further released to any third party by Harris County without Aetna's prior written consent.

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

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Conclusion

We present this proposal on the condition that it will be accepted in its entirety. Furthermore, we've assumed that you'll continue to offer all other coverages, products, and services that you purchased previously. If there is a material change in this regard, we reserve the right to review and reprice this proposal. If you're interested in a subset of our proposal, then we will gladly review and reprice, if necessary. Before accepting the rates in this proposal, you must disclose any material deviation, current or expected, from these assumptions.

The most recent version of this document issued by Aetna to you, including any attachments to this document (collectively, "Financial Documents") are part of your agreement with Aetna to offer Medicare Advantage plans and/or standalone Medicare prescription drug plans ("Group Agreement"). In the event of a conflict between the terms of the Financial Documents and your Group Agreement and the documents incorporated into the Group Agreement, the order of priority shall be as described in your Group Agreement. Any riders, amendments, inserts and attachments shall have the same priority as the document to which they are attached.

Harris County **February 1, 2026 through December 31, 2026**

Broker commissions – The enclosed rates exclude broker commissions.

We honor 'Agent of Record' or 'Broker of Record' letters when an agent, broker, or consultant sells new business or takes over an Aetna case from another agent, broker, or consultant. Please have an appropriate representative from your organization sign the letter using your organization's letterhead. The change will become effective on the first day of the month after our payment unit receives the 'Agent of Record' or 'Broker of Record' letter unless another future date is designated in the letter.

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The following plan benefit information is being provided to notify Harris County of some important information related to Aetna's Medicare Advantage and Part D plans.

Legislative changes: Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

Part D Information

Prescription drug coverage

Our retiree pharmacy coverage consists of two components: basic Medicare Part D benefits and supplemental benefits.

- We offer Medicare Part D plan coverage pursuant to our contract with the CMS. We receive monthly payments from CMS for the Part D portion of your coverage.
- We offer supplemental coverage that wraps around the basic Medicare Part D benefits, allowing you to offer enhanced pharmacy benefits. We receive monthly premium payments from you and/or your retirees for the supplemental coverage. Depending on your plan design, supplemental coverage may also include benefits for non-Part D covered drugs.

To address hyperinflated drugs, a small number of hyperinflated products will be removed from the Vitamins and Minerals rider in 2026.

These products offer no clinical advantage to our members over the appropriately priced vitamins and minerals available on our riders

We will report drug claims information to CMS, based on the source of the applicable coverage payment - Medicare Part D, plan sponsor or member.

Inflation Reduction Act (IRA) –

The IRA, enacted in 2022, has significant impacts on the Medicare Part D benefit. Since being enacted, changes have been made annually, including the following:

- Effective January 1, 2023, plans must cover most Part D vaccines at $0 cost share and required that members must not pay more than $35 for a one-month supply of each insulin product covered by the plan.
- Effective January 1, 2024, cost share in the Catastrophic Stage was reduced to $0 for covered Part D drugs.
- Effective January 1, 2025, the Coverage Gap phase was eliminated along with the corresponding Coverage Gap Discount Program, True Out-of-Pocket (TrOOP) was reduced to $2,000, introduction of the Manufacturer Discount Program, and introduction of the Medicare Prescription Payment Plan.

Harris County **February 1, 2026 through December 31, 2026**

Effective January 1, 2026, the Medicare negotiated Maximum Fair Price (MFP) program will begin. There are 10 highly utilized drugs included beginning 2026 (Eliquis, Enbrel, Entristo, Farxiga, Imbruvica, Januvia, Jardiance, Stelara, Xarelto, and Fiasp/Novolog). These drugs must be included in all forms on all formularies. The MFP is applied prospectively at point of sale based on rates directly negotiated and contracted by Medicare. This price will be less than the pharmacy purchase price. Manufacturers will make pharmacies whole by paying the MFP discount to a Medicare Transaction Facilitator (MTF) who will pay the pharmacy. The Manufacturer Discount Program does not apply to MFP drugs.

The P1 Preferred Network plan option
This option provides a lower price point through the use of a pharmacy with preferred status. Members generally pay a lower cost share when utilizing pharmacies that are preferred. Members will also have access to standard pharmacies within the network; however, they will likely pay a higher cost share when receiving covered medications at standard pharmacies. To find a network pharmacy, members can visit our website: http://www.aetnaretireeplans.com.

Aetna Mail Order
Aetna's mail order benefits are filled by CVS Caremark® Mail Service Pharmacy. This mail order service supplies medications for drugs taken on a regular basis, sometimes referred to as maintenance drugs. Examples of maintenance drugs include medications used to treat chronic conditions such as arthritis, high cholesterol, asthma, or high blood pressure. CVS Caremark® Mail Service Pharmacy does not supply medications used for short-term illnesses, such as cold medications or antibiotics. Additionally, certain drugs that require special handling may not be available through CVS Caremark® Mail Service Pharmacy. These drugs are sometimes called specialty drugs and may require storage at controlled temperatures or other unique handling requirements which cannot be accommodated through a traditional mail order arrangement. Therefore, most specialty drugs are not available at the mail order benefit (cost share) and instead will pay at the retail benefit (cost share). Also, specialty drugs are generally limited to a 30-day fill, to reduce waste of these high-cost drugs.

Legal Entity and Administrative Platform
Aetna Medicare Rx offered by SilverScript is a fully insured group standalone Medicare prescription drug plan ("PDP"). The PDP is offered by SilverScript Insurance Company ("SilverScript"). SilverScript is a CVS affiliate and is contracted with CMS for 2026. CVS is the parent company of both Aetna and SilverScript.

Medicare Part D creditable coverage
If an applicant cannot demonstrate that he/she had prior creditable coverage, the applicant may incur late enrollment penalties, consistent with laws, rules, and regulations applicable to the Part D program.

Harris County **February 1, 2026 through December 31, 2026**

Simultaneous enrollment in a MA only plan and PDP
CMS provides an employer group waiver that allows a Medicare beneficiary to simultaneously enroll in a group MA plan with no Medicare prescription drug benefits (MA-only plan) and a group standalone Medicare prescription drug plan (PDP). When these two plans are offered to a single plan sponsor through two separate carriers, the CMS waiver requires that the two carriers work closely with the plan sponsor to coordinate care and disease management services between the MA-only and PDP portion of the benefit. Aetna will offer the MA-only plan and PDP that are consistent with this CMS employer group waiver.

We need your help in meeting this requirement for your retirees. Please let us know if you are currently offering Medicare Advantage coverage through another carrier. We will work with you and your current Medicare Advantage carrier to provide Part D claims data to assist you in identifying members that can benefit from disease and case management programs.

Premiums

- **Premium and Low Income Subsidy ("LIS") Requirements and Late Enrollment Penalty ("LEP")** - Harris County will comply with the following conditions with respect to any subsidization of that portion of premiums paid by Harris County for the Medicare Prescription Drug benefit ("PD Premium") and any required PD Premium contribution by members enrolled in MAPDs or PDPs ("Members"):

  - Harris County may subsidize different amounts of PD Premium for different classes of Members and their dependents, provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Classes of Members and their dependents cannot be based on eligibility for the Low-Income Subsidy ("LIS").

  - PD Premium contribution levels cannot vary for Members within a given class.

  - Direct subsidy payments from CMS to Aetna must be passed through to reduce the amount of any required PD Premium payment by the Member ("Member Contribution") so the Member in no event shall be required to pay more than the sum of: a) the standard Medicare Part D premium, net of the direct subsidy payment from CMS, and b) one hundred percent (100%) for any supplemental coverage selected by the Member.

Harris County will comply with the following conditions with respect to any LIS payment received from CMS for any LIS-eligible Member:

- Any monthly LIS payment received from CMS for an LIS-eligible Member shall be used to reduce any Member Contribution. Any remainder may then be used to reduce the amount of the Harris County's PD Premium contribution. However, if the sum of the Member Contribution and Harris County's PD Premium is less than the LIS payment, any portion of the LIS payment will be returned to CMS by Aetna.

- If the LIS payment for any LIS-eligible Member is less than the Member Contribution required by such individual (including the Member Contribution for supplemental benefits, if any), Harris County shall communicate with the LIS-eligible Member about the cost of remaining enrolled in Harris County's Plan versus obtaining coverage as an individual under another Medicare Part D Prescription Drug plan.

- In the event that the LIS-eligible Member is due a refund of the LIS payment (i.e., there was no upfront reduction of the PD Premium by the LIS amount), such refund shall be completed by Aetna or Harris County, as applicable, within 45 days of the date Aetna receives the LIS payment for that Member from CMS.

Group Billed – If Aetna is billing and collecting the entire plan premium from Harris County and Harris County chooses to receive group list invoices, Aetna will apply LIS subsidy credits and LEP debits to the group invoice. Harris County must apply the LIS subsidy and collect the LEP consistent with applicable law.

Direct Billed - If Harris County chooses direct billing (i.e., Aetna directly bills and collects the entire plan premium from Members), Aetna will apply LIS to the Member invoice and will add LEP debits consistent with applicable law.

Pharmacy
Service and Fee Schedule
to the Master Services Agreement

Effective January 01, 2026
Harris County

aetna®

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Pharmacy Discounts & Fees

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

Pricing Arrangement	Traditional
Network	Aetna National with Extended Day Supply (Retail 90) Network
Employees	25,437

RETAIL 30			
	01/01/2026	**01/01/2027**	**01/01/2028**
Brand Discount	AWP - 19.50%	AWP - 19.50%	AWP - 19.50%
Generic Discount	AWP - 87.80%	AWP - 88.00%	AWP - 88.20%
Dispensing Fee	$0.50 per Script	$0.50 per Script	$0.50 per Script

RETAIL 90			
	01/01/2026	**01/01/2027**	**01/01/2028**
Brand Discount	Included in Retail 30 pricing above		
Generic Discount	AWP - 88.55%	AWP - 88.75%	AWP - 88.95%
Dispensing Fee	$0.35 per Script	$0.35 per Script	$0.35 per Script

MAIL ORDER PHARMACY			
Mail Benefit Type	Mail Order Pharmacy		
	01/01/2026	**01/01/2027**	**01/01/2028**
Brand Discount	AWP - 19.50%	AWP - 19.50%	AWP - 19.50%
Generic Discount	AWP - 92.00%	AWP - 92.20%	AWP - 92.40%
Dispensing Fee	$0.00 per Script	$0.00 per Script	$0.00 per Script

SPECIALTY PHARMACY			
Network	Specialty Performance Network		
Product List	Aetna Specialty Product List		
	01/01/2026	**01/01/2027**	**01/01/2028**
Discount	AWP - 22.75%	AWP - 22.85%	AWP - 22.95%

CLINICAL PROGRAM FEES*			
	01/01/2026	**01/01/2027**	**01/01/2028**
Vaccine Program Management Fee	$0.05 PMPM	$0.05 PMPM	$0.05 PMPM

*****Clinical Program Fees may be billed on a substantially equivalent PEPM Basis

ALLOWANCES			
	01/01/2026	**01/01/2027**	**01/01/2028**
General Allowance	$3.00 PMPY	$3.00 PMPY	$3.00 PMPY
PrudentRx Guarantee	$104.47 PMPY	$0.00 PMPY	$0.00 PMPY
WMBE Allowance	$0.25 PEPM	$0.25 PEPM	$0.25 PEPM

Rebates

REBATES			
Formulary	Aetna Standard Formulary		
Plan Design	3 Tier Qualifying		
Rebate Terms	Customer will receive the following minimum rebate guarantees:		
	01/01/2026	**01/01/2027**	**01/01/2028**
Retail	Greater of 100% or $406.62 Per Brand Script	Greater of 100% or $406.62 Per Brand Script	Greater of 100% or $406.62 Per Brand Script
Retail 90	Greater of 100% or $926.08 Per Brand Script	Greater of 100% or $926.08 Per Brand Script	Greater of 100% or $926.08 Per Brand Script
Mail Order	Greater of 100% or $926.08 Per Brand Script	Greater of 100% or $926.08 Per Brand Script	Greater of 100% or $926.08 Per Brand Script
Specialty	Greater of 100% or $5,374.71 Per Brand Script	Greater of 100% or $5,374.71 Per Brand Script	Greater of 100% or $5,374.71 Per Brand Script

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

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

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

Terms & Conditions

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

- This pricing has an effective date of January 1, 2026. In order for Aetna to implement the pricing as set forth above by the effective date, a notification of award must be given 90 days prior to effective date.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Participating Pharmacy shall give the Plan Participant the benefit of the lesser of (i) the Participating Pharmacy's Usual and Customary Charge, (ii) MAC (where applicable) or (iii) discounted AWP cost. Participating Pharmacy shall collect and retain from the Plan Participant at the time of dispensing the lesser of (i) the Cost Share; (ii) the Participating Pharmacy's Usual and Customary Charge, (iii) MAC (where applicable) or (iv) discounted AWP cost.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
    - Discount and Dispensing Fee guarantees are measured and reconciled individually; surpluses in one or more component guarantees may not be used to offset shortages in other component guarantees.
    - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within one hundred eighty (180) days following the guarantee period.
    - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant Cost Share and include zero balance due claims.
    - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein:
        - Compound Prescription claims
        - Limited distribution drug (LDD) claims
        - Direct Plan Participant reimbursement / out-of-network claims
        - Coordination of Benefits (COB) or secondary payor claims
        - In-house pharmacy claims
        - Vaccines (including for COVID) and other COVID testing-related claims
        - 340B claims
    - Retail pricing guarantees exclude claims that reflect the Usual & Customary Retail Price.
    - Single Source Generic Drugs are included in the Generic Discount guarantees.
    - Only Specialty Products dispensed by a Specialty Pharmacy are included in the Specialty Pharmacy Discount guarantee listed above. Specialty Products dispensed by Participating Retail Pharmacies are not included in any Discount guarantee listed above.

