Shannon Blakeslee
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June 24, 2026

City of Olathe
Erin Vader
100 E Santa Fe St
Olathe, KS 66061

Re: City of Olathe - Confirmation of Sold Medical and Pharmacy Products, Programs, Services and Fees

Dear Erin:

Thank you for selecting Aetna. We look forward to beginning our business relationship with you. Based on our original proposal and subsequent discussions, we have outlined the products and services City of Olathe has purchased for the plan, effective January 1, 2027. Please review and confirm this information accurately reflects your understanding. If you have any questions or concerns regarding the information outlined in this letter and the attachments, you may contact Kristi Swanson to discuss any necessary changes.

The contract period begins on January 1, 2027 and provides automatic renewal upon the completion of each Guarantee Period unless either party invokes the termination provision. The termination provision requires 90 days advance written notice of termination to the other party. This provision may be invoked at any time and is not limited to termination occurring on the renewal date, subject to the terms of the contract(s).

Refer to the attached documents for complete details of our offer. Our final offer includes:

- Medical Administrative Services - Attached ASC Fees, Programs and Services and Caveats
- Medical Fee Credit
- Pharmacy Service and Fee Schedule

If we do not receive a response from you by July 22, 2026, we will consider our proposal of products, programs, services, and fees to be approved. We appreciate your business and look forward to a successful plan implementation.

Both parties (City of Olathe and Aetna) agree to abide by the terms and conditions of this letter and the Master Services Agreement (MSA) until such time as the MSA is executed. The parties agree to work in good faith and finalize the MSA for the services outlined in this letter by December 1, 2026. Upon execution of the MSA, this letter and its attachments shall be of no further force and effect.

Sincerely,

Shannon Blakeslee
Underwriting Director
Aetna

cc: Kristi Swanson
Morgan Kiely
Lockton Companies LLC

Aetna Signature	Date
Customer Signature	Date

City of Olathe

Contact Information/Assumptions

Account Executive:	Kristi Swanson
Email:	Kristi.Swanson@aetna.com
Mem/EE Ratio:	2.22

Administrative Service Fees — Effective Date: January 1, 2027 — End Date: December 31, 2027

	Year 1	Year 2	Year 3
Guarantee Period Effective Date	January 1, 2027	January 01, 2028	January 01, 2029
Fee Contract Basis	Mature	Mature	Mature
Runoff Claim Processing	Included	Included	Included

Guaranteed Medical Administrative Fee (PEPM)*	Estimated Enrollment	Year 1	Year 2	Year 3
Choice POS II	1,057	$39.95	$39.95	$39.95
Administrative Fee Guarantee % Change*			**0.0%**	**0.0%**

Additional Administrative Fee Guarantee*	% Change
Year 4 of 5 (January 01, 2030)	3.0%
Year 5 of 5 (January 01, 2031)	3.0%

Administrative Fee Summary (Plan Year)	Year 1	Year 2	Year 3
Guaranteed Medical Administrative Fees	$506,726	$506,726	$506,726
Fee Credit*	($225,000)	$0	$0
Total Fees	**$281,726**	**$506,726**	**$506,726**

*Clarifications

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

Administrative Fee Guarantee

Our offer includes an administrative fee guarantee for the Guarantee Period January 1, 2027 to December 31, 2031. The guaranteed administrative fees excludes broker compensation, fee adjustments and other charges listed above. The guarantee is subject to the terms and conditions as stated in the caveats and is contingent upon the customer maintaining all lines of business with Aetna. Programs and Services billed via the Claim Wire and Additional Buy-up services outlined on the Programs and Services exhibit may be subject to annual increases provided at time of renewal.

Prescription Drug Benefits

Our quotation assumes that prescription drug benefits are included and will be provided by Aetna. Additional pharmacy administrative fees may apply. Refer to our Pharmacy Service and Fee Schedule and Program Summary for additional information.
If you terminate your prescription drug benefits with us, we will increase the ASC Service Fees and the medical trend assumption used for any applicable claim projections or guarantees. You may also be subject to additional charges to integrate data with external Pharmacy vendors. Refer to the reporting charges outlined in the Programs and Services exhibit for more information.
In addition to an increase in your ASC medical fees, the Fee Credit will not apply.

Fee Credit

We have included an administrative service fee credit. You agree to pay us the total amount of the fee credit issued if you terminate your medical plan(s) or any of the additional product(s) quoted (if applicable) prior to the end of the multi-year Guarantee Period. Refer to your fee credit letter for specific details.

Programs and Services – Self-Funded — Effective Date: January 01, 2027

Program Summary	Choice POS II

Programs & Services Included in the Service Fee

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

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

Care Management	
Aetna Compassionate Care℠	Included
Aetna Advice	Included
Aetna Healthy Chapters™	Included
Preventive Care Considerations (Electronic)	Included
Utilization Management (Inpatient Precertification, Concurrent Review, Discharge Planning, Retrospective Review)	Included

Programs and Services – Self-Funded — Effective Date: January 01, 2027

Program Summary	Choice POS II

Member Resources	
Designated Service Center	Included
Aetna Concierge (includes First Impression Treatment)	Included
Provider search (online provider directory)	Included
Aetna Smart Compare® Intelligent Matching	Included
Dedicated Toll Free Number	Included
Member Website and Mobile Experience	Included
Aetna Custom Connections™ Standard	Included
Online Programs	Included

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

Allowances	
Health Plan Allowance	Included

Reporting and Integration	
Analytic Consultation from Plan Sponsor Insights (10 Hours)	Included
ART Reports - New analytic reporting platform	Included
Aetna Health Information Advantage™ (AHIA)	Included
Monthly Financial Claim Detail Reports	Included
Monthly Banking Reports	Included
Monthly Universal File Feed Outbound Medical (12 total reports)	Included

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

Aetna Discount Program	
at home products, fitness, hearing, LifeMart® shopping website, natural products and services, oral health care, vision, weight management	Included

Program Summary	Choice POS II

Programs & Services Included in the Claim Wire*

No Surprises Act - Fees*	
No Surprises Act (NSA) claim administration fee (per NSA eligible claim)	$98
No Surprises Act (NSA) Independent Dispute Resolution (IDR) initial fee (per arbitration case)	Applicable fees are as set by law and passed through to the plan
No Surprises Act (NSA) Independent Dispute Resolution (IDR) arbitration expenses (per arbitration case)	Applicable fees are as set by law and passed through to the plan

Network Services	
Subrogation*	37.5% of savings
Contracted Services* (Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, Workers Compensation, DRG and Implant Audits)	37.5% of savings
Claim and Code Review Program*	30.0% of savings
National Advantage™ Program (NAP)*	We will retain 50% of savings (includes FCR, IBR, PCRS)
National Advantage™ Program Cap (includes Facility Charge Review, Itemized Bill Review, and PCRS when applicable)	Cap of $100,000 per individual claim

Programs and Services – Self-Funded **Effective Date: January 01, 2027**

Program Summary	Choice POS II
Care Management	
Aetna One® Flex (per engaged member, per month)*	$735
Enhanced Clinical Review Program (PMPM)*	$0.80
High Tech Imaging	Included
Diagnostic Cardiac	Included
Sleep Management	Included
Cardiac Implantable Devices	Included
Interventional Pain	Included
Hip and Knee Arthroplasties	Included
SmartChoice	Included

City of Olathe

Programs and Services – Self-Funded	Effective Date: January 01, 2027

Program Summary	Choice POS II

Additional Available Programs & Services (per employee, per month unless otherwise noted)

Network Services	
CVS Health Virtual Primary Care™ *	$1.65

Wellness	
Aetna Personal Health Solutions*	$1.70
First Responder Peer Support Program*	$1.10

Reporting and Integration	
If Pharmacy is not provided by Aetna or CVS Caremark	
Integrating 3rd-party Pharmacy data to support benefit accumulators (Set Up)	$5,000
Integrating 3rd-party Pharmacy data to support benefit accumulators (Ongoing)	$0.60
Integrating 3rd-Party Pharmacy data to support care management programs	$6,000
Other Reporting and Integration	
3rd Party Stop Loss Vendor Reports* (if stop loss is not awarded to Aetna)	$12,360

Custom Medical Programs	
Custom Network Reporting (Annual)	$18,000

Additional Available Programs & Services Billed through the Claim Wire*

Care Management	
Transform Diabetes Care® 2.0 (per diabetic, per month)*	$14.15
Transform Oncology (per engaged member, per month)*	$79

Wellness	
Aetna Back and Joint Care™ (per engaged member, per year)*	Not to exceed an average of $995

Integration Buy Up	
NACo Rx Integration (PEPM)	$2.00

*Additional Program Details

Claim Wire Billing, ID Cards, Subrogation, Contracted Services, Claim and Code Review
Details can be found in our UW Disclosure document located at the following URL:
https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/legal-notices/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-06-27-2025.pdf

Claim and Code Review Program
This financial proposal includes enhancements that have been made to our claim and code review programs. Some of these capabilities were previously a component of our base fees, but this proposal assumes they will now instead be part of our standard shared savings arrangement.

No Surprises Act - Fees
The NSA claim administration fee will increase at each annual renewal and apply to NSA eligible claims paid on or after that renewal date. Refer to the NSA Payment Practices in our Caveats for information on our payment practices for NSA eligible claims.

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

3rd Party Stop Loss Vendor Reports
The 3rd Party Stop Loss Vendor Reports fee will increase at each annual renewal. The fee can also change if the Stop Loss Contract Type is different from our assumption.

Aetna Back and Joint Care™
This program combines Hinge Health's MSK digital exercise therapy and prevention programs with Aetna's Care Management resources and claims predictive analytics to create a multi-faceted program to address musculoskeletal (MSK) related needs. It is available for medically covered members 18 years and older.

Prevention:
- There is no fee for members enrolled in the prevention program.