  - Aetna has assumed 0.00% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.

- Pricing and terms in this proposal assume the Customer has elected the Aetna Standard formulary and the Choose Generics program.
- The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members
- Specialty Performance Network means that Plan Participants are required to use CVS Specialty Pharmacies (no fills at retail allowed).
- Non-Specialty Claims dispensed by a CVS Specialty Pharmacy will adjudicate as a Retail Non-Specialty Claim.
- Aetna Specialty Performance Network – Reconciled OEDThe Overall Effective Discount (OED) offer is conditioned on Plan Participants using the Aetna Specialty Performance Network with Aetna being the exclusive provider of Specialty Services with the exception of the HIV class and Client implementing and maintaining a generics first plan design for specialty. The Aetna Specialty Performance Network option may not be available to Plan Participants in certain states. If Aetna Specialty Performance Network is no longer available in certain states, then Client must select an alternate Specialty Pharmacy network option made available by Aetna. Aetna may equitably adjust the financial terms in this Agreement to account for the impact of any such network change. The rates quoted herein apply to specialty products dispensed from CVS Specialty mail pharmacies, including through the Specialty Connect process. Aetna may amend the individual Specialty Drug discounts to manage the financial guarantee. The financial guarantee is measured and reconciled annually across all Specialty Drugs dispensed by CVS Specialty pharmacy, including through the Specialty Connect process, with the exception of the following exclusions (in addition to the discount and dispensing fee exclusions).
  - New to market Specialty Products
  - Limited and exclusive distribution drugs

  For the items noted here, the following quoted rates shall apply.
  - New to Market Specialty Products: AWP – 16.00%;
  - New to Market Limited and exclusive distribution drugs: AWP – 15.00%

  MAC: Certain dosage forms and strengths may not be included on the MAC list and shall be priced at the Specialty Product default rate.
  In the event retail leakage increases by a percentage change of 10%, or more, from the effective date of the agreement, Aetna reserves the right to amend pricing.

- Our financial offer does not assume any adoption of the Transform Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.

- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein.
- Rebate guarantees may be subject to:
    - The adoption of Specialty Guideline Management (SGM) program
    - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
- The above rebate guarantees exclude:
    - Limited distribution drug (LDD) Claims
    - Any other Claim identified as having received 340B program wholesale pricing
    - Compound Drug Claims
    - Paper or Member Submitted Claims
    - Coordination of Benefits (COB) or secondary payor Claims
    - Vaccine and vaccine administration Claims
    - COVID treatment Claims
    - Claims approved by Formulary Exception
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty Rebate Guarantees will only apply to Specialty Product Claims dispensed at CVS Specialty Pharmacies when mandatory Specialty Pharmacy fulfillment is instituted herein, subject to any exceptions set forth herein.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:
    - Two-tier qualifying plan designs - will consist of an open plan design, with the first tier comprised of Generic Drugs and the second tier comprised of Brand Drugs. There are no requirements for a minimum Cost Share differential between these tiers. The plan design may need to implement formulary interventions recommended by Aetna.
    - Three-tier non-qualifying plan designs – maintain a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs.
    - Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a $15.00 co-payment differential between preferred and non-preferred Brand Drugs, at least a $15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs

(for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).

- Rebate guarantees are measured individually by component and reconciled in the aggregate on an annual basis within 12 months following the end of the Plan year; a surplus in one or more component Rebate guarantees may be used to offset shortages in other component Rebate guarantees.
- The Aetna Extended Day Supply Network provides the flexible option of a nationwide network of retail pharmacies that can fill up to a 90 days' supply of medications. Aetna's Retail-90 Network pricing is applicable for non-specialty claims equal to or greater than an 84 days' supply filled by a participating Aetna Retail-90 Network pharmacy.

Allowances

Allowances which are based on the information available to Aetna during this process will be available as of the Effective Date of the Pharmacy Services and Fee Schedule. Aetna will pay related expenses directly to a third-party vendor once the Customer sends the invoice(s) outlining the expenses incurred to Aetna. Invoices must be submitted before the end of each Plan year otherwise the Customer forfeits the funds. Any unused allowance monies at the end of each Plan year will be forfeited. It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, this credit shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. §1320a-7b(b)(3)(A). The parties acknowledge and agree that the allowances provided by Aetna are commercially reasonable and necessary services related to this Agreement, including without limitation, implementation, audit, communication and/or external data file/feeds, and represent fair market value for the services provided.

WMBE Allowance

Aetna is including an a WMBE allowance of up to $0.25 per enrolled employee per month on an annual basis.

General Allowance

Aetna is including a general allowance up to $3.00 per enrolled member per year on an annual basis. The Customer can use this allowance to pay for implementation, audit or communication related expenses along with external data files or feeds.

PrudentRx Guarantee

CVS Health is guaranteeing Harris County a first year savings target generated from the PrudentRx Copay Optimization program provided by independent third party PrudentRx of Year 1 $106.85 per member per year (PMPY). The guarantee associated with the PrudentRx savings program assumes the following:

(i) Client continuing enrollment in the PrudentRx Copay Solution program, with standard conditions, by continuing their separate contract with PrudentRx and/or for the PrudentRx Copay Optimization program
(ii) No material change to copay cards funding or quantity limitations from manufacturers regardless of reason for the material change in copay card funding
(iii) Plan design, drug mix, and demographics remain consistent throughout the term of the agreement
(iv) Adoption of true accumulation plan design
(v) Requires exclusive specialty plan design without grace fills
(vi) Adoption of Advance Control Specialty Formulary

PrudentRx will provide a savings report at the time of invoice. If CVS Health fails to achieve the applicable savings target in any contract year, within ninety (90) days after the end of such contract year, CVS Health will provide Client with a credit against future billing to Client on a dollar for dollar basis up to a maximum payout of 30% of the cost of the program.

Market Check

On an annual basis, in the second quarter of each Contract Year, and at Customer's reasonable request, Aetna and Customer or a mutually agreed upon third party with a signed non-disclosure agreement may review the financial terms of Customer compared to financial offering presented to similar employers in the marketplace as deemed appropriate. The parties agree for the purpose of this market check that Aetna or Customer's representative will compare, among other things, the following factors to determine whether Customer is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable customers of comparable size, inclusive of the program savings, the retail pricing for brand and generic drugs, pricing for specialty drugs, administrative fees, rebates and guarantees; (ii) the services provided by Aetna to such customers; and (iii) the plan design of such customers, which may include plan formulary, brand/generic utilization information and mail and retail utilization information, available to Aetna. Customer, or its representative, shall provide Aetna with a report to substantiate its findings. Should the comparison demonstrate that the current market conditions would yield a savings of 2% or more in net costs (i.e. gross costs net of administration fees and rebate guarantees), then the parties will discuss in good faith a revision to the current pricing terms and other applicable contract provisions. If Customer and Aetna agree to any revisions to the financial terms as a result of this review (i) the agreement shall be amended and (ii) shall be effective January 1 of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the contract year as to which the revisions are to apply.

Additional Disclosures

The Customer acknowledges that the Discounts and Dispensing Fees contained in this Agreement reflect a Traditional or Lock-In pricing arrangement. Traditional or Lock-In Pricing means that the amount

charged to the Customer and Plan Participants for network claims may differ from the amount paid to Participating Pharmacy and Aetna retains the difference, in addition to any other fees or charges agreed upon by Aetna and Customer, as compensation for the pharmacy benefit management services provided to the Customer.

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

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

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

Aetna reserves the right to modify its products, services, and fees, and to recoup any costs, taxes, fees, or assessments, in response to legislation, regulation or requests of government authorities. Any taxes or fees (assessments) applied to self-funded benefit Plans related to The Patient Protection and

Affordable Care Act (PPACA) will be solely the obligation of the Customer. The pharmacy pricing contained herein does not include any such Customer liability.

Rebate Payment Terms

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

Rebate collections are paid quarterly one hundred and eighty (180) days after the quarter ends. Rebates are calculated and paid in accordance with the terms and conditions of this Agreement.

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

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

Additional 340B reconciliation and true-up may occur post annual minimum Rebate guarantee reconciliation.

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

Standard Rebate Credit Language

When remitting and reconciling minimum Rebate guarantees, Aetna may add Rebate Credit value to the total Rebates remitted to Customer for each respective Rebate component. Rebate Credits shall consist of (i) the differential between the Wholesale Acquisition Cost (WAC) of a lower net cost Brand Covered Product, including but not limited to a Biosimilar (Low Cost Brand), Claim processed and the WAC of the reference Brand Drug, subject to the below cap; and/or (ii) the value of price reductions for rebateable products that have experienced a WAC decrease, measured as the differential between the Baseline WAC of the product and the WAC of the product when the Claim is processed, subject to the below cap. The Baseline WAC will be the WAC of the product prior to a reduction in WAC or, as applicable, for Low Cost Brands, the Baseline WAC will be the WAC of the reference Brand Drug at the time of Claim processing.

In no way will the Rebate Credit exceed the Baseline Rebate less the earned Rebates on either the Low Cost Brand or the rebateable product that has experienced a WAC decrease. Baseline Rebate is

calculated as follows: in the year the price reduction occurred, Baseline Rebate will be the Rebate available for coverage of the product prior to the WAC reduction or, as applicable, for Low Cost Brands the Baseline Rebate will be the Rebate available for coverage of the reference Brand Drug on the date of claim processing. For a product experiencing a WAC reduction, in subsequent years the Baseline Rebate will increase over the prior year Baseline Rebate at the WAC inflation rate of the GPI subclass (GPI-6) of the applicable product. Aetna will notify Customer of any applicable Covered Product that qualifies for Rebate Credits. Aetna shall provide reporting upon Customer request demonstrating the net-cost impact in the therapeutic category.

Formulary Management

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

Other Payments

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

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

Aetna may also receive network transmission fees from our network pharmacies for services we provide for them. These amounts are not considered Rebates and are not shared with Customers. These

amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees, if applicable.

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

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

Early Termination

In the event Customer terminates Aetna's arrangement of prescription drug benefit services as described in the Prescription Drug Services Schedule and Pharmacy Service and Fee Schedule to the Agreement prior to December 31, 2028 (an "Early Termination") Aetna shall retain any earned but unpaid rebates as of the Early Termination date subject to any exception thereto provided herein.

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

In addition, in the event Customer terminates the Agreement prior to the expiration of the initial term for any reason other than for Aetna's material breach, Customer shall refund, prior to the termination date, to Aetna all allowances described herein and received by Customer for the unfulfilled term on a prorated basis.

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

Late Payment Charges

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

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

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

Pharmacy Audit Rights and Limitations

Customer is entitled to one annual Rebate audit, subject to the audit terms and conditions outlined in the Prescription Drug Services Schedule.

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

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

Aetna Pharmacy Program summary – Core Services

Unless otherwise specified, the services outlined below are available at no additional cost for our Customers and Members.