Acute and Chronic Care:
- You will be charged $250 for each engaged member's first session and $50 for each subsequent session.
- The maximum amount billed per individual engaged member will be capped at $1,750 per 365-day period, regardless of the number of programs or sessions utilized.
- The maximum average cost per member for your engaged members will be capped at $995. Calculation of this maximum average will occur after the end of the program year.
  – If your maximum average member program cost exceeds $995, a reconciliation credit will be allocated and provided by Hinge Health.

Aetna One® Flex
Engagement begins upon a two-way interaction (i.e. telephonic, email, secured messaging, etc.) with a member of the multi-disciplinary care team (i.e. nurse, registered social worker, pharmacist, health coach, or behavioral health specialist). After one month without a two-way interaction a member is no longer considered engaged.

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

CVS Health Virtual Primary Care™ (CVSH VPC)
CVSH VPC requires CVS Health Virtual Care™. CVSH VPC is not available on gated plans (plans requiring a primary care physician referral.) CVSH VPC cannot be offered with some narrow network arrangements. Specific exclusions are available upon request.

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

First Responder Peer Support Program
First Responder Peer Support program fee assumes 1,057 First Responders. We may adjust the program fee if the actual First Responder enrollment varies by more than 10 percent.

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

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

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

Transform Diabetes Care® 2.0
Members are identified for the program based on diabetes diagnosis codes and at least one other identifier which corroborates diabetes. Additional identifiers may include but are not limited to pharmacy claims for antidiabetic medication, and/or laboratory test results.

Transform Oncology
Engagement begins upon the second two-way call with a Personal Navigator, regardless of timeframe. After one month without a two-way call with a Personal Navigator a member is no longer considered engaged. Reengagement occurs after the first two-way call with a Personal Navigator for a member that was previously engaged. The minimum duration for engagement-based billing is 2 months.

Administrative Fee Credit Letter — Effective Date: January 1, 2027

We are offering you a fee credit which will save you $225,000.

We are offering you an administrative fee credit as shown in the chart below. This credit will be applied starting with the second month's bill in the Guarantee Period unless you notify us otherwise at the time of sale.

Administrative Fee Credit	Year 1
Plan Year Effective Date	01/01/2027
Fee Credit	$125,000
Additional Fee Credit if Medical and Rx is awarded	$100,000

The fee credit will be subject to the following provisions:

- Our self-funded medical Agreement will remain in effect for the duration of the Guarantee Period.
- You are required to make the medical fee payments in accordance with your Agreement.
- Standard termination provisions apply.
- All of the plan caveats as stated on the Caveats page in the final proposal are met.
- Any producer compensations will be excluded from the medical fee credit.
- Future renewals will be calculated based on the annualized medical fees before giving any effect to the medical fee credit.
- Contingent upon Aetna being the sole provider for all quoted lines of coverage.
- Contingent upon Aetna providing integrated Medical and Pharmacy coverage.

You agree to pay us the total amount of the fee credit issued for the multi-year Guarantee Period within 31 days of notice of non-compliance if any of the following occur:

- Any of the above provisions are not met
- You terminate the Agreement prior to the end of the multi-year Guarantee Period

The fees shown on the accompanying Fee Schedule will be billed every month of the Guarantee Period. The fee credit will be shown as a separate line item. When you accept our quote, the Fee Schedule will become part of your Agreement with us.

You may wish to consult with your legal advisors about any changes that you may need to make in the administration of your plan as a result of this credit consistent with your fiduciary obligations such as making adjustments to participant contributions.

Please sign and return to us by December 1, 2026 to indicate your acceptance of this offer.

Shannon Blakeslee – Underwriting Director — Date

Officer – City of Olathe — Date

Allowances - Self-Funded — Effective Date: January 01, 2027

We are including allowance(s) for your Aetna plans applicable to each year of the Guarantee Period as outlined in the chart below. Allowance dollars must be used for your commercial Aetna medical plans and Aetna medical members.

Annual Allowance Type	Year 1	Year 2	Year 3	Year 4	Year 5
Plan Year Effective Date	01/01/2027	01/01/2028	01/01/2029	01/01/2030	01/01/2031
Health Plan	$200,000	$125,000	$125,000	$125,000	$125,000
Total	**$200,000**	**$125,000**	**$125,000**	**$125,000**	**$125,000**

Annual allowance amounts may be adjusted if actual enrollment changes by 10 percent or more from our enrollment assumptions.

Health Plan Allowance

- The **Health Plan allowance** can be used to offset reasonable documented expenses applicable to the Guarantee Period(s) for which it is offered. Your allowance can be used for implementation, communication, reporting, and audit associated with your Aetna Medical plan. Examples of reimbursable expenses include:
  – implementing your contract with us
  – promoting our products, programs or services, such as, educational content and materials for enrollees or prospective enrollees
  – Aetna required technology platforms or our system front-end charges to support our plans
  – communicating with our members
  – auditing our readiness
  – recurring or ad hoc reporting with us
  – reporting costs to integrate our data with third-party vendors.
- Your allowance can also be used to offset reasonable documented wellness-related programs or activities incurred during the Guarantee Period for which the allowance is offered. Wellness allowance expenses must be for wellness-related programs or activities that are reasonably designed to promote the health and well-being of Aetna members, or to educate Aetna members about healthy lifestyles and/or prevent disease. This means that there must be a connection to the health and well-being of the members, with a focus on preventative measures or healthy living (i.e., diet, exercise), not on acute care. Wellness programs and activities funded by allowance funds are not covered benefits under your Aetna plan.
- Claims audit expenses must be incurred during the Guarantee Period for which the allowance is offered.
- Should you terminate your contract with us, the allowance cannot be used to fund implementation/communication expenses related to the new carrier's contract.
- Any expenses associated with the implementation, administration or communication of another carrier’s plans, programs or services are also ineligible.

The above referenced fund(s) will be available after the effective date of each plan year. Only those expenses performed and billed by a third party are payable. Reimbursement for time and materials incurred directly by the plan sponsor (e.g., hours worked by the plan sponsor's own employees) are not eligible. Your normal business operation expenses, including employee salaries and overtime, are not eligible under the allowance. Our preferred method of payment is directly to the third-party vendor. We require submission of appropriate documentation detailing charges for the services provided by the vendor. Acceptable documentation includes, but is not limited to, detailed vendor invoices itemizing services provided, specific cost-elements and associated line-item charges.

On an exception basis, we can reimburse you directly provided you submit both the detailed invoice and receipt showing payment to the third-party vendor.

You should submit documentation within 60 days of the invoice date. We must receive all documentation no later than 60 days following the close of the plan year to be considered for reimbursement.

The allowance amounts indicated above for the following Allowance Type(s) are available for the years indicated in the chart. These allowances are forfeited at the end of each plan year if not fully utilized. There is no roll over of unused funds to the next policy year. Any unredeemed wellness incentives that may be offered through a "reward program" are forfeited at the end of each plan year.

- Health Plan

We assume the funding of any allowance dollars is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. You are responsible for determining that your use of allowance dollars is appropriate and legally compliant. With respect to allowance dollars that are used in connection with a wellness program, you are responsible for ensuring

that the program and any incentives/rewards comply with applicable laws, including limitations on maximum allowable incentives/rewards. We will pay any allowances in accordance with applicable law. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and laws.

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

Caveats - Self-Funded — Effective Date: January 01, 2027

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

Our proposal is illustrative and subject to change based upon underwriting review of the information listed and requested below. Any of the information listed below, which has not been provided may be required prior to final approval of sale.

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

Underwriting Caveats

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

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

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

Enrollment

There is a 10 percent change in total or by product from the assumed enrollment shown on the Fee exhibit.
Our proposal assumes coverage will not be extended to additional employee groups without review of supplemental census information and other underwriting information for appropriate financial review.

Member-to-Employee Ratio

The member-to-employee ratio changes by more than 10 percent from the 2.22 ratio assumed in this quote.

Age 65 and Over Enrollment

The number of enrolled employees age 65 and over (excluding those enrolled on Medicare Direct plans) exceeds 10 percent of the total enrolled group or changes by more than 10 percent from the 101 enrollees assumed in this quote. Patient Management programs are excluded for Medicare primary members.

Maximum Account Structure

Maximum account structure exceeds the number of units illustrated in the table below. Account structure determines the reporting format. During the installation process, we'll work with you to finalize the account structure and determine which report formats will be most meaningful. Maximum total account structure includes Experience Rating Groups (ERGs), controls, suffixes, billing and claim accounts.

Total Employees (Choice POS II, Open Access Aetna Select, PPO, EPO, Aetna HealthFund®, Indemnity)	Maximum Total Structure Per Product
Less than 1,000	60
1,000 to 2,999	80
3,000 to 4,999	150
5,000 to 9,999	300
10,000 to 19,999	350
20,000 to 49,999	500
50,000 and over	750

Quoted Benefits and Administration

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

National Advantage™ Program

You change or terminate the National Advantage™ Program (NAP), Facility Charge Review (FCR), Itemized Bill Review (IBR), or Professional Claims Repricing Service (PCRS) programs.

Multi-Year Provision

You place the products, programs and services included in this multi-year fee guarantee out to bid with an effective date prior to December 31, 2031, then this guarantee is no longer valid.

Total Replacement

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

Performance Guarantees

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

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

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

We're relying on information from you and your representatives in establishing the fees and terms of this proposal. If any of this information is inaccurate and has an impact on the cost of the programs, we reserve the right to adjust our fees and terms upon the receipt of corrected information.

Assumptions

Underwriting

Agreement Provisions

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

Participation

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

Plan Design

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

Claim Fiduciary - Option 1

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

External Review

We've included external review in our proposal. External review uses outside vendors who coordinate medical review through their network of outside physician reviewers.

Non-ERISA

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

Member Communications

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

Wellness Incentives and Rewards

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

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

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

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

Third-Party Audits

We don't typically charge to recoup internal costs associated with a third-party audit. We reserve the right to recover these expenses if significant time and materials are required.