PBM Services	
Included in Core Services	
PBM Benefit Administration	**Member Services**
• Maintenance Choice	• Member Services Call Center – Available 24/7
• Aetna Standard Preventive Drug List (HDHP)	• Real-Time Benefits
• Aetna Standard Preventive Drug List (ACA)	• Aetna Health Mobile App and Internet Tools
• Integrated retail, mail and specialty claims with medical benefit claims in real-time • Benefit Automation • Loading Client Benefit Plan • RxSavingsPlus Savings Program • Generic Substitution/DAW Penalties	• Price-A-Drug Tool available at **aetna.com** or through our mobile app, Aetna Health
Member Communication Materials	**Customer Services**
• Initial Implementation benefits communication materials, printed and online support	• Claim funding and banking arrangements integrated with your Aetna medical plan
• Member specific e-mail communications	• Consultative services
• Aetna Integrated Pre- and Post-enrollment materials	• Education materials on key healthcare topics
• Clinical program member letters, including transition letters for formulary changes/updates	• Implementation support including eligibility loading and ongoing additions/deletions
• Informational brochures for using the CVS Caremark Mail Service Pharmacy, including order forms	• Regulatory and compliance support by specific line of business
• Member-specific formulary and plan design	• Meetings to discuss program performance
• Aetna Health website and app brochures	• Account Management • Client Authorized Override • Member Satisfaction Surveys • Post Rejection Communications (PRC) • Proactive Retail Refill Notice
Claims Processing Services	**Mail Service Pharmacy**
• Online, Point-of-Service (POS) claims adjudication with real-time integration with medical claims	• Use of CVS Caremark Mail Service Pharmacies • Information System Infrastructure & Maintenance • Profile/order form and return envelope • Member counseling labels – drug specific • First time fill prescription processing
Online Customer Access	
• Online Services (on-site eligibility maintenance and prior authorization overrides-viewing member claims history	

• Website Access allowing customized dashboard creating for members--keep

AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Analytics and Reporting	
Included in Core Services	
Analytic Support	**Analytic Support cont.**
• Aetna Report Rx self-service reporting tool suite for up to 10 Customer users • RxNavigator Self-Service Reporting Tool Suite • E Tool Access (Self Service for Rx Insight Reports)	• Claim detail reporting combined with medical reporting through the new reporting tool, ART
• Account Team Supported Reporting • Clinical Program Opportunity Analysis	• Quarterly clinical and financial reports based on aggregate customer utilization

Formulary	
Included in Core Services	
Standard Formulary Administration	**Standard Formulary Administration cont.**
• Formulary maintenance	• Rebate administration
• Formulary exclusions lists	• Point of Sale (POS) Rebates Type 3
• Hyperinflation management	• Compound Management

Clinical Programs and Utilization Management Edits	
Included in Core Services	
Clinical Solutions	**Clinical Solutions cont.**
• Diabetic Meter Program • Standard Utilization Management edits, including quantity limits and step therapy • Pharmacy Advisor Support – Automatic refill and renewal programs	• Dose Optimization • Core Medication Management: Closing Gaps in Medication Therapy • Retrospective Safety Review • Point of Sale (POS) Drug Safety Alerts
• Pharmacy Advisor Support – Adherence to Drug Therapy	• Member and Physician clinical education
• Smart Edit overrides	• Global safety edits
• Opioid safety edits	• Compound drugs management
• Maximum pay edits • Mail Order DAW Solution	• Select OTC Coverage

AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Specialty

Included in Core Services

Specialty Clinical Solutions

- Specialty Starter Fill

AccordantCare Specialty

- Proactively supports and empowers Members with rare conditions to manage their whole condition, not just adherence to their medication (beyond traditional specialty pharmacy care). Members identified by Aetna Specialty dispense for nine (9) specialty conditions. Available to Customers who use the Aetna Specialty Performance Network.

Specialty Benefit Administration

- Specialty Guideline Management (SGM) – criteria development and maintenance
- Specialty Copay Card Plan Designs
- Standard Specialty Product List
- Exclusive Specialty Grace Fill Member Letter (Under Member Communication Materials)

Specialty Support cont.

- Specialty Expedite
- Specialty Connect
- Digital - Secure Messaging
- First time fill prescription processing
- Specialty CareTeam
- Patient Assistance Program

Specialty Pharmacy

- Use of the CVS Specialty Pharmacy network with full integration of retail, mail and specialty claims
- Information System Infrastructure & Maintenance
- Member Onboarding
- Member counseling label – drug specific
- Supply Management Optimization (SMO (Exclusive and Preferred Specialty Customers)
- Specialty Connect
- Digital Secure Messaging
- Specialty Expedite
- Specialty CareTeam

Digital

Included in Core Services

Standard Digital Services

- Open enrollment links
- Aetna.com configurations

Standard Digital Services cont.

- Single Sign on (SSO)
- Integrated medical and pharmacy websites

AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Mandatory Fees

The services outlined below are associated with meeting federal, state, and local regulatory compliance requirements

Regulatory Programs	Member Threshold, if any	Fee	Basis
State Regulatory Impact Assessment[1]		$0.30	Per Retail Claim Only
Traditional Pricing Auxiliary Fee[2]		$1.50	Per Retail Claim Only
Retail Network Pharmacy Third Party Appeal		Pass through Fees Per Review	

[1]Applies to claims in select states with relevant regulatory requirements. The current list of states includes AL, AR, AZ, CO, DE, FL, GA, IA, LA, MD, MI, ND, NM, OK, SD, MS, NJ, TN, VA, TX, WA, WV, WY and is subject to change

[2]Applicable to clients under Traditional pricing arrangements only. Applies to claims in states with extraterritorial regulations requiring transparent pricing. The current list of states includes AR, FL, OK, TN, WV and is subject to change.

AETNA PHARMACY PROGRAM SUMMARY – ADDITIONAL SERVICES

Custom Formulary	Fee	
Custom Formulary and Maintenance, including services such as: • Custom UM Criteria • Custom Exclusion Lists • Custom Preventive Lists • Hyperinflation Management • Compound Management • Net Cost Analysis and Consultation	$100,000	
Enhanced Safety, Adherence and Gaps in Care Programs	**Fee**	**Basis***
Pharmacy Advisor Counseling at CVS Pharmacy [1]	$0.25**	PMPM
Pharmacy Advisor Counseling All Channels[1]	$0.60**	PMPM
Pharmacy Advisor Counseling Retail All Channels[1]	$0.60**	PMPM
Integrated Fraud and Safety Solutions	$0.06	PMPM
Drug Savings Review (DSR) (2:1 ROI over 1 year)[2]	$0.30	PMPM
Precertification	**Fee**	**Basis**
Clinical and Non-Clinical Review		
• Precertification	$45.00	Per review
• Formulary Exceptions	$45.00	Per review
• Wegovy Cardiovascular	$45.00	Per review
Specialty Precertification	**Fee**	**Basis**
Specialty Guideline Management (SGM) Precertification	$45.00	Per review
Initial Reviews & Appeals	**Fee**	**Basis**

Initial Clinical and Non-Clinical Reviews, including Prior Authorization and Exceptions[4]	$45.00	Per review
Appeals		
• First Level Appeals	$100.00	Per review
• Second Level Appeals	$500.00	Per review
• Urgent Appeals (Combination of 1st & 2nd Level Appeals)	$600.00	Per review
• External Review	$500.00	Per review
Vendor Transition Files	**Fee**	**Basis**
Termination files for all open mail service and specialty pharmacy refill files (one test and two production files)	$5,200	As listed
Specialty User Report (SUR) – specialty pharmacy file	$1,500	Per file
Refill Transfers upon termination	$4,500	Per file
Precertification history	$3,500	Per file
Accumulator files	$1,000	Per file
Historical claims data	$1,000	Per file
Additional Services	**Fee**	**Basis**
Custom programming (includes customer-specific data file formats, reporting, or IT systems work)	$150	Per Hour
Standard on-going claim files to third-parties (includes Universal Pharmacy Claim File)	$500	$500 for initial set up and $500 per file for ongoing frequencies.
Optional pre-transition Open Refill Transfer	$1,500	Per file
Audit Claim Files for data over 24 months old	$5,000	Per file
Open enrollment site: applicable link changes not included	$150	Per hour

Prior Authorization Microsite	$150	Per hour
Prescription Drug Data collection - annual reporting	$0.02	PMPY
Aetna Report Rx Self-Service Reporting Tool License over 10 Customer users	$1,500	Per License
Caremark Cost Saver™ 3	$0.00	Optional
Vaccine Program Management Fee	$0.05	PMPM
Manual Claim Administration Fee	$1.50	Per claim
Shipping and Handling of Temperature Sensitive Products	$22.00	Per Non-Specialty Mail Rx Temperature Sensitive

AETNA PHARMACY PROGRAM SUMMARY – ADDITIONAL SERVICES

Additional Specialty Programs	Fee	Basis
Custom Specialty Network - When Accreditation Support is Required	Quoted Upon Request	

Charges for services not identified above and/or changes in financial terms resulting from a change in the scope of services shall be quoted upon request.

Pricing noted above for programs not implemented within twelve (12) months from the time of pricing negotiations is subject to change.

NOTES:

[1] Pharmacy Advisor Counseling Additional Terms:

(a) Customer may terminate the Pharmacy Advisor Counseling program by providing Aetna at least 60-days prior written notice.

(b) The pricing described above for Pharmacy Advisor Counseling program is based on the following conditions:

(i) In the event Customer desires to include additional lines of business, implement a portion of the Plan Participants, or reduces the Plan Participants participating in the Pharmacy Advisor program, Aetna may revise pricing for the program.

(ii) Customer agrees to implement all the current conditions in Pharmacy Advisor Counseling: Asthma/COPD, Breast Cancer, Depression, Diabetes, Cardiovascular conditions, and Osteoporosis.

(iii) The above pricing reflects the current program and future program expansions may require an additional fee.

[2] Drug Savings Review Additional Terms:

Aetna guarantees that the gross customer savings realized from DSR Program over the first Clinical Program Year shall be 200% of the DSR Program fees paid by Customer during the first Clinical Program Year. For the subsequent Clinical Program Years, Aetna guarantees that the gross customer savings realized from DSR Program shall be 300% of the DSR Program fees paid by Customer during subsequent Clinical Program Years. "Clinical Program Year" means the twelve (12) month period commencing on the start date of the Drug Savings Review Program and each full consecutive twelve (12) month period thereafter that the Drug Savings Review Program is provided. In the event Aetna fails to meet the targeted savings, Customer shall be credited for any guaranteed savings short-fall following the end of the applicable Clinical Program Year, up to the amount of fees paid by Customer for the Drug Savings Review Program during the Clinical Program Year. Aetna calculates the guaranteed savings short-fall and reimburses Customer a portion of the fees paid based on the difference between the actual savings generated and the guaranteed savings, divided by the ROI guarantee amount. The amount of the fees

credited to Customer reduces the DSR Program Fees paid by Customer to an amount that satisfies the savings guarantee based on actual savings. Reconciliation will occur during the quarter after the conclusion of Clinical Program Year.

Aetna may revise the performance guarantee at time of reconciliation in a manner designed to account for membership shifts of 20% or more during the Clinical Program Year. The performance guarantee offered for the Drug Savings Review Program is conditioned on (1) Customer maintaining a monthly average of at least 1,500 Members throughout the Clinical Program Year and (2) Customer participating in the Drug Savings Review Program for the entire Clinical Program Year.

[3] Caremark Cost Saver™ **:** The pricing in the Pharmacy Service and Fee Schedule assumes the use of the Caremark Cost Saver™ program, under which Aetna may compare the price available under the Aetna contracted network with the price available through a non-Aetna contracted network if available for that pharmacy. If the price is lower through a non-Aetna contracted network (including an administrative fee paid to the third-party that contracts the network), the Claim will be processed through that network. These Claims are included in the reconciliation of all financial guarantees. In these instances, the prescription through retail may be less than the same Drug, dosage form, and dose through mail on the same day of adjudication.

[4] Reviews through the Specialty Guideline Management and Specialty Preferred Drug Plan Design programs will be charged this per review fee.

***DEFINITIONS:**

PMPM = Per Member Per Month

PEPM = Per Employee Per Month

****i**f retiree membership is over 15%, referral needed to review for custom pricing.

AETNA PHARMACY PROGRAM SUMMARY – THIRD-PARTY SERVICES

The services outlined below are provided by third party providers.

Optional Third-Party Services	Fee
PrudentRx Copay Optimization • The PrudentRx offering minimizes the impact of manufacturer copay cards, targeting all Specialty Drugs, including highly utilized classes such as hepatitis C, autoimmune, oncology and multiple sclerosis, to drive maximum value for Customers while providing Members with $0 out-of-pocket costs. • Customers contract directly with PrudentRx for this service. • Program costs are a percentage of shared savings billed monthly by PrudentRx. Aetna does not charge any fees to Customer to support the PrudentRx Copay Optimization services.	Quoted by Prudent Rx upon request