Mental Health/Substance Abuse Benefits

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

Prescription Drug Benefits

Our quotation assumes that prescription drug benefits are included and will be provided by Aetna.
Additional pharmacy administrative fees may apply. Refer to our Pharmacy Service and Fee Schedule and Program Summary for additional information.
If you terminate your prescription drug benefits with us, we will increase your ASC medical fees and the medical trend assumption used for any applicable claim projections or guarantees. You may also be subject to additional charges to integrate data with external Pharmacy vendors. Refer to the reporting charges outlined in the Programs and Services exhibit for more information. In addition to an increase to your ASC medical fees, the Fee Credit will not apply.

Stop Loss Reporting

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

Medical Pharmacy Rebates

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

Additional Products, Programs and Services

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

Caveats - Self-Funded — Effective Date: January 01, 2027

Billing Information

Advanced Notification of Fee Change

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

Late Payment

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

- if you fail to pay plan benefit payments the same day of the request.
- if you fail to pay administrative service fees within 31 days of the due date.

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

Incurred late wire interest charges will be added to a future wire request and collected through your claim wire billing account. Incurred late fee payment interest charges will be added to a future service fee bill.

Producer Compensation

The quoted fees don't include producer compensation.

Claim and Member Services

Run-In Claim Processing

Our proposal excludes run-in claim processing from the prior carrier (claims incurred before the effective date of the plan).

Runoff Claims Processing

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

Summary Plan Description (SPD) Modification

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

Reporting and Data Transfer

Aetna Intellectual Property

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

Claims History Transfer

These files are used to administer deductible and internal maximums. There is no cost associated with receiving claim history files electronically from the prior carrier for initial implementation. There is a charge for files received in a format other than electronically; costs are based on the complexity and format of the data.

Data Integration (Historical)

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

Data Integration (Ongoing)

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

Data Transfer at Termination

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

Banking

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

Our standard banking arrangement is to request funds when claims have accumulated to more than $20,000. In this arrangement, a wire request is sent to you and/or your bank requesting funds for the total claims from the previous day(s). For most customers, this would mean daily claim wire transfers. In place of this arrangement, we'll request funds for claims weekly on Friday. In addition, there will be a month end close out request on the first banking day of each subsequent month. We've included the cost of this service in your Guaranteed Fees.

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

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

Network Services

Alternate Discount Arrangements

In select markets, we've negotiated alternative contracts with providers and networks to provide additional savings to you and your members. These alternative contracts are available to customers that meet certain criteria and have been granted approval where applicable. Alternate Discount Arrangements cannot be offered alongside:

- Aetna Premier Care Network (APCN)
- Aetna Whole Health℠ Product (ACO)

The following Alternate Discount Arrangements are offered with this proposal.

State	Alternate Discount Arrangement	Corresponding Aetna Network
KS/MO	KS Local Best	KS: Johnson and Wyandotte Counties MO: Jackson, Cass, Platte, or Clay Counties

Custom Network

We've quoted a Custom Network in order to support your specific needs. A Custom Network can include, but is not limited to:

- Providers that we add to our standard network at your request
- Providers that you add through a third-party network to our standard network
- You negotiate a different reimbursement contract with providers

A Custom Network may assume:

- You designate certain providers, either added to or already in our standard network, for purposes of benefit level
- You incent members, through plan design steerage, to use the designated hospital(s) and affiliated physician(s) for their care

Typically, this plan design provides for two in-network benefit levels where a higher reimbursement level is associated with a set of providers designated by you. The Custom Network with the corresponding incentives through plan design steerage is an Integrated Delivery System.

Our quoted fees include the cost for establishing and maintaining your Custom Network. Our charge is partially based on the actual number of physicians and hospitals in the Custom Network. For purposes of our quote, we assume that your Custom Network has less than 300 hospitals/physicians. Our charge may change if the number of physicians and hospitals differs from our assumption.

If your Custom Network includes adding providers not currently in our network ("customer-specific provider"), we assume these customer-specific providers will be in addition to our standard network. You'll be responsible for securing agreement by any customer-specific provider or third-party network vendor to provide us with the information* necessary to allow automated claims adjudication.

Caveats - Self-Funded — Effective Date: January 01, 2027

Our pricing for administration of claims associated with the customer-specific providers assumes that we'll receive this data in one electronic file in our standard layout from one administrator. If the information required for automated claims adjudication:

- is not provided by your vendor, or
- more than one electronic file is provided, or
- the files come from more than one administrator,

we may charge additional amounts. If we don't receive the required data and contracts by the date in the implementation timeline provided or 60 days before the effective date of our administration, we may not be able to pay claims on the effective date. If so, related performance guarantees may no longer be applicable.

Final pricing will be determined after we have assessed the overlap between our standard network and your Custom Network along with additional administrative requirements and specifications.

*Required provider demographic data includes: Provider TIN, First Name, Middle Name, Last Name, Specialty, Address 1, Address 2 (if applicable), City, State, Zip Code, Phone Number, Billing Address Line 1, Billing Address Line 2, City, State, Zip Code, Phone Number, Fee Schedule for all applicable service locations. Also required: physician and hospital reimbursement information and contracts.

Additional

Please review the additional important information found at the following URL. This information is incorporated by reference into this package and considered part of your Agreement. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriting Disclosure Document, the information in your package prevails.
https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/legal-notices/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-06-27-2025.pdf

Legislative and Regulatory Requirements

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

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

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

NSA Payment Practices

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

Recovery of Overpayments

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

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

We believe that measuring the activities described below is an important indicator of how well we service your account, as such, we have included the following performance guarantee(s) as part of our proposed offering.

This information pertains to any performance guarantee(s) shown below, or for any additional guarantees which may be offered for the same Guarantee Period. Refer to the guarantee documents for additional conditions and details.

The performance guarantee(s) described herein will not apply if the Agreement is terminated prior to the end of the Guarantee Period. In addition, all included performance guarantee(s) are subject to enrollment requirements as outlined in the financial conditions of each included guarantee.

Aggregate Maximum

The maximum payout for all guarantees combined is 50 percent of the fees at risk based on the calculation as noted in the provisions below.

General Guarantee Provisions

1. Fees at risk are calculated at the year-end reconciliation, using the paid medical administrative service fees for employees covered under each guarantee for the Guarantee Period and excludes:
   - Allowance(s)
   - Any charges for services performed which are not included on the monthly administrative service fee bill
2. Results are estimated to be available at the end of the quarter noted below, following the close of the Guarantee Period:
   Second Quarter
   - Service Performance Guarantee

   Third Quarter
   - Claim Target Guarantee
   - Discount Guarantee
3. If the guarantee(s) have not been met, we will either:
   - Provide reimbursement to you for the amount due, or
   - Reduce future administrative fee payment(s) by the amount due to you.
4. We reserve the right to revise or remove these guarantee(s) if a material change to the plan is initiated by you or legislative or regulatory action which:
   - Impacts our standard claim adjudication process, member services functions, medical management or network management
   - Changes the products, programs and services we offer you
5. The guarantee(s) are considered met if:
   - You terminate participation in products, programs and services tied directly to guarantee(s), prior to the end of the Guarantee Period.
   - You terminate your Aetna medical plan in whole or in part (defined as 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the multi-year Fee Guarantee Period, December 31, 2031.
   - You fail to meet your obligations under the Agreement (for example, a submission of incomplete eligibility or failure to fund claim payments)
   - We do not receive all of the necessary information in the allotted timeframe, as outlined in the guarantee document(s).
6. If you do not purchase a product, program or service tied directly to a guarantee, the guarantee will be removed.

City of Olathe

Guarantee Summary — Effective Date: January 01, 2027

Medical Service Performance Guarantee

We guarantee the administration of your medical and behavioral health product(s) in the following areas:

Performance Category	Minimum Standard	Maximum Fees at Risk
Implementation		
Implementation	Average score of 3.0	2.0%
ID Card Production & Distribution	97% within 10-14 days	2.0%
Account Management		
Overall Account Management	Average score of 3.0	2.0%
Management Reports	Within 45 days/90 days	2.0%
Plan Sponsor Services		
Non-Open Enrollment Eligibility Files (Tier 1)	97% within 2 days	2.0%
Claim Administration		
Turnaround Time (TAT Tier-2)	30 days for 97.0%	1.0%
Financial Accuracy	99.0%	2.0%
Total Claim Accuracy	95.0%	1.0%
Member Satisfaction		
Member Satisfaction	85.5%	2.0%
Member Services		
Average Speed of Answer (ASA)	30 seconds	1.0%
Abandonment Rate	2.5%	1.0%
Open Inquiries Resolution (Tier 2)	90% within 28 days	2.0%
Total		**20.0%**

Discount Guarantee

We guarantee that your in-network discount for the Guarantee Period will be 70.6 percent or better, assuming current enrollment and book-of-business service mix. The illustrative composite discounts are below.

Illustrative Inpatient Hospital Discount	Illustrative Outpatient Hospital Discount	Illustrative Physician/Other Discount	Illustrative Composite Target Discount	% of Fees at Risk
74.4%	74.5%	61.6%	70.6%	**40.0%**

Claim Target Guarantee

We guarantee your claim trend won't exceed target(s) listed below.