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Specialty Fee Schedule

PSUID 12412748

Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Acromegaly	BYNFEZIA PEN	7.00%
Acromegaly	LANREOTIDE ACETATE INJ	14.00%
Acromegaly	OCTREOTIDE	82.50%
Acromegaly	SANDOSTATIN	14.00%
Acromegaly	SOMATULINE	14.50%
Acromegaly	SOMAVERT	13.25%
Allergic Asthma	CINQAIR	13.00%
Allergic Asthma	DUPIXENT_ASTHMA	15.75%
Allergic Asthma	FASENRA	13.50%
Allergic Asthma	NUCALA	13.25%
Allergic Asthma	TEZSPIRE	14.00%
Allergic Asthma	XOLAIR	13.50%
Alpha-1 Antitrypsin Deficiency	ARALAST NP	18.00%
Alpha-1 Antitrypsin Deficiency	GLASSIA	18.00%
Alpha-1 Antitrypsin Deficiency	ZEMAIRA	18.00%
Amyloidosis	AMVUTTRA	12.50%
Amyloidosis	ONPATTRO	13.50%
Amyloidosis	VYNDAMAX	14.25%
Amyloidosis	VYNDAQEL	12.00%
Anemia	ARANESP	11.00%
Anemia	ENJAYMO	7.00%
Anemia	EPOGEN	5.50%
Anemia	PROCRIT	10.50%
Anemia	REBLOZYL	14.50%
Anemia	RETACRIT	3.00%
Atopic Dermatitis	ADBRY	15.75%
Atopic Dermatitis	CIBINQO	13.00%
Atopic Dermatitis	DUPIXENT_ATOPIC DERMATITIS	15.75%
Bone Disorders - Other	SOHONOS	7.00%
Bone Disorders - Other	VOXZOGO	12.50%
Cardiac Disorders	CAMZYOS	10.25%
Cardiac Disorders	DOFETILIDE	MAC
Cardiac Disorders	TIKOSYN	11.75%
Coagulation Disorders	CEPROTIN	15.00%
Cryopyrin Associated Periodic Syndromes	ARCALYST	13.00%
Cryopyrin Associated Periodic Syndromes	ILARIS	14.75%
Cystic Fibrosis	BETHKIS	11.00%
Cystic Fibrosis	BRONCHITOL	11.75%
Cystic Fibrosis	CAYSTON	13.50%
Cystic Fibrosis	KITABIS PAK	16.00%
Cystic Fibrosis	PULMOZYME	13.00%
Cystic Fibrosis	TOBI	14.75%
Cystic Fibrosis	TOBI PODHALER	13.75%
Cystic Fibrosis	TOBRAMYCIN	MAC
Dupuytren's Contracture	XIAFLEX	6.00%
Electrolyte Disorders	DICHLORPHENAMIDE	33.00%
Electrolyte Disorders	SAMSCA	15.50%
Electrolyte Disorders	TOLVAPTAN	MAC
Endocrine Disorders	CORTROPHIN	11.75%
Enzyme Deficiency Disorders - Other	BETAINE ANHYDROUS	MAC
Enzyme Deficiency Disorders - Other	NITISINONE	MAC
Gastrointestinal	GATTEX	13.25%
Gastrointestinal	OCALIVA	12.50%
Gastrointestinal	SOLESTA	12.00%
Gout	KRYSTEXXA	14.50%
Growth Hormone	EGRIFTA	14.00%
Growth Hormone	GENOTROPIN	13.50%
Growth Hormone	HUMATROPE	15.50%

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Specialty Fee Schedule

PSUID 12412748

Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Growth Hormone	INCRELEX	16.75%
Growth Hormone	NGENLA	12.75%
Growth Hormone	NORDITROPIN	21.25%
Growth Hormone	NUTROPIN	13.00%
Growth Hormone	OMNITROPE	12.75%
Growth Hormone	SAIZEN	14.75%
Growth Hormone	SEROSTIM	14.25%
Growth Hormone	SKYTROFA	20.50%
Growth Hormone	SOGROYA	9.75%
Growth Hormone	ZOMACTON	10.50%
Growth Hormone	ZORBTIVE	15.75%
Hematopoietics	MOZOBIL	15.50%
Hematopoietics	PLERIXAFOR	14.75%
Hemophilia	ADVATE	42.50%
Hemophilia	ADYNOVATE	35.00%
Hemophilia	AFSTYLA	40.00%
Hemophilia	ALPHANATE	39.00%
Hemophilia	ALPHANINE SD	42.00%
Hemophilia	ALPROLIX	21.00%
Hemophilia	ALTUVIIIO	29.00%
Hemophilia	BENEFIX	20.00%
Hemophilia	COAGADEX	31.50%
Hemophilia	CORIFACT	30.00%
Hemophilia	ELOCTATE	27.00%
Hemophilia	ESPEROCT	28.00%
Hemophilia	FEIBA	30.00%
Hemophilia	FIBRYGA	12.00%
Hemophilia	HEMLIBRA	21.50%
Hemophilia	HEMOFIL M	43.00%
Hemophilia	HUMATE-P	36.00%
Hemophilia	IDELVION	20.00%
Hemophilia	IXINITY	27.00%
Hemophilia	JIVI	27.00%
Hemophilia	KOATE	47.00%
Hemophilia	KOGENATE	45.00%
Hemophilia	KOVALTRY	44.00%
Hemophilia	MONONINE	28.50%
Hemophilia	NOVOEIGHT	42.00%
Hemophilia	NOVOSEVEN RT	28.00%
Hemophilia	NUWIQ	37.00%
Hemophilia	OBIZUR	10.00%
Hemophilia	PROFILNINE SD	20.00%
Hemophilia	REBINYN	24.00%
Hemophilia	RECOMBINATE	40.00%
Hemophilia	RIASTAP	28.00%
Hemophilia	RIXUBIS	32.50%
Hemophilia	SEVENFACT	18.50%
Hemophilia	STIMATE	13.00%
Hemophilia	TRETTEN	14.00%
Hemophilia	VONVENDI	10.50%
Hemophilia	WILATE	44.00%
Hemophilia	XYNTHA	41.00%
Hepatitis B	ADEFOVIR DIPIVOXIL	MAC
Hepatitis B	BARACLUDE	11.50%
Hepatitis B	ENTECAVIR	MAC

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Specialty Fee Schedule
PSUID 12412748

Harris County		Exclusive
Drug Therapy	Drug Name	AWP Discount
Hepatitis B	EPIVIR HBV	2.00%
Hepatitis B	HEPSERA	12.50%
Hepatitis B	LAMIVUDINE_HEPB	MAC
Hepatitis B	VEMLIDY	9.00%
Hepatitis C	EPCLUSA	17.00%
Hepatitis C	HARVONI	17.00%
Hepatitis C	LEDIPASVIR/SOFOSBUVIR	18.00%
Hepatitis C	MAVYRET	16.50%
Hepatitis C	PEGASYS	12.00%
Hepatitis C	PEG-INTRON	16.75%
Hepatitis C	RIBAVIRIN	MAC
Hepatitis C	SOFOSBUVIR/VELPATASVIR	18.00%
Hepatitis C	SOVALDI	17.00%
Hepatitis C	VIEKIRA PAK	15.25%
Hepatitis C	VOSEVI	16.50%
Hepatitis C	ZEPATIER	18.50%
Hereditary Angioedema	BERINERT	16.00%
Hereditary Angioedema	CINRYZE	12.50%
Hereditary Angioedema	FIRAZYR	13.00%
Hereditary Angioedema	HAEGARDA	12.50%
Hereditary Angioedema	ICATIBANT ACETATE	MAC
Hereditary Angioedema	KALBITOR	14.25%
Hereditary Angioedema	RUCONEST	13.50%
Hereditary Angioedema	TAKHZYRO	12.50%
HIV	ABACAVIR	MAC
HIV	ABACAVIR SULFATE-LAMIVUDINE	MAC
HIV	ABACAVIR SULFATE-LAMIVUDINE-ZIDOVUDINE	68.80%
HIV	APRETUDE	13.00%
HIV	APTIVUS	14.00%
HIV	ATAZANAVIR SULFATE	MAC
HIV	BIKTARVY	14.00%
HIV	CABENUVA	13.00%
HIV	CIMDUO	11.75%
HIV	COMBIVIR	11.25%
HIV	COMPLERA	13.50%
HIV	CRIXIVAN	9.50%
HIV	DARUNAVIR	66.00%
HIV	DELSTRIGO	12.00%
HIV	DESCOVY	12.25%
HIV	DIDANOSINE	50.00%
HIV	DOVATO	12.50%
HIV	EDURANT	11.50%
HIV	EFAVIRENZ	MAC
HIV	EFAVIRENZ/LAMIVUDINE/TENOFOVIR	69.50%
HIV	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	MAC
HIV	EMTRICITABINE	59.75%
HIV	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	MAC
HIV	EMTRIVA	6.50%
HIV	EPIVIR	2.75%
HIV	EPZICOM	13.25%
HIV	ETRAVIRINE	MAC
HIV	EVOTAZ	12.75%
HIV	FOSAMPRENAVIR	61.50%
HIV	FUZEON	14.50%
HIV	GENVOYA	13.50%

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Specialty Fee Schedule

PSUID 12412748

Harris County		Exclusive
Drug Therapy	Drug Name	AWP Discount
HIV	INTELENCE	12.00%
HIV	INVIRASE	12.50%
HIV	ISENTRESS	12.50%
HIV	JULUCA	13.00%
HIV	KALETRA	11.50%
HIV	LAMIVUDINE/ZIDOVUDINE	MAC
HIV	LAMIVUDINE_HIV	MAC
HIV	LEXIVA	13.50%
HIV	LOPINAVIR/RITONAVIR	MAC
HIV	MARAVIROC	58.00%
HIV	NEVIRAPINE	MAC
HIV	NORVIR	5.00%
HIV	ODEFSEY	13.50%
HIV	PIFELTRO	10.75%
HIV	PREZCOBIX	12.75%
HIV	PREZISTA	12.50%
HIV	RETROVIR	6.75%
HIV	REYATAZ	13.50%
HIV	RITONAVIR	MAC
HIV	RUKOBIA	14.25%
HIV	SELZENTRY	12.75%
HIV	STAVUDINE	50.00%
HIV	STRIBILD	14.50%
HIV	SUNLENCA	7.00%
HIV	SUSTIVA	12.75%
HIV	SYMFI	12.75%
HIV	SYMTUZA	13.50%
HIV	TEMIXYS	7.25%
HIV	TENOFOVIR DISOPROXIL FUMA	MAC
HIV	TIVICAY	12.75%
HIV	TRIUMEQ	13.50%
HIV	TRIZIVIR	14.00%
HIV	TROGARZO	13.75%
HIV	TRUVADA	12.75%
HIV	TYBOST	3.25%
HIV	VIRACEPT	13.00%
HIV	VIRAMUNE	12.00%
HIV	VIRAMUNE XR	11.50%
HIV	VIREAD	12.00%
HIV	ZIAGEN	5.50%
HIV	ZIDOVUDINE	MAC
Hormonal Therapies	AVEED	10.00%
Hormonal Therapies	ELIGARD	11.00%
Hormonal Therapies	FENSOLVI	15.75%
Hormonal Therapies	FIRMAGON	2.25%
Hormonal Therapies	LEUPROLIDE ACETATE	MAC
Hormonal Therapies	LEUPROLIDE ACETATE_BRAND	9.50%
Hormonal Therapies	LUPANETA PACK	13.50%
Hormonal Therapies	LUPRON DEPOT	13.75%
Hormonal Therapies	SUPPRELIN	14.75%
Hormonal Therapies	TRELSTAR	12.25%
Hormonal Therapies	VANTAS	12.75%
Hormonal Therapies	ZOLADEX	7.00%
I.V.I.G.	ASCENIV	11.25%
I.V.I.G.	BIVIGAM	9.50%

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Specialty Fee Schedule

PSUID 12412748

Harris County		Exclusive
Drug Therapy	Drug Name	AWP Discount
I.V.I.G.	CUTAQUIG	10.50%
I.V.I.G.	CUVITRU	31.50%
I.V.I.G.	CYTOGAM	7.00%
I.V.I.G.	FLEBOGAMMA	14.00%
I.V.I.G.	GAMASTAN S/D	0.00%
I.V.I.G.	GAMMAGARD	37.00%
I.V.I.G.	GAMMAGARD LIQUID	42.00%
I.V.I.G.	GAMMAKED	14.25%
I.V.I.G.	GAMMAPLEX	44.00%
I.V.I.G.	GAMUNEX	32.00%
I.V.I.G.	HEPAGAM B	0.00%
I.V.I.G.	HIZENTRA	44.00%
I.V.I.G.	HYPERHEP B	0.00%
I.V.I.G.	HYPERRHO S/D	0.00%
I.V.I.G.	HYQVIA	33.00%
I.V.I.G.	MICRHOGAM	0.00%
I.V.I.G.	NABI-HB	9.00%
I.V.I.G.	OCTAGAM	32.00%
I.V.I.G.	PANZYGA	13.00%
I.V.I.G.	PRIVIGEN	43.00%
I.V.I.G.	RHOGAM	0.00%
I.V.I.G.	RHOPHYLAC	0.00%
I.V.I.G.	VARIZIG	0.00%
I.V.I.G.	WINRHO	13.00%
I.V.I.G.	XEMBIFY	30.00%
Infectious Disease	ACTIMMUNE	15.00%
Infectious Disease	ALFERON N	9.00%
Infertility	CETROTIDE	9.50%
Infertility	CHORIONIC GONADOTROPIN	0.00%
Infertility	FOLLISTIM AQ	14.00%
Infertility	FYREMADEL	MAC
Infertility	GANIRELIX ACETATE	MAC
Infertility	GANIRELIX ACETATE_BRAND	6.00%
Infertility	GONAL-F	13.50%
Infertility	MENOPUR	13.00%
Infertility	NOVAREL	0.00%
Infertility	OVIDREL	0.00%
Infertility	PREGNYL	0.00%
Inflammatory Bowel Disease	CIMZIA	15.25%
Inflammatory Bowel Disease	CIMZIA POW	13.25%
Inflammatory Bowel Disease	ENTYVIO	13.75%
Inflammatory Bowel Disease	RENFLEXIS	17.75%
Iron Overload	DEFERASIROX	MAC
Iron Overload	DEFERIPRONE	MAC
Iron Overload	DEFEROXAMINE	72.00%
Iron Overload	DESFERAL	14.00%
Iron Overload	EXJADE	15.25%
Iron Overload	JADENU	14.25%
Lysosomal Storage Diseases	ALDURAZYME	13.75%
Lysosomal Storage Diseases	CERDELGA	12.25%
Lysosomal Storage Diseases	CEREZYME	13.75%
Lysosomal Storage Diseases	CYSTAGON	0.00%
Lysosomal Storage Diseases	ELAPRASE	12.75%
Lysosomal Storage Diseases	ELELYSO	14.75%
Lysosomal Storage Diseases	FABRAZYME	12.50%