	Year 1	% of Fees at Risk
Trend Target	0.0%	**40.0%**

Medical Service Guarantees — Effective Date: January 01, 2027

Guarantee Period: January 1, 2027 through December 31, 2027
Medical Fees at Risk: 20.0%

We guarantee the administration of your MHA self-funded medical and behavioral health product(s) in the following areas:

Category	Guarantee	Fees at Risk	Criteria
Implementation			
Implementation	An average score of 3.0 on the Implementation Evaluation Tool survey(s). Each question has a rating scale of 1 to 5 (1 = lowest, 5 = highest). The results of the surveys are used to facilitate a discussion between you, your Implementation Manager and your Account Team regarding the results achieved and opportunities for improvement. The implementation period begins at the initial implementation meeting and runs through the implementation sign-off. If the Implementation Evaluation Tool is not completed and returned within 30 business days of receipt, it is assumed that the service provided to you is satisfactory and the guarantee is deemed met.	Mutually agreed upon adjustment if the final evaluation score falls below a 3.0, (meaning that service levels have not improved), up to a maximum of 2.0% of medical fees.	Measurement basis Customer specific Measurement period Annually Reporting period Annually
Open Enrollment ID Card Production & Distribution	97% of Open Enrollment ID cards will be produced and mailed within 10-14 business days following the receipt of complete, accurate and viable electronic enrollment files.	0.40% for each full business day that we fail to produce and mail ID cards within 10-14 business days, up to a maximum of 2.0% of medical fees.	Measurement basis Customer specific Measurement period Annually Reporting period Annually

Medical Service Guarantees			Effective Date: January 01, 2027
Account Management			
Overall Account Management	An average score of 3.0 on the semi-annual surveys for on-going account management, financial, eligibility, drafting and benefit administration. The average is based on 24 questions with a rating scale of 1 to 5 (1 = lowest, 5 = highest). The results of the surveys are used to facilitate a discussion between you and your Account Team regarding the results achieved and opportunities for improvement. If the online surveys are not completed within 15 business days of receipt, it is assumed that the service provided to you is satisfactory and the guarantee is deemed met.	Mutually agreed upon adjustment if the final evaluation score falls below a 3.0, (meaning that service levels have not improved), up to a maximum of 2.0% of medical fees.	Measurement basis Customer specific Measurement period Annually Reporting period Annually
Management Reports	Processed claim information within 45 days; Incurred claim information within 90 days	0.50% for each quarter the reports were not available within the guaranteed time frame, up to a maximum of 2.0% of medical fees.	Measurement basis Customer specific Measurement period Annually Reporting period Annually

Medical Service Guarantees			Effective Date: January 01, 2027
Plan Sponsor Services			
	97% of non-Open Enrollment eligibility updates (defined as the number of electronic eligibility files updated) are processed within 2 business days of receipt of complete, accurate and viable data (if a file requires adjustments, you will be notified by email as soon as the need is identified).		
Non-Open Enrollment Eligibility Files (Tier 1)	Complete eligibility data is defined as employee name, address, provider selection, DOB, SSN, and covered dependent information (if applicable) as well as mutually agreed upon eligibility specifications. This guarantee is contingent upon the file being transmitted successfully to us (files received after noon ET will be considered as having been received on the next business day). Any eligibility file received which must be adjusted by us using a file fix will not be included in the reconciliation. The Electronic Report (ELR) is used to determine the completeness of the data provided by you.	0.40% for each full 1.0% that eligibility updates drop below 97% within 2 business days, up to a maximum of 2.0% of medical fees.	Measurement basis Customer specific Measurement period Annually Reporting period Annually
Claim Administration			
	30 calendar days for 97.0% of the processed claims on a cumulative basis.		
Turnaround Time (TAT Tier-2)	We measure TAT from the claimant's viewpoint; that is, from the date the claim is received in the service center to the date that it is processed (paid, denied or pended). TAT excludes those claims identified as rework**. Weekends and holidays are included in turnaround time.**	0.20% for each full day that the TAT exceeds 30 calendar days for 97.0% of the processed claims, up to a maximum of 1.0% of medical fees.	Measurement basis Customer specific: *≥ 3,000 enrolled members* Site Level: *< 3,000 enrolled members* Measurement period Annually Reporting period Quarterly

Financial Accuracy	99.0% Financial accuracy is measured using industry accepted stratified audit methodology. The results are determined by calculating the financial accuracy for a subset of claims (a stratum). We extrapolate the results based on the size of the population and combine them with the extrapolated results of the other strata. Each overpayment and underpayment is considered an error; they do not offset each other. Financial accuracy includes both manual and auto adjudicated claims. Dollars Paid Correctly Total Dollars Paid	0.40% for each full 1.0% that financial accuracy drops below 99.0%, up to a maximum of 2.0% of medical fees.	Measurement basis Unit(s) processing your claims (all customers' claims handled in that unit, not just your plan's claims) Measurement period Annually Reporting period Quarterly
Total Claim Accuracy	95.0% Total claim accuracy is measured using industry accepted stratified audit methodology. We extrapolate the results based on the size of the population and combine them with the extrapolated results of the other strata. Accuracy in each stratum (a subset of the claim population) is calculated by: Number of claims processed correctly Total number of claims audited	0.20% for each full 1.0% that total claim accuracy drops below 95.0%, up to a maximum of 1.0% of medical fees.	Measurement basis Unit(s) processing your claims (all customers' claims handled in that unit, not just your plan's claims) Measurement period Annually Reporting period Quarterly
Member Satisfaction			
Member Satisfaction	Positive response rate of 85.5% or higher on the following question "please rate your overall satisfaction with Aetna". The survey assumes a 5-point scale with the top 3 responses viewed as positive. The survey is based on a statistically valid, randomly selected sample of actively enrolled members aged 18-64. Interviews are conducted on a continuous basis throughout the year.	0.40% for each full 1.0% that the member satisfaction response rate falls below 85.5%, up to a maximum of 2.0% of medical fees.	Measurement basis Book of business Measurement period Annually Reporting period Quarterly

Medical Service Guarantees			Effective Date: January 01, 2027
Member Services			
Average Speed of Answer (ASA)	30 seconds ASA is the amount of time that elapses between the time a call is received into the telephone system and the time a Customer Service Professional (CSP) responds to the call. The result is calculated as follows: Sum of all waiting times (in seconds) for all calls answered by the queue Number of incoming calls answered ASA measures the average speed of answer for all call answered. Interactive Voice Response (IVR) system calls are not included in the measurement of ASA.	0.20% for each full second that the ASA exceeds 30 seconds, up to a maximum of 1.00% of medical fees.	Measurement basis Phone skill(s) providing your customer service Measurement period Annually Reporting period Quarterly
Abandonment Rate	2.5% The result is calculated as follows: Total number of calls abandoned Number of calls accepted into the skill(s)	0.20% for each full 1.0% that the average abandonment rate exceeds 2.5%, up to a maximum of 1.00% of medical fees.	Measurement basis Phone skill(s) providing your customer service Measurement period Annually Reporting period Quarterly
Open Inquiries Resolution (Tier 2)	Resolve 90% of member services open inquiries within 28 calendar days	0.40% for each full 1.0% that the member services open inquiries call resolution rate falls below 90% completed within 28 calendar days, up to a maximum of 2.0% of medical fees.	Measurement basis Accountable unit that services your plan Measurement period Annually Reporting period Annually

General Guarantee Provisions

- For purposes of the performance guarantees, the term "Business Day" is defined as Aetna's normal business hours on any day other than a Saturday or Sunday or a day on which Aetna is closed for general business purposes.
- These guarantees do not apply to third party benefit administrators contracted by Aetna.
- This offer does not contemplate significant changes in volume of claims and calls that may occur with novel conditions or circumstances affecting broad populations that place a significant strain on the health care system and/or your plan(s). These conditions include but are not limited to COVID-19. We reserve the right to adjust the terms and factors of this guarantee in response to these conditions and/or circumstances if necessary.
- In the event there is an outage or when experiencing peak volumes, calls may be transferred to other Aetna call centers. This guarantee may not apply, and a payment may not be made if results are not achieved due to severe weather events which directly or indirectly impact performance during the Guarantee Period.

- If we process runoff claims upon termination of the Agreement, the Turnaround Time, Financial Accuracy, and/or Total Claim Accuracy performance guarantee(s) will not apply to runoff claims.

Guarantee Period: January 01, 2027 through December 31, 2027

Your in-network discount will be 70.6 percent or better*

**Assuming current enrollment and book-of-business service mix.*

Products: Aetna Choice® Point of Service II (CPII)

What we guarantee

Attachment A of the Discount Guarantee Attachment shows:

- Our guaranteed network contracted discounts by market, for each of the following three service types:
  - Inpatient hospital
  - Outpatient hospital
  - Physician/other
- Illustrative aggregate guaranteed network contracted discount based on a weighting of:
  - Projected, customer-specific employees by market
  - Book-of-business weighting by service type

We finalize the discount target during the reconciliation process. The final aggregate guaranteed discount will be determined by weighting the discounts by the actual aggregate billed eligible charges by product and service type. The reconciliation will be completed once the actual enrolled employees by market and product, and the actual billed eligible charges are known.

How discounts are calculated

The achieved discount percentage is calculated using the following calculation:

$$\frac{\text{In-network provider discounts in dollars}}{\text{Total in-network billed eligible charges*}}$$

We calculate the discount using data from our Aetna Informatics® data warehouse. Three months of runout data will be included in the calculation. The guarantee reconciliation excludes each medical case where the claims in that medical case exceed $100,000.

A medical case summarizes clinical events by linking or associating all of the claims submitted for a member during the same treatment For example, all claims associated with an Inpatient Acute hospital stay or an Outpatient Facility based procedure.

The guarantee results combine the CPII product(s) and we report in aggregate for purposes of this guarantee reconciliation.

*Billed eligible charges are charges prior to application of plan design, discounts and member cost sharing (copays and deductibles). Billed eligible charges exclude the following:

- Duplicate or other ineligible/not covered/denied claims
- Claims paid by coordination of benefits where we are not primary (e.g. Medicare)
- Claims on members age 65 and over
- Claims incurred in passive or custom networks
- Behavioral health claims
- Non-medical claims (e.g. dental and vision hardware claims, pharmacy and specialty pharmacy claims, including some of those specialty pharmacy claims paid under the medical plan)
- Charges where the provider billed at or below the allowed amount
- All pay for performance payments, including but not limited to, accountable care payments (ACP) and coordination of care (COC) payments.

Alternate Discount Arrangements

In select markets, we have negotiated alternative contracts with providers and networks to provide additional savings to you and your employees and members. These alternative contracts are available if you meet criteria and have been granted approval where applicable. Alternate discount arrangements do not apply in locations where narrow network solution is offered. Discount factors and corresponding geographic locations may be modified if you offer Aetna Premier Care Network in any of the locations where we offered an alternate discount arrangement. This Medical Discount Guarantee Exhibit includes the Alternate Discount Arrangements noted within our proposal.