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Specialty Fee Schedule

PSUID 12412748

Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Lysosomal Storage Diseases	KANUMA	15.50%
Lysosomal Storage Diseases	LUMIZYME	14.25%
Lysosomal Storage Diseases	MIGLUSTAT	MAC
Lysosomal Storage Diseases	NAGLAZYME	13.75%
Lysosomal Storage Diseases	NEXVIAZYME	14.25%
Lysosomal Storage Diseases	VIMIZIM	12.75%
Lysosomal Storage Diseases	VPRIV	12.00%
Lysosomal Storage Diseases	XENPOZYME	14.25%
Mental Health Conditions	ZULRESSO	14.75%
Movement Disorders	APOKYN	16.00%
Movement Disorders	APOMORPHINE HYDROCHLORIDE INJ	40.00%
Movement Disorders	AUSTEDO	14.75%
Movement Disorders	DROXIDOPA	MAC
Movement Disorders	DUOPA	15.50%
Movement Disorders	INGREZZA	13.25%
Movement Disorders	KYNMOBI	13.00%
Movement Disorders	NORTHERA	13.75%
Movement Disorders	NUPLAZID	15.00%
Movement Disorders	RADICAVA ORS	12.25%
Movement Disorders	RELYVRIO	10.50%
Movement Disorders	TETRABENAZINE	MAC
Movement Disorders	XENAZINE	15.00%
Multiple Sclerosis	AMPYRA	11.00%
Multiple Sclerosis	AUBAGIO	16.25%
Multiple Sclerosis	AVONEX	15.75%
Multiple Sclerosis	BAFIERTAM	16.25%
Multiple Sclerosis	BETASERON	15.75%
Multiple Sclerosis	BRIUMVI	11.75%
Multiple Sclerosis	COPAXONE 20	14.25%
Multiple Sclerosis	COPAXONE 40	14.25%
Multiple Sclerosis	DALFAMPRIDINE	MAC
Multiple Sclerosis	DIMETHYL FUMARATE	MAC
Multiple Sclerosis	EXTAVIA	15.50%
Multiple Sclerosis	FINGOLIMOD	MAC
Multiple Sclerosis	GILENYA	15.75%
Multiple Sclerosis	GLATIRAMER ACETATE 20	88.00%
Multiple Sclerosis	GLATIRAMER ACETATE 40	78.75%
Multiple Sclerosis	GLATOPA 20	87.00%
Multiple Sclerosis	GLATOPA 40	78.75%
Multiple Sclerosis	KESIMPTA	16.00%
Multiple Sclerosis	LEMTRADA	15.75%
Multiple Sclerosis	MAVENCLAD	16.25%
Multiple Sclerosis	MAYZENT	15.25%
Multiple Sclerosis	MITOXANTRONE	0.00%
Multiple Sclerosis	OCREVUS	15.00%
Multiple Sclerosis	PLEGRIDY	15.75%
Multiple Sclerosis	PONVORY	16.00%
Multiple Sclerosis	REBIF	14.25%
Multiple Sclerosis	TECFIDERA	16.25%
Multiple Sclerosis	TERIFLUNOMIDE	MAC
Multiple Sclerosis	TYSABRI	14.00%
Multiple Sclerosis	VUMERITY	15.75%
Multiple Sclerosis	ZEPOSIA	16.25%
Neurological Disorders	ADUHELM	13.75%
Neuromuscular	RYSTIGGO	12.00%

Specialty Fee Schedule

PSUID 12412748

Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Neuromuscular	VYVGART	16.25%
Neuromuscular	VYVGART HYTRULO	15.25%
Neutropenia	FULPHILA	13.50%
Neutropenia	FYLNETRA	7.75%
Neutropenia	GRANIX	12.50%
Neutropenia	LEUKINE	13.25%
Neutropenia	NEULASTA	14.00%
Neutropenia	NEUPOGEN	13.00%
Neutropenia	NIVESTYM	11.75%
Neutropenia	NYVEPRIA	12.75%
Neutropenia	RELEUKO	10.25%
Neutropenia	ROLVEDON	9.75%
Neutropenia	STIMUFEND	10.50%
Neutropenia	UDENYCA	13.50%
Neutropenia	ZARXIO	12.25%
Neutropenia	ZIEXTENZO	13.00%
Ocular Disorders	SUSVIMO	14.50%
Oncology - Injectable	ABRAXANE	14.75%
Oncology - Injectable	ADCETRIS	14.50%
Oncology - Injectable	ALYMSYS	14.50%
Oncology - Injectable	AVASTIN	14.50%
Oncology - Injectable	AZACITIDINE	85.75%
Oncology - Injectable	BELEODAQ	15.75%
Oncology - Injectable	BELRAPZO	14.75%
Oncology - Injectable	BENDAMUSTINE HYDROCHLORID	15.00%
Oncology - Injectable	BENDAMUSTINE HYDROCHLORIDE INJ	14.25%
Oncology - Injectable	BENDEKA	15.25%
Oncology - Injectable	BESPONSA	15.25%
Oncology - Injectable	BLINCYTO	11.75%
Oncology - Injectable	BORTEZOMIB	15.00%
Oncology - Injectable	BORTEZOMIB FOR INJ	11.75%
Oncology - Injectable	BORTEZOMIB FOR INJ_BRAND	7.00%
Oncology - Injectable	COLUMVI	11.75%
Oncology - Injectable	CYRAMZA	15.00%
Oncology - Injectable	DACOGEN	15.25%
Oncology - Injectable	DARZALEX	15.25%
Oncology - Injectable	DECITABINE	53.50%
Oncology - Injectable	EMPLICITI	15.25%
Oncology - Injectable	ENHERTU	11.50%
Oncology - Injectable	ERBITUX	15.25%
Oncology - Injectable	EVOMELA	15.50%
Oncology - Injectable	FOLOTYN	16.00%
Oncology - Injectable	GAZYVA	15.50%
Oncology - Injectable	HALAVEN	15.00%
Oncology - Injectable	HERCEPTIN	15.00%
Oncology - Injectable	HERCEPTIN HYLECTA	14.50%
Oncology - Injectable	HERZUMA	14.25%
Oncology - Injectable	IMFINZI	15.00%
Oncology - Injectable	IMJUDO	14.25%
Oncology - Injectable	INTRON A	14.50%
Oncology - Injectable	ISTODAX	15.50%
Oncology - Injectable	IXEMPRA	15.25%
Oncology - Injectable	JEMPERLI	14.75%
Oncology - Injectable	JEVTANA	15.50%
Oncology - Injectable	KADCYLA	15.00%

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Specialty Fee Schedule

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Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Oncology - Injectable	KANJINTI	14.25%
Oncology - Injectable	KEYTRUDA	15.25%
Oncology - Injectable	KHAPZORY	10.75%
Oncology - Injectable	KYPROLIS	15.50%
Oncology - Injectable	LEVOLEUCOVORIN CALCIUM	14.50%
Oncology - Injectable	LUMOXITI	7.00%
Oncology - Injectable	LUNSUMIO	11.75%
Oncology - Injectable	MARGENZA	14.75%
Oncology - Injectable	MVASI	13.50%
Oncology - Injectable	MYLOTARG	14.75%
Oncology - Injectable	OGIVRI	14.25%
Oncology - Injectable	ONIVYDE	8.00%
Oncology - Injectable	ONTRUZANT	11.25%
Oncology - Injectable	OPDIVO	15.25%
Oncology - Injectable	OPDUALAG	15.00%
Oncology - Injectable	PACLITAXEL PROTEIN-BOUND	14.75%
Oncology - Injectable	PACLITAXEL PROTEIN-BOUND_BRAND	14.75%
Oncology - Injectable	PADCEV	14.75%
Oncology - Injectable	PERJETA	15.00%
Oncology - Injectable	PHESGO	14.75%
Oncology - Injectable	POLIVY	15.00%
Oncology - Injectable	PORTRAZZA	15.00%
Oncology - Injectable	POTELIGEO	7.00%
Oncology - Injectable	PROLEUKIN	16.00%
Oncology - Injectable	RIABNI	11.75%
Oncology - Injectable	RITUXAN	14.50%
Oncology - Injectable	RITUXAN HYCELA	14.75%
Oncology - Injectable	ROMIDEPSIN	15.25%
Oncology - Injectable	ROMIDEPSIN_BRAND	14.75%
Oncology - Injectable	RUXIENCE	14.50%
Oncology - Injectable	RYBREVANT	11.75%
Oncology - Injectable	RYLAZE	14.25%
Oncology - Injectable	SARCLISA	10.50%
Oncology - Injectable	SYLVANT	14.50%
Oncology - Injectable	TECENTRIQ	15.00%
Oncology - Injectable	TEMODAR (INJECTABLE)	15.50%
Oncology - Injectable	TEMSIROLIMUS	22.00%
Oncology - Injectable	TEPADINA	12.75%
Oncology - Injectable	THYROGEN	14.25%
Oncology - Injectable	TIVDAK	14.75%
Oncology - Injectable	TORISEL	15.25%
Oncology - Injectable	TRAZIMERA	14.50%
Oncology - Injectable	TREANDA	15.00%
Oncology - Injectable	TRUXIMA	14.50%
Oncology - Injectable	VALRUBICIN	16.25%
Oncology - Injectable	VALSTAR	15.50%
Oncology - Injectable	VECTIBIX	15.00%
Oncology - Injectable	VEGZELMA	11.50%
Oncology - Injectable	VELCADE	15.00%
Oncology - Injectable	VIDAZA	11.00%
Oncology - Injectable	VIVIMUSTA	11.50%
Oncology - Injectable	VYXEOS	14.75%
Oncology - Injectable	XGEVA	12.75%
Oncology - Injectable	YERVOY	15.50%
Oncology - Injectable	YONDELIS	15.25%

Specialty Fee Schedule

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Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Oncology - Injectable	ZALTRAP	15.25%
Oncology - Injectable	ZEPZELCA	14.75%
Oncology - Injectable	ZIRABEV	14.50%
Oncology - Injectable	ZOLEDRONIC ACID_ONC	85.75%
Oncology - Injectable	ZOLEDRONIC ACID_ONC_BRAND	0.00%
Oncology - Injectable	ZYNYZ	11.50%
Oncology - Oral	ABIRATERONE ACETATE	MAC
Oncology - Oral	AFINITOR	14.25%
Oncology - Oral	ALECENSA	14.25%
Oncology - Oral	BALVERSA	6.00%
Oncology - Oral	BEXAROTENE CAP	MAC
Oncology - Oral	BEXAROTENE GEL	MAC
Oncology - Oral	BOSULIF	14.25%
Oncology - Oral	BRAFTOVI	13.50%
Oncology - Oral	CABOMETYX	13.00%
Oncology - Oral	CAPECITABINE	MAC
Oncology - Oral	COMETRIQ	13.75%
Oncology - Oral	COPIKTRA	13.00%
Oncology - Oral	COTELLIC	13.75%
Oncology - Oral	DAURISMO	15.25%
Oncology - Oral	ERIVEDGE	14.25%
Oncology - Oral	ERLEADA	14.50%
Oncology - Oral	ERLOTINIB HYDROCHLORIDE	MAC
Oncology - Oral	EVEROLIMUS_ONC	MAC
Oncology - Oral	FARYDAK	15.00%
Oncology - Oral	GAVRETO	13.75%
Oncology - Oral	GEFITINIB	MAC
Oncology - Oral	GLEEVEC	14.50%
Oncology - Oral	GLEOSTINE	9.75%
Oncology - Oral	HYCAMTIN	14.00%
Oncology - Oral	IBRANCE	14.75%
Oncology - Oral	IDHIFA	13.00%
Oncology - Oral	IMATINIB MESYLATE	MAC
Oncology - Oral	INLYTA	14.50%
Oncology - Oral	INQOVI	12.25%
Oncology - Oral	INREBIC	12.75%
Oncology - Oral	IRESSA	15.50%
Oncology - Oral	JAKAFI	13.50%
Oncology - Oral	JAYPIRCA	10.75%
Oncology - Oral	KISQALI	14.50%
Oncology - Oral	LAPATINIB DITOSYLATE	59.75%
Oncology - Oral	LENALIDOMIDE	45.90%
Oncology - Oral	LENVIMA	11.75%
Oncology - Oral	LONSURF	13.00%
Oncology - Oral	LORBRENA	14.25%
Oncology - Oral	LUMAKRAS	13.75%
Oncology - Oral	LYNPARZA	14.25%
Oncology - Oral	MEKINIST	14.25%
Oncology - Oral	MEKTOVI	13.50%
Oncology - Oral	NERLYNX	13.00%
Oncology - Oral	NEXAVAR	13.00%
Oncology - Oral	NINLARO	13.00%
Oncology - Oral	NUBEQA	12.75%
Oncology - Oral	ODOMZO	14.25%
Oncology - Oral	ONUREG	11.00%