Guarantee reconciliation

We compare the guaranteed discount against the total achieved discount. The guaranteed discount is based on the actual enrollment by product and market, and billed eligible charges by product and service type. Based on the outcome of the comparison, we will make any applicable fee adjustments as shown in the table below.

Fee Adjustment	Max Guarantee Period Adjustment
3.0% fee reduction for each full 1.0% the achieved discount falls below the risk-free corridor	40.0%

There is a risk-free corridor of 0.0 percentage points.

Any fee adjustment is calculated as follows:

- A fee reduction occurs when the achieved discount falls below the difference of the guaranteed discount minus the risk-free corridor by a full percentage point or greater.

We've provided you a choice of a of a Discount Guarantee and Claim Target Guarantee. Let us know which guarantee you have chosen before the effective date.

Conditions for the guarantee

We rely on information from you and your representatives in creating and reconciling the terms of this guarantee. If any of this information is inaccurate, it may have an impact on the guaranteed network discounts. We reserve the right to revise the guarantee if any of the following conditions are not met.

- **Group Composition**
  You do not close any acquisitions or divestitures during the Guarantee Period.
- **Minimum Enrollment**
  You must enroll a minimum of 300 subscribers in the quoted Aetna self-funded medical products.
- **Pharmacy claims**
  Pharmacy and specialty pharmacy claims, including those paid under the medical plan, are excluded.
- **In-Network Claim Utilization**
  Our discount guarantee requires at least 80 percent of claims paid are in-network.
- **Provider Practice**
  Guarantee Year provider billing and reimbursement practices remain consistent with current practices.

Medical Discount Savings Illustration — Effective Date: January 01, 2027

Attachment A

Illustrative Inpatient Hospital Discount [1]	Illustrative Outpatient Hospital Discount [1][3]	Illustrative Physician/Other Discount [1][3]	Illustrative Composite Target Discount [2]
74.4%	74.5%	61.6%	70.6%

(1) These discounts are illustrative only as they have been weighted by the distribution of employees by network from the current census file.

(2) This composite target is illustrative only. The final guaranteed target will depend on the actual enrolled members by network and claim service mix known at the end of the Guarantee Period. For purposes of this illustration, the service mix of network billed eligible charges prior to discount is based on network level assumed utilization of hospital inpatient, hospital outpatient, and physician/other.

(3) Charges where the provider billed at or below the allowed amount.

Discounts by Location

We consider information concerning fees negotiated with providers to be proprietary, commercially valuable information, which is not in public domain. Consequently, the information contained herein is to be maintained in a confidential manner, and used solely for the purposes of reviewing this proposal.

Product	Market Name	Rating Area	Employees Within	Hospital Inpatient	Hospital Outpatient	Physician/ Other
CPII	KS Local Best	KS - Kansas City	933	74.73%	75.00%	61.71%
CPII	KS Local Best	MO - Kansas City	86	77.01%	76.46%	62.03%
CPII	KS Local Best	MO - SW Missouri	8	79.15%	60.63%	58.10%
CPII	SW MO Region MC	KS - Topeka	8	48.72%	51.22%	58.70%
CPII	KS Local Best	KS - Topeka	3	55.40%	59.80%	57.40%
CPII	KS Local Best	MO - N. Rural	3	53.97%	50.46%	61.67%
CPII	Ft. Myers (MC)	FL - Fort Myers	2	65.72%	70.02%	65.10%
CPII	Colorado (MC)	CO - Rural	1	53.22%	49.12%	55.50%
CPII	Arizona (multi site) MC	AZ - Northern	1	53.02%	53.42%	63.40%
CPII	Arizona (multi site) MC	AZ - Phoenix	1	64.12%	73.12%	63.30%
CPII	TampaBay/St.Petersburg MC	FL - Tampa	1	74.52%	78.52%	61.40%
CPII	Brevard County, FL (MC)	FL - Brevard County	1	62.92%	67.32%	59.00%
CPII	Arkansas (MC)	AR - Little Rock	1	58.82%	59.12%	54.80%
CPII	Florida Panhandle MC	FL - Panhandle	1	73.82%	74.42%	60.70%
CPII	Hawaii - MDX Hawaii POSII	HI - Hawaii	1	59.82%	64.02%	55.40%
CPII	Rural POS2 Multiplan	AR - Little Rock	1	58.82%	57.02%	56.60%
CPII	SW MO Region MC	MO - SW Missouri	1	60.02%	57.62%	49.60%
CPII	South Dakota MC	SD - South Dakota	1	41.02%	37.62%	41.20%
CPII	Eastern MI Aetna MC	MI - Detroit	1	65.22%	63.42%	60.10%
CPII	Wichita Region MC	KS - Western	1	56.02%	51.62%	61.20%
CPII	Nebraska OAMC/POSII	NE - Omaha	1	58.62%	60.12%	44.60%
		Total Subscribers	**1,057**			

Claim Target Guarantee — Effective Date: January 01, 2027

We guarantee your 2027 claim trend won't exceed 0.0%.

Your Guarantee Period claims will not exceed your base period claims by more than the trend percentages shown below.

	Year 1
Trend Target	**0.0%**
Enrolled active employees and covered dependents*	2,347
Assumptions	
Claim Basis	Allowed†
High claim exclusion threshold	$100,000
Guarantee Period	January 01, 2027 through December 31, 2027
Base Period	January 01, 2026 through December 31, 2026

**This guarantee assumes the enrolled active employee group and their covered dependents does not vary in size by more than 10 percent from this estimate, or from the average enrollment in the base period.*

†Allowed claims are the portion of the providers' billed amount considered eligible for benefits determination after discount. This amount is prior to application of any benefits provisions such as copays, deductibles, etc.

How the guarantee is calculated

- We calculate target medical claims per member, per month (PMPM) by multiplying base period claims times the net trend adjustment. Six months of runout data will be included in the calculation for the base and Guarantee Periods.
- We will finalize your base period medical incurred claims using the data provided to us by your prior carrier(s). Please refer to the Addendum for the data needed.
- Medical claims exclude pharmacy and specialty pharmacy claims, including those paid under the medical plan.

To ensure that we are comparing the base period and Guarantee Period on the same basis, we adjust base period claims for factors impacting the relativity of the population including, but not limited to, changes in plan design, demographics, geography, included products, programs and services, third-party vendor solutions, or the impact of legislation or novel conditions.

Claim Target Guarantee Reconciliation

We compare the actual claims PMPM to the target claims PMPM to determine whether we have met the performance guarantee. Based on the outcome of the comparison, we will make any applicable fee adjustment as shown in the table below.

Fee Adjustment	Maximum Guarantee Period Adjustment
5.0% fee reduction to the PEPM fee for each full 1.0% of actual claims exceed 100% of the target claims	40.0%

We've provided you a choice of a Discount Guarantee and Claim Target Guarantee. Let us know which guarantee you have chosen before the effective date.

Claim Target Guarantee **Effective Date: January 01, 2027**

Conditions for the guarantee

We rely on information from you and your representatives in creating and reconciling the terms of this guarantee. If any of this information is inaccurate, it may have an impact on the net allowed trend. We reserve the right to revise the guarantee if any of the following conditions apply:

- **Contribution strategy conditions**
  Your contribution strategy is structured in the following manner:
  – You contribute at least 50 percent of the total cost at each tier rate and your contribution percentage does not decline by more than 5 percentage points from the prior plan year by product.
  – You set employee contribution rates for each plan according to its benefit value relative to all other plans offered.
- **Pharmacy Data**
  Changes to your pharmacy benefit manager or frequency of data feeds from what we have assumed:
  Prescription drug coverage will be provided by Aetna.

General Guarantee Provisions

- The Guarantee is considered met if you:
  – We do not receive all of the necessary base period information, as outlined in our Addendum, by September 15, 2027.

Two different types of data sets are required for successful implementation. Both are necessary for the Claim Target Guarantee to remain in-force.

1. **Standard Data Submissions when changing carriers**
   - Claim history files (e.g. universal files). These are the industry standard prior carrier claim experience files you send in, regardless of whether you have a Claim Target Guarantee. A universal file includes claim and encounter data in a common format. The universal file is a data 'dump' of all medical processed claims and are at the expense line level.
     - The prior carrier claim data is critical for effective execution of our care management programs and may directly impact our claim trend.
   - Open Enrollment member eligibility file
     - Associated member census information is required to successfully load the claim history files.

This data must be submitted and successfully loaded prior to the effective date.

What we need	Incurred Time Period	Processed Time Period	Why?	Due Date
Accurate member eligibility file of those members joining our medical and pharmacy plans	n/a	n/a	This is required to match a member's prior carrier medical and pharmacy information with members continuing on the Aetna plan	12/11/2026
First detailed claim history file by member (universal file)	1/1/25 – 10/31/26	1/1/25 – 10/31/26	Effective execution of our medical and pharmacy management programs beginning on the effective date	12/11/2026
Second detailed claim history file by member	1/1/25 – 12/31/26	11/1/26 – 2/28/27	To provide the last two months of claim history data	04/01/2027

2. Additional information needed outside of the standard submission process

- Monthly claim and member information is needed to set the base to compare to the target to calculate the actual year over year medical trend.

What we need	Incurred Time Period	Processed Time Period	Why?	Due Date
Summary of Benefits and Coverage (SBC) for each of the plans offered prior to moving to Aetna and any mid-year plan changes (if applicable)	n/a	n/a	To accurately calculate the plan change factor adjustment	03/15/2027
First request for summary processed claim information* by plan design and large claims processed in excess of $100,000 per member	1/1/26 – 12/31/26	1/1/26 – 12/31/26	To complete a preliminary analysis of the data. It is also to make sure that the data given is based on the parameters set forth in this document.	03/15/2027
Member census files by month in Excel	1/1/26 – 12/31/26	n/a	Detailed census files are needed to calculate demographic and geographic adjustments	03/15/2027
Second request for summary processed claim information* by plan design and large claims processed in excess of $100,000 per member	1/1/26 – 12/31/26	1/1/26 – 6/30/27	To complete the actual Claim Target Guarantee reconciliation	08/15/2027

*Claim information should include capitations for medical and behavioral health

Note: Allowed amounts will reflect the total amount after Coordination of Benefits, where applicable. For example, let's assume a provider is reimbursed $100, of which Medicare (primary) pays $80, the plan (secondary) pays $15, and the member pays $5. The allowed amount would equal $20 in this case, which is the sum of the plan and member expense.

City of Olathe

Account Management Evaluation Survey Tool — **Effective Date: January 01, 2027**

Evaluation Period:

We would like to better understand how you view your relationship with us. In responding to this survey, we ask you to look at the services received from your Account Management Team for the time period listed above. Your feedback will enable us to better meet your needs. Thank you for your participation.

Knowledge: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
· understands your plan of benefits	Please Select	
· understands the business needs of your company	Please Select	
· understands the service expectations of your company	Please Select	
· displays knowledge regarding our products and services	Please Select	
· clearly explains report results	Please Select	
Total Rating	**0.0**	

Professionalism: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
· actively listens to and acknowledges your issues and concerns	Please Select	
· provides appropriate verbal communication	Please Select	
· provides appropriate written communication	Please Select	
· works with you to develop a positive working relationship	Please Select	
Total Rating	**0.0**	

Proactive Management: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
· monitors your account on an on-going basis	Please Select	
· communicates potential problematic issues	Please Select	
· provides viable alternatives to meet your business needs	Please Select	
· manages system conversions and changes in plan design in an organized	Please Select	
· sets realistic expectations regarding turn-around time	Please Select	
· sets realistic expectations regarding cost	Please Select	
Total Rating	**0.0**	

Accessibility: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
· is available to you	Please Select	
· allocates appropriate time when meeting with you	Please Select	
· demonstrates flexibility with regard to schedule changes	Please Select	
· provides/communicates alternate contacts in the event of their absence	Please Select	
· advises you of schedule limitations	Please Select	
Total Rating	**0.0**	

Responsiveness: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
· responds to your inquiries in a timely manner	Please Select	
· provides thorough responses to your inquiries	Please Select	
· follows-through regarding outstanding issues/items	Please Select	
· solicits the assistance of our product experts when needed	Please Select	
Total Rating	**0.0**	

Overall Account Management Team Evaluation:

Total Overall Rating	**0.0**
Average Overall Rating	**0.00**

Any other comments or suggested action steps:

Implementation Telephonic Implementation Survey — Effective Date: January 01, 2027

PLAN SPONSOR

	Script: Please rate your satisfaction that the Implementation Manager :	Completely Satisfied	Very Satisfied	Satisfied	Not Too Satisfied	Not At All Satisfied
1	Understood your overall implementation objective.	5	4	3	2	1
2	Explained the implementation process.	5	4	3	2	1
3	Provided appropriate and timely verbal and/or written communication.	5	4	3	2	1
4	Provided viable alternatives and suggestions to meet your business needs.	5	4	3	2	1
5	Effectively directed meetings/conference calls maintaining focus on critical issues and	5	4	3	2	1
6	Demonstrated effective follow through and responsiveness to outstanding inquiries/items.	5	4	3	2	1
	Script: Please rate your satisfaction with the following attributes of the Installation	**Completely Satisfied**	**Very Satisfied**	**Satisfied**	**Not Too Satisfied**	**Not At All Satisfied**
7	Our ability to set clear expectations about the production and delivery of your employee ID Cards.	5	4	3	2	1
	(For example: Were you provided an approximate date of when the ID cards would be mailed? **Applicable for Key Accounts Only**: Did we show you a sample of the card for your review?)					
8	Accuracy of the ID cards.	5	4	3	2	1
	If 3 or below: What type of errors or issues were there with your ID cards?					
9	Have you received your first bill?	Yes	No	N/A		
9A	Our ability to set clear expectations regarding the appearance and content of your First Bill	5	4	3	2	1
	(For example, Did we explain what it will look like? How and when it will be					
10	Accuracy of your First Bill.	5	4	3	2	1
	If 3 or below: Can you expand on that so I can capture what the issues were with your First Bill? (Did it reflect the correct rates and correct eligibility?)					
11	The manner in which your concerns or issues were addressed by the implementation team.	5	4	3	2	1
12	Overall, how would you rate your experience with the Implementation Process?	5	4	3	2	1
13	On the same rating scale (5-1), How would you rate this installation with similar services you may have received from other Health benefit companies?	5	4	3	2	1

BROKER

	Script: Please rate your satisfaction that the Implementation Manager :	Completely Satisfied	Very Satisfied	Satisfied	Not Too Satisfied	Not At All Satisfied
1	Understood your overall implementation objective.	5	4	3	2	1
2	Explained the implementation process.	5	4	3	2	1
3	Provided appropriate and timely verbal and/or written communication.	5	4	3	2	1
4	Provided viable alternatives and suggestions to meet your business needs.	5	4	3	2	1
5	Effectively directed meetings/conference calls maintaining focus on critical issues and	5	4	3	2	1
6	Demonstrated effective follow through and responsiveness to outstanding inquiries/items.	5	4	3	2	1
	Script: Please rate your satisfaction with the following attributes of the Installation	**Completely Satisfied**	**Very Satisfied**	**Satisfied**	**Not Too Satisfied**	**Not At All Satisfied**
11	The manner in which your concerns or issues were addressed by the implementation team.	5	4	3	2	1
12	Overall, how would you rate your experience with the Implementation Process?	5	4	3	2	1
13	On the same rating scale (5-1), How would you rate this installation with similar services you may have received from other Health benefit companies?	5	4	3	2	1

Pharmacy
Service and Fee Schedule
to the Master Services Agreement

Effective January 01, 2027
City of Olathe

aetna®

Table of Contents

Pharmacy Discounts & Fees

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

Pricing Arrangement	Pass Through at Retail
Network	Aetna National with Extended Day Supply (Retail 90) Network
Employees	1,095

RETAIL 30			
	01/01/2027	**01/01/2028**	**01/01/2029**
Brand Discount	AWP - 20.50%	AWP - 20.50%	AWP - 20.50%
Generic Discount	AWP - 87.10%	AWP - 87.20%	AWP - 87.20%
Dispensing Fee	$0.20 per Script	$0.20 per Script	$0.20 per Script

RETAIL 90			
	01/01/2027	**01/01/2028**	**01/01/2029**
Brand Discount	AWP - 20.50%	AWP - 20.50%	AWP - 20.50%
Generic Discount	88.60%	88.70%	88.70%
Dispensing Fee	$0.00 per Script	$0.00 per Script	$0.00 per Script

MAIL ORDER PHARMACY			
Mail Benefit Type	Mail Order Pharmacy		
	01/01/2027	**01/01/2028**	**01/01/2029**
Brand Discount	AWP - 20.50%	AWP - 20.50%	AWP - 20.50%
Generic Discount	AWP - 92.10% (MAC & NON-MAC Combined)	AWP - 92.20% (MAC & NON-MAC Combined)	AWP - 92.20% (MAC & NON-MAC Combined)
Non-MAC Generics	AWP - 25.00%	AWP - 25.00%	AWP -25.00%
Dispensing Fee	$0.00 per Script	$0.00 per Script	$0.00 per Script

SPECIALTY IN RETAIL			
	01/01/2027	**01/01/2028**	**01/01/2029**
Brand Discount	AWP - 18.00%	AWP - 18.00%	AWP - 18.00%
Generic Discount	AWP - 50.00%	AWP - 50.00%	AWP - 50.00%
Limited Distribution Drugs (With & Without Access)	AWP - 17.00%	AWP - 17.00%	AWP - 17.00%
Dispensing Fee	$0.20 per script	$0.20 per script	per script

SPECIALTY PHARMACY			
Network	Specialty Performance Network		
Product List	Aetna Specialty Product List		
	01/01/2027	**01/01/2028**	**01/01/2029**
Discount	AWP - 23.50%	AWP - 23.50%	AWP - 23.50%

ADMINISTRATIVE FEES			
	01/01/2027	**01/01/2028**	**01/01/2029**
Electronic Claim Administration Fee	$1.80 per Claim	$1.80 per Claim	$1.80 per Claim
Manual Claim Administration Fee	$1.50 per Claim	$1.50 per Claim	$1.50 per Claim
Third Party Payment	$2.00 per Claim	$2.00 per Claim	$2.00 per Claim

ALLOWANCES			
	01/01/2027	**01/01/2028**	**01/01/2029**
Implementation Allowance	$5.00 PMPY	NA	NA
General Allowance	$3.00 PMPY	$3.00 PMPY	$3.00 PMPY

Rebates

REBATES			
Formulary	Aetna Standard Formulary		
Rebate Terms	Customer will receive the following guaranteed rebates:		
	01/01/2027	**01/01/2028**	**01/01/2029**
Retail	$570.00 Per Brand Script	$600.00 Per Brand Script	$600.00 Per Brand Script
Retail 90	$1,280.00 Per Brand Script	$1,230.00 Per Brand Script	$1,230.00 Per Brand Script
Mail Order	$1300.00 Per Brand Script	$1340.00 Per Brand Script	$1340.00 Per Brand Script
Specialty	$8,200.00 Per Brand Script	$8,500.00 Per Brand Script	$8,500.00 Per Brand Script
Specialty at Retail	$8,200.00 Per Brand Script	$8,500.00 Per Brand Script	$8,500.00 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.

Additional Disclosures

This pricing has an effective date of January 1, 2027 and is contingent upon signing a three-year agreement. In order for Aetna to implement the pricing as set forth above by the effective date, acceptance of the pricing must be given (120) days prior to the effective date. A legal document must be signed by Customer and returned to Aetna sixty (60) days prior to the effective date.

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

Discount and dispensing fee guarantees apply to all paid Claims with the exception of the following exclusions: 340B Claims; Compound drug Claims; Paper or Member submitted Claims; Coordination of Benefits (COB) or secondary payor Claims; Claims paid at government required amounts; Vaccine and vaccine administration Claims.