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Specialty Fee Schedule

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Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Oncology - Oral	PIQRAY	14.25%
Oncology - Oral	POMALYST	13.50%
Oncology - Oral	PURIXAN	11.00%
Oncology - Oral	RETEVMO	11.00%
Oncology - Oral	REVLIMID	14.25%
Oncology - Oral	ROZLYTREK	14.00%
Oncology - Oral	RUBRACA	13.00%
Oncology - Oral	RYDAPT	11.00%
Oncology - Oral	SCEMBLIX	14.00%
Oncology - Oral	SORAFENIB TOSYLATE	MAC
Oncology - Oral	SPRYCEL	15.75%
Oncology - Oral	STIVARGA	13.00%
Oncology - Oral	SUNITINIB MALATE	MAC
Oncology - Oral	SUTENT	15.25%
Oncology - Oral	TABRECTA	14.50%
Oncology - Oral	TAFINLAR	14.25%
Oncology - Oral	TAGRISSO	14.75%
Oncology - Oral	TALZENNA	14.00%
Oncology - Oral	TARCEVA	15.00%
Oncology - Oral	TARGRETIN	14.50%
Oncology - Oral	TASIGNA	14.25%
Oncology - Oral	TEMODAR (ORAL)	15.25%
Oncology - Oral	TEMOZOLOMIDE	MAC
Oncology - Oral	THALOMID	12.75%
Oncology - Oral	TYKERB	15.00%
Oncology - Oral	VERZENIO	14.00%
Oncology - Oral	VITRAKVI	13.00%
Oncology - Oral	VIZIMPRO	15.00%
Oncology - Oral	VOTRIENT	14.25%
Oncology - Oral	XALKORI	14.25%
Oncology - Oral	XELODA	13.50%
Oncology - Oral	XOSPATA	12.50%
Oncology - Oral	XTANDI	16.25%
Oncology - Oral	YONSA	13.75%
Oncology - Oral	ZEJULA	10.50%
Oncology - Oral	ZELBORAF	14.25%
Oncology - Oral	ZOLINZA	14.25%
Oncology - Oral	ZYDELIG	12.00%
Oncology - Oral	ZYKADIA	14.25%
Oncology - Oral	ZYTIGA	16.75%
Osteoporosis	EVENITY	11.50%
Osteoporosis	FORTEO	13.00%
Osteoporosis	PROLIA	9.75%
Osteoporosis	RECLAST	8.00%
Osteoporosis	TERIPARATIDE	9.50%
Osteoporosis	TYMLOS	13.00%
Osteoporosis	ZOLEDRONIC ACID_OST	MAC
Paroxysmal Nocturnal Hemoglobinuria	SOLIRIS	14.50%
Paroxysmal Nocturnal Hemoglobinuria	ULTOMIRIS	14.50%
Phenylketonuria	KUVAN	13.00%
Phenylketonuria	PALYNZIQ	13.00%
Phenylketonuria	SAPROPTERIN DIHYDROCHLORIDE	MAC
Psoriasis	COSENTYX	16.25%
Psoriasis	ILUMYA	14.00%
Psoriasis	OTEZLA	15.50%

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Specialty Fee Schedule

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Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Psoriasis	SILIQ	12.50%
Psoriasis	SKYRIZI	17.25%
Psoriasis	SOTYKTU	16.75%
Psoriasis	STELARA	18.25%
Psoriasis	STELARA (SOLN)	15.25%
Psoriasis	STELARA IV	13.75%
Psoriasis	TALTZ	15.75%
Psoriasis	TREMFYA	16.75%
Pulmonary Arterial Hypertension	ADCIRCA	12.25%
Pulmonary Arterial Hypertension	ADEMPAS	12.50%
Pulmonary Arterial Hypertension	ALYQ	MAC
Pulmonary Arterial Hypertension	AMBRISENTAN	MAC
Pulmonary Arterial Hypertension	BOSENTAN	MAC
Pulmonary Arterial Hypertension	EPOPROSTENOL	29.00%
Pulmonary Arterial Hypertension	FLOLAN	13.00%
Pulmonary Arterial Hypertension	LETAIRIS	12.75%
Pulmonary Arterial Hypertension	LIQREV	18.75%
Pulmonary Arterial Hypertension	OPSUMIT	13.25%
Pulmonary Arterial Hypertension	ORENITRAM	11.75%
Pulmonary Arterial Hypertension	REMODULIN	13.00%
Pulmonary Arterial Hypertension	REVATIO	14.50%
Pulmonary Arterial Hypertension	SILDENAFIL CITRATE	MAC
Pulmonary Arterial Hypertension	TADALAFIL	MAC
Pulmonary Arterial Hypertension	TADLIQ	17.75%
Pulmonary Arterial Hypertension	TRACLEER	10.75%
Pulmonary Arterial Hypertension	TREPROSTINIL SODIUM	53.90%
Pulmonary Arterial Hypertension	TYVASO	12.75%
Pulmonary Arterial Hypertension	UPTRAVI	13.75%
Pulmonary Arterial Hypertension	VELETRI	10.75%
Pulmonary Arterial Hypertension	VENTAVIS	12.00%
Pulmonary Disorders	ESBRIET	13.75%
Pulmonary Disorders	OFEV	13.25%
Pulmonary Disorders	PIRFENIDONE	MAC
Rare Disorders	CRYSVITA	13.00%
Rare Disorders	DOJOLVI	12.25%
Rare Disorders	ENSPRYNG	13.75%
Rare Disorders	LITFULO	11.50%
Rare Disorders	VIJOICE	14.00%
Rare Disorders	ZOKINVY	8.00%
Renal Disease	CINACALCET HCL	MAC
Renal Disease	FILSPARI	12.50%
Renal Disease	PARSABIV	13.00%
Renal Disease	SENSIPAR	11.50%
Renal Disease	TIOPRONIN	27.75%
Retinal Disorders	BEOVU	12.50%
Retinal Disorders	BYOOVIZ	9.75%
Retinal Disorders	CIMERLI	6.00%
Retinal Disorders	EYLEA	12.75%
Retinal Disorders	ILUVIEN	15.25%
Retinal Disorders	IZERVAY	12.00%
Retinal Disorders	LUCENTIS	12.00%
Retinal Disorders	OZURDEX	11.50%
Retinal Disorders	RETISERT	15.50%
Retinal Disorders	VABYSMO	11.50%
Retinal Disorders	VISUDYNE	9.50%

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Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Rheumatoid Arthritis	ACTEMRA	13.25%
Rheumatoid Arthritis	AMJEVITA	15.00%
Rheumatoid Arthritis	AMJEVITA_NS	12.00%
Rheumatoid Arthritis	AVSOLA	13.25%
Rheumatoid Arthritis	ENBREL	17.75%
Rheumatoid Arthritis	HUMIRA	18.00%
Rheumatoid Arthritis	HYRIMOZ	18.00%
Rheumatoid Arthritis	INFLECTRA	13.00%
Rheumatoid Arthritis	INFLIXIMAB	12.75%
Rheumatoid Arthritis	KEVZARA	13.00%
Rheumatoid Arthritis	OLUMIANT	13.50%
Rheumatoid Arthritis	ORENCIA	15.00%
Rheumatoid Arthritis	OTREXUP	8.50%
Rheumatoid Arthritis	RASUVO	5.75%
Rheumatoid Arthritis	REDITREX	0.00%
Rheumatoid Arthritis	REMICADE	14.00%
Rheumatoid Arthritis	RINVOQ	16.00%
Rheumatoid Arthritis	SIMPONI	15.00%
Rheumatoid Arthritis	XELJANZ	17.25%
RSV	SYNAGIS	15.25%
Seizure Disorders	EPIDIOLEX	11.75%
Seizure Disorders	HP ACTHAR GEL	13.25%
Seizure Disorders	SABRIL	14.00%
Sickle Cell Disease	ADAKVEO	13.75%
Sickle Cell Disease	ENDARI	10.50%
Sickle Cell Disease	OXBRYTA	11.75%
Sleep Disorder	LUMRYZ	13.75%
Sleep Disorder	TASIMELTEON	66.75%
Sleep Disorder	WAKIX	12.00%
Systemic Lupus Erythematosus	BENLYSTA	13.50%
Systemic Lupus Erythematosus	SAPHNELO	11.50%
Thrombocytopenia	DOPTELET	13.00%
Thrombocytopenia	MULPLETA	14.25%
Thrombocytopenia	NPLATE	14.50%
Thrombocytopenia	PROMACTA	14.50%
Transplant	ASTAGRAF XL	8.00%
Transplant	CELLCEPT	12.50%
Transplant	CYCLOSPORINE	MAC
Transplant	ENVARSUS XR	8.50%
Transplant	EVEROLIMUS_TRANSPLANT	MAC
Transplant	GENGRAF	MAC
Transplant	MYCOPHENOLATE MOFETIL	MAC
Transplant	MYCOPHENOLIC ACID	MAC
Transplant	MYFORTIC	11.00%
Transplant	NEORAL	7.00%
Transplant	NULOJIX	13.75%
Transplant	PROGRAF	9.00%
Transplant	RAPAMUNE	13.25%
Transplant	SANDIMMUNE	10.75%
Transplant	SIROLIMUS	MAC
Transplant	TACROLIMUS	MAC
Transplant	ZORTRESS	13.50%
Urea Cycle Disorders	BUPHENYL	13.75%
Urea Cycle Disorders	CARGLUMIC ACID	MAC
Urea Cycle Disorders	OLPRUVA	7.00%

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Harris County		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Urea Cycle Disorders	RAVICTI	13.25%
Urea Cycle Disorders	SODIUM PHENYLBUTYRATE	MAC
Wilson's Disease	CLOVIQUE	MAC
Wilson's Disease	CUPRIMINE	15.75%
Wilson's Disease	DEPEN TITRA	15.25%
Wilson's Disease	PENICILLAMINE	MAC
Wilson's Disease	SYPRINE	15.75%
Wilson's Disease	TRIENTINE HCL	MAC
	Default Rate:	17.00%
	Dispensing Fee:	$0.00

NOTES:

- New to Market Specialty Products will be priced at: AWP – 16.00%
- New to Market Limited and exclusive distribution drugs will be pricied at AWP – 15.00%

PRODUCT SHORTAGE:

- In the event of an industry-wide product shortage, we reserve the right to adjust pricing upon notice to the customer.

CONFIDENTIALITY:

- Customer acknowledges and agrees that the information included is confidential, proprietary and trade secret to Aetna and will agree to protect the information from disclosure.

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MEDICARE ADVANTAGE RATE PROPOSAL

Plan Sponsor Name:	**Harris County**
Policy Period Start Date:	**2/1/2026**
Policy Period End Date:	**12/31/2026**
Pharmacy Plan:	**Rx 20%/25%/35%/30%**

- Please refer to the Financial Conditions and Plan Design Exhibits for an outline of the level of benefits quoted, as well as the terms and conditions of this proposal.
- Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1 of each year and are subject to CMS contract approval.
- All rates are on a Per Member Per Month (PMPM) basis.
- These rates exclude commissions.
- The Aetna Medicare Rx Prescription Drug Plan(PDP) is offered by SilverScript Insurance Company(SilverScript). SilverScript is a CVS affiliate and is contracted with CMS for 2026. CVS is the parent company of both Aetna and SilverScript.

- **Demonstration** - On July 29, 2024, CMS announced a voluntary 3-year Part D premium stabilization demonstration (demonstration) for standalone Medicare prescription drug plans (PDPs). Aetna notified CMS in August 2025 of its intent to participate in this demonstration for CY 2026 (2/1/2026 effective date). The PDP rates provided for the 2026 plan year reflect Aetna's participation in the demonstration as currently established by CMS. Aetna reserves the right to adjust the PDP rates if CMS terminates, delays or adjusts the demonstration. Aetna also reserves the right to adjust the PDP rates if CMS does not allow Aetna to participate in the demonstration, or Aetna declines to participate in or withdraws from the demonstration due to CMS adjustments to the demonstration or delays in implementation in the demonstration.

Aetna may be required to submit data to CMS and/or the Department of Health & Human Services (HHS) that assists with evaluation of the impacts of the demonstration on the stabilization of PDP premiums. Therefore, if your members make PDP premium payments to you, please ensure that you continue to maintain data that demonstrates your compliance with CMS' Part D premium subsidization requirements, as you may be required to provide access to such data in the future.

- **Full Replacement** - This proposal assumes Aetna group retiree benefits will be a full replacement of the Medicare-eligible retirees and dependents currently enrolled in the Commercial Aetna Prescription Drug Plan and future retirees from any source or other entity. This proposal further assumes that all members currently enrolled in the Humana Medicare Advantage with Part D plan will remain in said plan. If at any point in time during the period of the coverage, the above is not valid, we reserve the right to revise, modify or terminate this proposal.