Pricing guarantees are measured and reconciled as four separate components with the components defined as retail network, Aetna mail pharmacy, CVS Specialty mail pharmacy, and rebates. Retail network, Aetna mail pharmacy, and CVS Specialty mail pharmacy Pricing guarantees will be reconciled separately for each Participating Group, and any underperformance, dollar for dollar, will be paid to the Participating Group. AWP discounts and MAC, if applicable, are managed to achieve pricing guarantees

within each component. If selected, Maintenance Choice will be reconciled as part of the mail pharmacy channel.

Pricing in this proposal is based upon Aetna as the exclusive provider to Customer for each of the Services quoted in this proposal, including without limitation, retail pharmacy network contracting, pharmacy claims processing, mail and specialty pharmacy services, utilization management and formulary and rebate administration services.

The amount billed to the Customer will be equal to the amount paid to the participating pharmacies. The retail networks proposed are based on the number of participating pharmacies at the time of the proposal and may vary from time to time.

The pricing in this document 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 generic drug prescription through retail may be less than the same generic drug, dosage form, and dose through mail on the same day of adjudication.

The National Network is a managed network that includes most major chains and independents and may not include some regional chains. The composition of this network may differ from Customer's existing National Network composition. While member disruption is expected to be minimal, if a member disruption report has not been provided to Customer, a report can be provided upon request.

Retail 90 Network

The Aetna Retail-90 Network is a subset of the National Network which provides the flexible option of a nationwide network of retail pharmacies that can fill up to a 90 days' supply of medications. Aetna 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. Claims up to the Customers' qualified retail days' supply plan design limits can be filled at any participating pharmacy. Claims greater than the Customers' qualified retail plan design limits shall only be filled by a Aetna Retail-90 Network pharmacy. Implementation of Maintenance Choice and/or a mandatory plan design may limit the implementation of this offering.

Rebate Terms

Customer will receive the greater of the aggregate minimum rebate guarantees quoted herein or 100% of total rebates plus manufacturer administrative fees collected by Aetna in its capacity as a group purchasing organization on behalf of Customer, that are attributable to the utilization of prescription drugs by Customer's members.

Rebates guarantees are conditioned upon alignment with one of the formulary options in the pricing grid above, and the claims utilization mix and volume available at the time of pricing negotiations remaining consistent through the term of the agreement. Specialty Rebate Guarantees are contingent upon the Customer adopting a Plan Design that allows up to 90-day supply at Specialty. 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 adjudicated, 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 Biosimilars, 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 Claim 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. A Covered Drug Claim will only be eligible for application of a Rebate Credit if a minimum Rebate guarantee reduction has not already been made by Aetna for the same WAC reduction or change in reference Brand Drug placement event.

Rebates are paid quarterly for each channel and reconciled 120 days after year end in the aggregate. Additional 340B reconciliation and true-up may occur post annual minimum Rebate guarantee reconciliation.

Rebate guarantees will apply to all paid Brand Drug Claims, with the exception of the following exclusions; however, any Rebates collected by Aetna for such Claims will be passed to Customer in accordance with the rebate terms described herein: 340B Claim; Compound drug Claims; Paper or Member submitted Claims; Coordination of Benefits (COB) or secondary payor Claims; Vaccine and vaccine administration Claims; COVID treatment claims; any other Claim identified as having received 340B program pricing and therefore ineligible for a Rebate; Over the Counter (OTC) product Claims; Claims approved by formulary exception; Limited distribution and exclusive distribution drugs.

Rebate are paid quarterly for each channel and reconciled annually in the aggregate across all groups within the coalition. If a group has greater than 20,000 members and has elected group-specific rebates,

those rebates will be reconciled at the group level. Additional 340B reconciliation and true-up may occur post annual minimum Rebate guarantee reconciliation.

The proposed Aetna Standard formulary includes certain preferred brand drugs where the Tier 1 cost share shall be assessed to members.

CVS Specialty mail pharmacies, including through the Specialty Connect program, will be the exclusive provider of specialty pharmacy services. Claims for specialty products will not be processed through the retail network, except for those specialty drugs that CVS Specialty mail pharmacies are unable to dispense.

In order to encourage coalition growth, Aetna will evaluate group-specific rebate guarantees for any group of 20,000 lives or greater upon request.

Aetna reserves the right to adjust rebate guarantees if aggregate rebate performance is less than 5% of Aetna projections on annual basis. This could occur if a subset lives in the coalition results in significantly different mix than assumed in this RFP.

The Overall Effective Discount (OED) offer is conditioned on Aetna being the exclusive provider of Specialty Services and Customer implementing and maintaining a generics first plan design for specialty. 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 from CVS Specialty mail pharmacy, including through the Specialty Connect program, with the exception of the following exclusions (in addition to the discount and dispensing fee exclusions). Note: New to market and existing Biosimilars are included in the discount guarantees.

New to Market Brand Drugs

For the items notes here, the following quoted rates shall apply.

- New to Market Brand Drugs: AWP -15.00%;
- New to Market Generic Drugs: AWP -15.00%;
- New to Market Limited and exclusive distribution drugs: AWP -10.00%.

It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, the following Allowance(s) shall constitute and shall be treated as a discount against the purchase price of drugs dispensed under the Agreement within the meaning of 42 U.S.C. §1320a-7b(b)(3)(A).

General Allowance

Aetna agrees to provide Customer an annual Allowance in the amount up to $3.00 per member which will be available during the term of the Agreement. The number of members shall be based on the information provided by Customer during this process. This Allowance may be used to offset certain expenses incurred by Customer in the administration of Customer's prescription benefit plan or the

services provided by Aetna during the term. The Allowance, for example, may be applied to offset legitimate implementation expenses, communication expenses, member I.D. cards, postage, special programming charges, or applied to clinical programs offered by Aetna. Customer will be requested to provide reasonable documentation of expenses incurred that are to be applied to this Allowance. If Customer terminates this Agreement prior to the expiration of its Initial Term for any reason other than Aetna breach, or if Aetna terminates the agreement as a result of Customer's breach, Customer shall repay Aetna a pro rata portion of the applied general Allowance amount based upon the number of months remaining in the Initial Term.

Implementation Allowance

Aetna shall provide Customer with a one-time implementation Allowance up to $5.00 Per Net New Member to defray certain transition costs associated with moving Customer's business to Aetna. This Allowance can be used to offset typical and/or mutually agreed upon implementation costs in transferring from the current provider to Aetna. Customer shall be responsible for all transition and implementation expenses in excess of the implementation Allowance provided to Customer as set forth above. Examples of transition and implementation expenses include costs of customized Member I.D. cards, postage expense for direct mail of I.D. cards and other communication materials to Members, and special programming required by Aetna or Customer's prior prescription benefit manager to provide data to Aetna. Identification of the costs shall occur no later than six (6) months after the effective date of the Agreement. Customer shall provide Aetna with documentation of eligible expenses directly incurred by Customer in the form of an invoice, an account statement, or other detailed documentation. For agreed upon implementation or transition services provided by Aetna towards this allowance, Aetna shall provide expense detail for such items. If Customer's Agreement with Aetna is terminated prior to the expiration of the Initial Term for any reason (other than Aetna's uncured breach), or if Aetna terminates the Agreement as a result of Customer's uncured breach, Customer will repay Aetna a pro rata portion of the applied implementation allowance amount based upon the number of months remaining in the Initial Term. The parties acknowledge and agree that the implementation allowances provided by Aetna are commercially reasonable and necessary services related to the implementation of this Agreement and represent fair market value for the services provided.

Third Party Payment

Aetna will bill the Participating Groups an administrative fee of $2.00 per Claim and will collect and remit this amount to the Coalition, after the Effective Date of the Agreement.

Market Check

Annually, during the 2nd quarter of each contract year, at Coalition's reasonable request, Aetna and Coalition or Coalition's representative may review the financial terms of Customer compared to financial offering presented to similar Customers in the marketplace as deemed appropriate. A third party selected and engaged by Customer shall execute Aetna's form confidentiality agreement prior to

conducting the market check. The parties agree for the purpose of this market check that the parties will compare, among other things, the following factors to determine whether Coalition is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable Coalition 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 Coalition; 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. Coalition, 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 1% 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 Coalition 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 of the revisions are to apply. A legal document must be signed by Customer and returned to Aetna 60 days prior to pricing effective date.

Termination Rights

Subject to the terms of the Agreement either party may terminate the Agreement without cause, anytime, with 90 days prior written notice.

This document is a summary of Aetna offer, and is not intended to be all-inclusive. Other standard Aetna terms, conditions and pricing may apply. Specific contract language will be provided upon request. Shipping fees and/or postage may not be increased if Aetna's third party carrier increases its charges to Aetna.

The financial provisions in the offer are based upon information available to Aetna during the pricing request process. Upon thirty (30) days prior written notice to Customer, Aetna reserves the right to modify or amend the financial provisions in the offer in a manner designed to account for the impact of events identified below. Such notice will include Aetna’s explanation of the manner in which the modification accounts for the impact of the event.

1. Greater than 15% change in total membership or claims volume (83,000 members will be used as the baseline member count for total membership);

2. Customer-initiated change to pharmacy benefit program, plan design, or formulary alignment. Adding, deleting, or modifying member choice or incentives to enroll in pharmacy benefit options (e.g., Exchanges, Medicare Part D plans);

3. Product offering decisions by drug manufacturers that result in a reduction of rebates, including the introduction of a lower cost alternative product which may replace an existing rebatable brand product; an unexpected launch of an interchangeable version of a brand product; or a branded product

converted to OTC status, recalled or withdrawn from the market; or a material reduction in Wholesale Acquisition Cost (WAC); or

4. Any government imposed or industry-wide change, including any prohibition or restriction on Aetna's ability to receive rebates or discounts from pharmaceutical manufacturers; changes to methodology, availability, or publication of AWP; changes to tax laws; or changes in CMS guidelines for government regulated programs, if applicable.