	Pharmacy Rate
2026 Proposed Rate	$199.00
2026 Demonstration Value	-$9.80
2026 Proposed Billed Rate	$189.20

Total Medicare Eligible Members	6,498

State	Medicare Eligible Members	2026 Proposed Rate	2026 Demonstration Value	2026 Proposed Billed Rate
Alabama	8	$199.00	-$9.80	$189.20
Alaska	1	$199.00	-$9.80	$189.20
Arizona	10	$199.00	-$9.80	$189.20
Arkansas	20	$199.00	-$9.80	$189.20
California	18	$199.00	-$9.80	$189.20
Colorado	16	$199.00	-$9.80	$189.20
Delaware	1	$199.00	-$9.80	$189.20
Florida	40	$199.00	-$9.80	$189.20
Georgia	5	$199.00	-$9.80	$189.20
Idaho	3	$199.00	-$9.80	$189.20
Illinois	5	$199.00	-$9.80	$189.20
Indiana	7	$199.00	-$9.80	$189.20
Iowa	3	$199.00	-$9.80	$189.20
Kansas	4	$199.00	-$9.80	$189.20
Kentucky	9	$199.00	-$9.80	$189.20
Louisiana	16	$199.00	-$9.80	$189.20
Maine	1	$199.00	-$9.80	$189.20
Maryland	2	$199.00	-$9.80	$189.20
Massachusetts	6	$199.00	-$9.80	$189.20
Michigan	8	$199.00	-$9.80	$189.20

Minnesota	2	$199.00	-$9.80	$189.20
Mississippi	17	$199.00	-$9.80	$189.20
Missouri	8	$199.00	-$9.80	$189.20
Montana	1	$199.00	-$9.80	$189.20
Nevada	7	$199.00	-$9.80	$189.20
New Jersey	1	$199.00	-$9.80	$189.20
New Mexico	6	$199.00	-$9.80	$189.20
New York	5	$199.00	-$9.80	$189.20
North Carolina	10	$199.00	-$9.80	$189.20
Ohio	7	$199.00	-$9.80	$189.20
Oklahoma	10	$199.00	-$9.80	$189.20
Oregon	5	$199.00	-$9.80	$189.20
Pennsylvania	7	$199.00	-$9.80	$189.20
Rhode Island	1	$199.00	-$9.80	$189.20
South Carolina	1	$199.00	-$9.80	$189.20
South Dakota	2	$199.00	-$9.80	$189.20
Tennessee	12	$199.00	-$9.80	$189.20
Texas	6,186	$199.00	-$9.80	$189.20
Utah	3	$199.00	-$9.80	$189.20
Vermont	2	$199.00	-$9.80	$189.20
Virginia	3	$199.00	-$9.80	$189.20
Washington	11	$199.00	-$9.80	$189.20
West Virginia	5	$199.00	-$9.80	$189.20
Wisconsin	3	$199.00	-$9.80	$189.20

Benefit Buy-Up Options	
Non-Part D Weight Loss Rider	$8-$8.50 PMPM

** The above buy-up option costs are estimates and subject to revised pricing, if elected*

SilverScript® aetna™

Harris County

Pharmacy Plan Highlights:	**Rx 20%/25%/35%/30%**
Deductible	$0
Formulary	Classic Plus
Network	P1
ICL Retail 30-Day Supply	T1: 25%, min $5, max $50; T2: 25%, min $25, max $150; T3: 35%, min $50, max $250; T4: 30%, min $75, max $350
ICL Preferred Retail 30-Day Supply	T1: 20%, min $4, max $50; T2: 25%, min $25, max $150; T3: 35%, min $50, max $250; T4: 30%, min $75, max $350
ICL Retail 90-Day Supply	T1: 25%, min $10, max $100; T2: 25%, min $50, max $300; T3: 35%, min $100, max $500; T4: Limited to one-month supply
ICL Preferred Mail Order 90-Day Supply	T1: 20%, min $8, max $100; T2: 25%, min $50, max $300; T3: 35%, min $100, max $500; T4: Limited to one-month supply
Catastrophic Coverage:	You pay $0. Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of $2,100 for covered Part D prescription drugs is reached.
Rx Plan Annual Max Out-of-Pocket	None

Not for Member Distribution. The benefits presented above are a high-level summary. Please review the Aetna Medicare Rx offered by SilverScript Summary of Benefits for a more detailed list of covered services, member cost shares, services subject to deductibles and any plan limitations.

SilverScript®

HARRIS COUNTY
Aetna Medicare Rx offered by SilverScript
Rx 20%/25%/35%/30%

Benefits and Premiums are effective February 1, 2026 through December 31, 2026

SUMMARY OF BENEFITS
PROVIDED BY SILVERSCRIPT INSURANCE COMPANY

PHARMACY - PRESCRIPTION DRUG BENEFITS	
Monthly Premium	Please contact your former employer/union/trust for more information on your plan premium.
Pharmacy Network	P1
Your Medicare Part D plan uses the network above. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com.)	
Formulary (Drug List)	Classic Plus
Calendar-Year Deductible for Prescription Drugs	$0
Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible. The deductible does not apply to covered insulins and most Part D vaccines.	

Initial Coverage Phase - The table below represents cost sharing after the deductible, if applicable, has been reached.

4 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	**Standard**	**Preferred Retail**	**Preferred Mail**	**Standard Retail or Mail**
Tier 1 - Generic Generic Drugs	Greater of $4 or 20%, but not more than $50	Greater of $5 or 25%, but not more than $50	Greater of $8 or 20%, but not more than $100	Greater of $8 or 20%, but not more than $100	Greater of $10 or 25%, but not more than $100
Tier 2 - Preferred Brand Preferred Brand Drugs	Greater of $25 or 25%, but not more than $150	Greater of $25 or 25%, but not more than $150	Greater of $50 or 25%, but not more than $300	Greater of $50 or 25%, but not more than $300	Greater of $50 or 25%, but not more than $300

SilverScript®

HARRIS COUNTY
Aetna Medicare Rx offered by SilverScript
Rx 20%/25%/35%/30%

4 Tier Plan	30-day Supply through Retail		90-day Supply through Retail or Mail		
	Preferred	**Standard**	**Preferred Retail**	**Preferred Mail**	**Standard Retail or Mail**
Tier 3 - Non-Preferred Brand Non-Preferred Brand Drugs	Greater of $50 or 35%, but not more than $250	Greater of $50 or 35%, but not more than $250	Greater of $100 or 35%, but not more than $500	Greater of $100 or 35%, but not more than $500	Greater of $100 or 35%, but not more than $500
Tier 4 - Specialty Includes high-cost/unique generic and brand drugs	Greater of $75 or 30%, but not more than $350	Greater of $75 or 30%, but not more than $350	Limited to one-month supply	Limited to one-month supply	Limited to one-month supply

If you reside in a long-term care facility, your cost share is the same as a 30 day supply at a retail pharmacy and you may receive up to a 31 day supply.

You won't pay more than $35 for a one-month supply or $105 for up to a three-month supply of each covered insulin product regardless of the cost-sharing tier.

Catastrophic Coverage: You pay $0 for covered Part D prescription drugs.

Catastrophic Coverage benefits start once the CMS-determined annual out-of-pocket threshold of $2,100 for covered Part D prescription drugs is reached.

Requirements:

Precertification Applies

Step-Therapy Does Not Apply

Non-Part D Supplemental Benefit

- Agents used for cosmetic purposes or hair growth

- Agents used to promote fertility
- Agents when used for the symptomatic relief of cough and colds
- Agents when used for the treatment of sexual or erectile dysfunction (ED)
- Miscellaneous agents
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

Essential Health Supplemental Benefit

- $0 cost share for certain preventative drugs. A valid prescription is required.

For more information about Aetna Medicare Rx offered by SilverScript plans, go to **AetnaRetireePlans.com** or call Member Services toll-free at 1-800-594-9390 (TTY: 711). Hours are 8 a.m. to 9 p.m. EST, Monday through Friday.

Pharmacy Disclaimers

Aetna Medicare Rx offered by SilverScript's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna Medicare Rx offered by SilverScript based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

Due to legislation in Arkansas, effective January 1, 2026, you may not be able to utilize the following services within the state of Arkansas: CVS Retail, CVS Caremark Mail Service, CVS Specialty, and OMNI Care long term pharmacies.

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply.

Pharmacy clinical programs such as precertification, step therapy and quantity limits may apply to your prescription drug coverage.

Members who get “extra help” don’t need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered “mail-order pharmacies.” Therefore, most specialty drugs are not available at the mail-order cost share.

The typical number of business days after the mail order pharmacy receives an order to receive your shipment is up to 10 days. Enrollees have the option to sign up for automated mail order delivery. If your mail order drugs do not arrive within the estimated time frame, please contact us toll-free at 1-855-222-6857, 24 hours a day, 7 days a week. TTY users call 711.

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for “off label” use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as “exclusions” or “non-Part D drugs”. These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Your plan includes supplemental coverage for some drugs not typically covered by a Medicare Part D plan. Refer to the "Non-Part D Supplemental Benefit" section in the chart above. Non-Part D drugs covered under the enhanced drug benefit can be purchased at the appropriate plan copay. Copayments and other costs for these prescription drugs will not apply toward the deductible, initial coverage limit or true out-of-pocket threshold. Some drugs may require prior authorization before they are covered under the plan.

Plan Disclaimers

Aetna Medicare Rx offered by SilverScript is a group standalone Medicare Prescription Drug Plan (PDP). This Plan is offered by SilverScript Insurance Company, which has a Medicare contract. SilverScript Insurance Company and Aetna are affiliated companies. Enrollment in the Plan depends on Medicare contract renewal.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

You can read the *Medicare & You 2026* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-800-594-9390 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-594-9390 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-800-594-9390 (TTY: 711).

You can also visit our website at http://www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our pharmacy network (Pharmacy Directory) and our list of covered drugs (Formulary/Drug List).

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-307-4830. Someone who speaks English/Language can help you. This is a free service.

*****This is the end of this plan benefit summary*****

Y0080_GRP_1099_3733a_2021_M

Approved By:

Date:

Group Employer Medicare Advantage Plan and Medicare Prescription Drug Plan Application

APPLICANT

Plan Sponsor Unique ID Number (PSU#)
(for Aetna use only)

PSU#
Current Aetna Customer ☒ Yes ☐ No

Company Name: Harris County
Doing Business As (DBA): _____

City: Houston State: Texas Zip Code: 77002
Federal Tax ID Number: _____ Situs state: Texas
Parent Company name (if applicable):
Employer Sponsor Type: ___ Employer (click on "choose an item")
Employer Organization Type: ____Local Government (click on "choose an item")
The purpose of the application is to request: a. ☒ Issuance of new coverage
b. ☐ Change in existing coverage
c. ☐ Extension of existing coverage to additional eligible individuals
d. ☐ Company change of ownership
e. ☐ Change in premium billing method

Once the Medicare Group agreement is drafted, it will be emailed to Customer Email Address: _Sarah.Acosta@harriscountytx.gov_____
Application will not be processed if Customer Email Address is not provided.

Medicare Coverage
Medical/RX Coverage Selection: Provided or administered by Aetna Life Insurance Company, Aetna Health of California Inc., SilverScript Insurance Company and/or Aetna Health Inc. ("Aetna")

Types of Coverage – Select All that Apply

☐ Medicare Advantage HMO Plan
☐ Medicare Advantage HMO Plan with Medicare prescription drug benefits

☐ Medicare Advantage PPO Plan and/or Medicare Advantage PPO Plan with Extended Service Area
☐ Medicare Advantage PPO Plan with Medicare prescription drug benefits and/or Medicare Advantage PPO Plan with Extended Service Area with Medicare prescription drug benefits
☐ Flex Funding

☒ Fully-Insured Standalone Medicare prescription drug plan
☐ Self-Insured Standalone Medicare prescription drug plan

Type of Group Health Plan Maintained by Plan Sponsor – Select Type that Applies

☐ *ERISA plan.* An employee welfare benefit plan providing medical care as defined in Section 607(1) of ERISA.

☒ *Federal or State governmental plan*. A plan providing medical care established or maintained by a federal, state or local government agency for its employees.

☐ *Collectively bargained plan.* A plan providing medical care established or maintained under or by one or more collective bargaining agreements.

☐ *Church plan.* A plan providing medical care established and maintained for its employees or their beneficiaries by a church or by a convention or association of churches.

☐ *Health Reimbursement Arrangement (HRA).*

☐ *Health Flexible Spending Arrangement (FSA).*

☐ *Health Savings Account (HSA)*.

	☐ *Archer MSA*. The MSA must be subject to ERISA as an employee welfare benefit plan providing medical care (unless exempt from ERISA because it is a governmental plan or church plan).

Premium Billing – Select All that Apply

Aetna offers three different methods for billing premiums. A monthly premium can either be billed to individuals enrolled in the Aetna Medicare Plan ("Direct Billing"), to you ("Contract Holder Billing") or to both you and individuals enrolled in the Aetna Medicare Plan ("Split Billing"). Please select all of the billing methods that apply to the Medicare coverage you selected in this application:

☐ Direct Billing
☒ Contract Holder Billing
☐ Split Billing

General Enrollment and Eligibility Section

Requested effective date: 02/01/2026 (Actual effective date will be assigned by Aetna if this application is accepted and an agreement between Aetna and Applicant for the coverage specified herein is issued)

Renewal date: 01/01/2027 For all Medicare Advantage HMO and PPO plans with Medicare prescription drug coverage and Standalone Medicare prescription drug plans, the renewal date must be January 1st.

Late Enrollment Penalty Attestation (Please review and complete if applying to obtain coverage under a Medicare Advantage plan with Medicare prescription drug coverage ("MA-PD plans") or Standalone Medicare prescription drug plan ("PDP")

Pursuant to Section 1860D-13(b) of the Social Security Act and 42 C.F.R. §§ 423.46 and 423.56(g), Medicare beneficiaries may incur a late enrollment penalty ("LEP") if there is a continuous period of 63 days or more at any time after the end of the beneficiary's Medicare Part D initial enrollment period during which the beneficiary was eligible to enroll, but was not enrolled in a Medicare Part D plan and was not covered under any creditable prescription drug coverage. "Creditable prescription drug coverage" is prescription drug coverage that is expected to pay at least as much as Medicare's standard prescription drug coverage. To ease the administrative burden associated with implementation of these LEP-related procedures, the Centers for Medicare and Medicaid Services permits Aetna to accept attestations from plan sponsors wherein the plan sponsor attests to the creditable coverage history of eligible individuals submitted for enrollment in the plan sponsor's group MA-PD plan or PDP for purposes of reporting covered months. If an individual was assessed a LEP prior to the effective date of the new coverage, the individual's LEP will carry over even if the employer attests to creditable coverage.

☒ **Yes, Applicant will attest to the creditable prescription drug coverage history of all individuals submitted by Applicant for enrollment in Aetna's MA-PD plans or PDP for purposes of reporting covered months.** By checking this box and signing this application, Applicant attests that all individuals submitted for enrollment in Aetna's MA-PD plans or PDPs were either previously enrolled in another Medicare prescription drug plan or had other creditable prescription drug coverage prior to applying to enroll in an Aetna MA-PD plan or PDP. Applicant understands that by signing this application, Applicant is attesting that it has read and understands the contents of this attestation and that this attestation is truthful, accurate and complete.

☐ **No, Applicant will not attest to the creditable prescription drug coverage history of all individuals submitted for enrollment in Aetna's MA-PD plans or PDPs for purposes of reporting covered months**. Applicant understands that without an attestation from Applicant, all individuals submitted by Applicant for enrollment in Aetna's MA-PD plans or PDPs will be submitted by Aetna through CMS systems to determine if gaps of 63 days or more exist in creditable prescription drug coverage since the close of the individual's initial Medicare Part D enrollment period. Individuals who are identified to have such gaps of creditable prescription drug coverage will receive letters requesting that they attest to any creditable prescription drug coverage during those gaps, and these individuals may contact Applicant for assistance in determining creditable coverage history.

☐ **Other, the Applicant will partially attest to the creditable prescription drug coverage history for select individuals submitted for enrollment in Aetna's MA-PD plans or PDPs for purposes of reporting covered months**. By checking this box and signing this application, Applicant attests that the selected individuals submitted for enrollment in Aetna's MA-PD plans or PDPs were either previously enrolled in another Medicare prescription drug plan or had other creditable prescription drug coverage before applying to enroll in an Aetna MA-PD plan or PDP. Individuals the applicant will not provide an attestation for will be submitted by Aetna through CMS systems to determine if gaps of 63 days or more exist in creditable prescription drug coverage since the close of the individual's initial Medicare Part D enrollment period. Individuals who are identified to have such gaps of creditable prescription drug coverage will receive letters requesting that they attest to any creditable prescription drug coverage during those gaps, and these individuals may contact Applicant for assistance in determining creditable coverage history.

"Age-In" Program

Aetna executes an optional communications program (monthly or every few months) known as the "Age-in" Program. This Program provides Applicant's retirees who are approaching age 65 with timely information regarding your Aetna Medicare Plan. The "Age-in" Program currently consists of a mailing(s) that can be sent 2-3 months before the 65th birthday month and the mailing list is determined solely based on age. This

means that these mailings may be sent to both Applicant's retirees and active employees who are nearing their 65th birthday. The scope of this Program is subject to change.

Important Note: Please notify your Account Executive if your organization does not want to participate in the "Age-in" Program. If your organization does not provide this notice to your Account Executive within 30 days of the date you sign this Application, Aetna will proceed with including your organization in the "Age-in" Program.

Electronic Enrollment & Optional Mechanism Enrollment

Please check the appropriate box to document if you will use one of the following methods to enroll eligible individuals in the Aetna Medicare Plan(s) selected by you in this application:

Applicant will use electronic enrollment or optional mechanism enrollment (choose one)? ☐ Yes ☒ No

If you selected "yes" with either option, please review the following section titled "Enrollment Requirements". By signing this application, you are agreeing to the requirements in this Section.

Enrollment Requirements

The Centers for Medicare and Medicaid Services ("CMS") allows Applicant to enroll eligible individuals in an Aetna Medicare Plan using an electronic group enrollment process ("Electronic Enrollment Process") or a process referred to by CMS as the "Group Enrollment Process – Optional Mechanism" ("Optional Mechanism Enrollment Process"). With both enrollment processes, eligible individuals must be informed prior to enrollment that they can make the initial election of a new Aetna Medicare Plan by taking no action. This eliminates the need for eligible individuals to complete and submit a paper enrollment application.

If Applicant elects to use either the Electronic Enrollment Process or the Optional Mechanism Enrollment Process, Applicant must comply with all applicable laws, regulations and CMS instructions, including the following:

1. For each eligible individual that Applicant submits for enrollment to Aetna through the Electronic Enrollment Process or Optional Mechanism Enrollment Process, Applicant agrees to:
   - Provide a Summary of Benefits and all information necessary for the eligible individual to make an informed choice regarding Aetna Medicare Plan benefits, including, but not limited to, Aetna Medicare Plan rules and requirements and enrollment processes.
   - Provide written notice not less than 21 calendar days prior to the requested effective date of the eligible individual's enrollment in an Aetna Medicare Plan. This notice must advise eligible individuals that they can elect to enroll in a new Aetna Medicare Plan by taking no action, and that they will be enrolled in the Aetna Medicare Plan unless they notify Applicant of their intent to opt out of enrollment. This written notice must describe in detail the opt-out process the eligible individual must follow to decline enrollment in the new Aetna Medicare Plan.
2. Applicant acknowledges that it received from Aetna the data element and format requirements for submission of enrollment transactions to Aetna ("Enrollment Submission Requirements"), and Applicant agrees that all enrollment transactions it submits to Aetna for processing will comply with these Enrollment Submission Requirements. Applicant acknowledges and agrees that Aetna will not process an enrollment transaction submitted by Applicant that does not comply with Enrollment Submission Requirements. Applicant agrees to exclude all eligible individuals who have elected to opt out of enrollment in an Aetna Medicare Plan from any enrollment transactions submitted to Aetna for processing.

Post Office (PO) Box Attestation (this Section applies only if you will use electronic or optional mechanism enrollment)

CMS Requirements:

- To be eligible for enrollment, CMS requires that the individual permanently reside in the Aetna Medicare Plan service area.
- When an individual submits a PO Box as his/her primary address on an enrollment request, CMS considers the enrollment request incomplete and requires that you contact the individual to confirm his/her permanent address.
- If the individual claims permanent residency in two or more states or if there is a dispute over where the individual permanently resides, CMS requires that you consult the State law in which Aetna operates and determine whether the individual is considered a resident of the State.
- If the individual's permanent address cannot be confirmed, CMS requires the enrollment to be denied.

By signing this application, Applicant is agreeing to comply with the CMS requirements in this Section and attesting that any individuals with a PO Box as an address who are submitted to Aetna for enrollment permanently reside in the Aetna Medicare Plan service area.

Applicant Acknowledgements and Agreements

It is agreed that no coverage shall become effective as to any person who is not then eligible for coverage under applicable laws, rules, regulations and CMS instructions ("Mandates"). All statements herein shall be deemed representations and not warranties. The Applicant acknowledges that it has selected the coverage specified herein based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. Applicant has selected, in accordance with Mandates, the coverage to be offered to Applicant's retirees and Applicant has solely determined any/all coverage options for the Applicant's retirees and the contribution amounts.

The plan documents (which consist of the Evidence of Coverage and the agreement(s) between Aetna and Applicant relating to the coverage(s) specified herein ("Medicare Agreement") will determine the contractual provisions, including procedures, exclusions and limitations relating to the coverage and will govern in the event they conflict with any benefits comparison, summary or other description of the coverage. Aetna will use the e-mail address provided by Applicant in this application to send Applicant the Medicare Agreement. Applicant will notify Aetna in writing if it prefers that the Medicare Agreement be sent to a different address. Aetna and Applicant agree that the Medicare Agreement will be considered received by Applicant on the date that Aetna sends the Medicare Agreement to the e-mail address provided by Applicant (as described in this application). All data that may have a bearing on coverage or premiums will be open for Aetna to inspect while the Medicare Agreement is in force, and as required under Mandates and the Medicare Agreement. The availability of a plan or program may vary by geographic service area. "Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

With the exception of Aetna Rx Home Delivery, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed. With respect to those Aetna group Medicare plans that are network-based, provider network composition is subject to change. Notice of a change in provider network composition shall be provided to individuals enrolled in these Aetna group Medicare plans in accordance with applicable federal law. Aetna does not provide health or dental care services and, therefore, cannot guarantee any results or outcome. Some benefits are subject to limitations or maximums.

Important Information

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Alaska, Connecticut, Idaho, Nevada, New Hampshire, North Carolina & South Carolina: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arkansas, District of Columbia, Louisiana, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Indiana/Illinois: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Kansas/Missouri: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine and Tennessee: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact

material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who with intent to injure, defraud, or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Utah: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading information concerning any fact material thereto may commits a fraudulent insurance act, which is may be a crime and may subjects such person to criminal and civil penalties.

Vermont: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Virginia: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

ORDER OF PRIORITY

Once this application is signed and Aetna accepts it, this application will form part of a Medicare Agreement issued by Aetna. If there is a conflict between anything in this application and any other part of the Medicare Agreement, the other parts of the Medicare Agreement will take priority.

Signature Section

I hereby apply for the coverage(s) indicated above. I certify that all information provided in this application is accurate and complete. I understand that this application will form a part of the Medicare Agreement issued by Aetna relating to such coverage and by my signature below I agree to be bound by the terms and conditions of that Medicare Agreement. Aetna will issue a Medicare Agreement to Applicant that will automatically renew for subsequent twelve month renewal terms, unless sooner terminated in accordance with the Medicare Agreement. I understand that Aetna may choose not to accept this application at its sole discretion, subject to any federal and/or state requirements.

Signed at (location): _____ _____

City, State | Applicant (Company Name)

By: _____ _____

Authorized Applicant Signature | Official Title

_____ _____

Witness | Date

Your premium purchases insurance coverage from Aetna, as well as the services of any Aetna-appointed licensed independent agent or broker identified in the member's Application For Group Coverage. Aetna has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which Aetna has made to your producer, or other material relationships your producer may have with Aetna, you may contact your producer or your

Aetna account representative. Information regarding Aetna's programs for compensating producers is also available at www.aetna.com. **We appreciate your business and the opportunity to serve you.**

Please keep a copy of this application for your records. If this application is accepted by Aetna, this application will become part of the issued Medicare Agreement.

Distribution: Sales submits as part of new business submission

ORDER OF COMMISSIONERS COURT
Authorizing execution of an amendment to an agreement

The Commissioners Court of Harris County, Texas, convened at a meeting of said Court at the Harris County Administration Building in the City of Houston, Texas, on the ____ day of _____, 2026 with all members present except _____.

A quorum was present. Among other business, the following was transacted:

ORDER AUTHORIZING EXECUTION OF FIRST AMENDMENT TO THE ADDENDUM TO THE AGREEMENT BETWEEN HARRIS COUNTY , HARRIS COUNTY FLOOD CONTROL DISTRICT AND AETNA LIFE INSURANCE COMPANY

Commissioner _____ introduced an order and moved that Commissioners Court adopt the order. Commissioner _____ seconded the motion for adoption of the order. The motion, carrying with it the adoption of the order, prevailed by the following vote:

Vote of the Court	Yes	No	Abstain
Judge Hidalgo	□	□	□
Comm. Ellis	□	□	□
Comm. Garcia	□	□	□
Comm. Ramsey, P.E.	□	□	□
Comm. Briones	□	□	□

The County Judge thereupon announced that the motion had duly and lawfully carried and that the order had been duly and lawfully adopted. The order adopted follows:

IT IS ORDERED that County Judge Hidalgo be and is hereby authorized to execute for and on behalf of Harris County the First Amendment to the Addendum to the Agreement between Harris County, Harris County Flood Control District, and Aetna Life Insurance Company for group medical insurance coverage for Harris County and the Harris County Flood Control; to add certain documents to the Agreement; said First Amendment being incorporated as though fully set forth herein word for word.

All Harris County officials and employees are authorized to do any and all things necessary or convenient to accomplish the purpose of this Order.