By accepting this proposed pricing for review, 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.

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

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
• 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 Support cont.**
• 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 Expedite • Specialty Connect • Digital - Secure Messaging • First time fill prescription processing • Specialty CareTeam • Patient Assistance Program
Specialty Benefit Administration	**Specialty Pharmacy**
• Specialty Guideline Management (SGM) – criteria development and maintenance	• Use of the CVS Specialty Pharmacy network with full integration of retail, mail and specialty claims • Information System Infrastructure & Maintenance
• Specialty Copay Card Plan Designs • Standard Specialty Product List	• Member Onboarding • Member counseling label – drug specific
• Exclusive Specialty Grace Fill Member Letter (Under Member Communication Materials)	• 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	**Standard Digital Services cont.**
• Open enrollment links	• Single Sign on (SSO)
• Aetna.com configurations	• 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]		$1.65	Per Retail Claim Only
Retail Network Pharmacy Third Party Appeal		Pass through Fees Per Review	
State of Illinois PBM Fee		$15.00	PMPY[3]

[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.

[3]Members will be defined as covered individual enrolled by Caremark residing in the State of IL and in accordance with the States' requirements.

AETNA PHARMACY PROGRAM SUMMARY – ADDITIONAL SERVICES

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

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Acromegaly	octreotide	49.50%
Acromegaly	SANDOSTATIN	17.25%
Acromegaly	SOMATULINE	17.50%
Acromegaly	SOMAVERT	16.25%
Allergic Asthma	CINQAIR	15.25%
Allergic Asthma	DUPIXENT_ASTHMA	17.50%
Allergic Asthma	FASENRA	16.50%
Allergic Asthma	NUCALA	16.75%
Allergic Asthma	TEZSPIRE	17.25%
Allergic Asthma	XOLAIR	16.00%
Alpha-1 Antitrypsin Deficiency	ARALAST NP	18.00%
Alpha-1 Antitrypsin Deficiency	GLASSIA	18.00%
Alpha-1 Antitrypsin Deficiency	ZEMAIRA	18.00%
Amyloidosis	AMVUTTRA	15.75%
Amyloidosis	ONPATTRO	15.75%
Amyloidosis	VYNDAMAX	17.25%
Amyloidosis	VYNDAQEL	14.50%
Anemia	ARANESP	14.25%
Anemia	ENJAYMO	10.00%
Anemia	EPOGEN	8.00%
Anemia	PROCRIT	14.00%
Anemia	REBLOZYL	17.00%
Anemia	RETACRIT	6.00%
Atopic Dermatitis	ADBRY	18.50%
Atopic Dermatitis	CIBINQO	16.25%
Atopic Dermatitis	DUPIXENT_ATOPIC DERMATITIS	17.50%
Bone Disorders - Other	SOHONOS	10.00%
Bone Disorders - Other	VOXZOGO	15.75%
Cardiac Disorders	CAMZYOS	13.50%
Cardiac Disorders	dofetilide	MAC
Cardiac Disorders	TIKOSYN	13.75%
Coagulation Disorders	CEPROTIN	16.75%
Cryopyrin Associated Periodic Syndromes	ARCALYST	16.50%
Cryopyrin Associated Periodic Syndromes	ILARIS	17.75%
Cystic Fibrosis	BETHKIS	14.25%
Cystic Fibrosis	BRONCHITOL	15.00%
Cystic Fibrosis	CAYSTON	17.00%
Cystic Fibrosis	KITABIS PAK	17.50%
Cystic Fibrosis	PULMOZYME	16.50%
Cystic Fibrosis	TOBI	17.25%
Cystic Fibrosis	TOBI PODHALER	17.25%
Cystic Fibrosis	tobramycin	MAC
Dupuytren's Contracture	XIAFLEX	10.00%
Electrolyte Disorders	dichlorphenamide	38.00%
Electrolyte Disorders	SAMSCA	17.50%
Electrolyte Disorders	tolvaptan	MAC
Endocrine Disorders	CORTROPHIN	13.75%
Enzyme Deficiency Disorders - Other	betaine anhydrous	MAC
Enzyme Deficiency Disorders - Other	nitisinone	MAC
Enzyme Deficiency Disorders - Other	RYPLAZIM	10.00%
Gastrointestinal	GATTEX	16.25%
Gastrointestinal	OCALIVA	15.50%
Gastrointestinal	SOLESTA	14.25%
Gout	KRYSTEXXA	17.50%
Growth Hormone	EGRIFTA	17.00%
Growth Hormone	GENOTROPIN	16.50%
Growth Hormone	HUMATROPE	18.00%
Growth Hormone	INCRELEX	17.75%
Growth Hormone	NGENLA	10.00%
Growth Hormone	NORDITROPIN	21.00%

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Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Growth Hormone	NUTROPIN	16.00%
Growth Hormone	OMNITROPE	15.75%
Growth Hormone	SAIZEN	16.75%
Growth Hormone	SEROSTIM	17.00%
Growth Hormone	SKYTROFA	21.00%
Growth Hormone	SOGROYA	10.00%
Growth Hormone	ZOMACTON	13.50%
Growth Hormone	ZORBTIVE	18.00%
Hematopoietics	MOZOBIL	17.50%
Hematopoietics	plerixafor	15.00%
Hemophilia	ADVATE	38.00%
Hemophilia	ADYNOVATE	30.00%
Hemophilia	AFSTYLA	34.50%
Hemophilia	ALPHANATE	38.00%
Hemophilia	ALPHANINE SD	35.50%
Hemophilia	ALPROLIX	17.00%
Hemophilia	ALTUVIIIO	26.00%
Hemophilia	BENEFIX	15.00%
Hemophilia	COAGADEX	25.50%
Hemophilia	CORIFACT	26.00%
Hemophilia	ELOCTATE	22.00%
Hemophilia	ESPEROCT	25.00%
Hemophilia	FEIBA	24.50%
Hemophilia	FIBRYGA	14.25%
Hemophilia	HEMLIBRA	19.00%
Hemophilia	HEMOFIL M	37.50%
Hemophilia	HUMATE-P	30.00%
Hemophilia	IDELVION	18.00%
Hemophilia	IXINITY	26.00%
Hemophilia	JIVI	20.50%
Hemophilia	KOATE	40.50%
Hemophilia	KOGENATE	39.00%
Hemophilia	KOVALTRY	39.00%
Hemophilia	MONONINE	22.00%
Hemophilia	NOVOEIGHT	36.00%
Hemophilia	NOVOSEVEN RT	25.00%
Hemophilia	NUWIQ	32.00%
Hemophilia	OBIZUR	10.00%
Hemophilia	PROFILNINE SD	21.50%
Hemophilia	REBINYN	20.00%
Hemophilia	RECOMBINATE	35.50%
Hemophilia	RIASTAP	21.50%
Hemophilia	RIXUBIS	25.00%
Hemophilia	SEVENFACT	25.00%
Hemophilia	STIMATE	14.50%
Hemophilia	TRETTEN	15.25%
Hemophilia	VONVENDI	10.00%
Hemophilia	WILATE	39.00%
Hemophilia	XYNTHA	35.50%
Hepatitis C	EPCLUSA	19.00%
Hepatitis C	HARVONI	19.00%
Hepatitis C	LEDIPASVIR/SOFOSBUVIR	19.00%
Hepatitis C	MAVYRET	18.50%
Hepatitis C	PEGASYS	15.25%
Hepatitis C	ribavirin	MAC
Hepatitis C	SOFOSBUVIR/VELPATASVIR	19.00%
Hepatitis C	SOVALDI	19.00%
Hepatitis C	VOSEVI	18.50%
Hepatitis C	ZEPATIER	19.25%

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Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Hereditary Angioedema	BERINERT	19.00%
Hereditary Angioedema	CINRYZE	14.00%
Hereditary Angioedema	FIRAZYR	16.00%
Hereditary Angioedema	HAEGARDA	14.00%
Hereditary Angioedema	icatibant acetate	MAC
Hereditary Angioedema	KALBITOR	14.00%
Hereditary Angioedema	RUCONEST	16.50%
Hereditary Angioedema	TAKHZYRO	15.50%
Hormonal Therapies	AVEED	13.00%
Hormonal Therapies	ELIGARD	14.25%
Hormonal Therapies	FENSOLVI	19.00%
Hormonal Therapies	FIRMAGON	8.25%
Hormonal Therapies	leuprolide acetate	MAC
Hormonal Therapies	LEUPROLIDE ACETATE_BRAND	11.50%
Hormonal Therapies	LUPRON DEPOT	16.75%
Hormonal Therapies	SUPPRELIN	18.00%
Hormonal Therapies	TRELSTAR	15.50%
Hormonal Therapies	ZOLADEX	10.50%
I.V.I.G.	ASCENIV	13.50%
I.V.I.G.	BIVIGAM	12.75%
I.V.I.G.	CUTAQUIG	13.50%
I.V.I.G.	CUVITRU	25.00%
I.V.I.G.	CYTOGAM	9.00%
I.V.I.G.	FLEBOGAMMA	16.25%
I.V.I.G.	GAMASTAN S/D	17.00%
I.V.I.G.	GAMMAGARD	32.00%
I.V.I.G.	GAMMAGARD LIQUID	37.00%
I.V.I.G.	GAMMAKED	15.50%
I.V.I.G.	GAMMAPLEX	34.00%
I.V.I.G.	GAMUNEX	27.00%
I.V.I.G.	HEPAGAM B	17.00%
I.V.I.G.	HIZENTRA	40.00%
I.V.I.G.	HYPERHEP B	17.00%
I.V.I.G.	HYPERRHO S/D	17.00%
I.V.I.G.	HYQVIA	28.00%
I.V.I.G.	MICRHOGAM	17.00%
I.V.I.G.	NABI-HB	15.50%
I.V.I.G.	OCTAGAM	36.00%
I.V.I.G.	PANZYGA	15.50%
I.V.I.G.	PRIVIGEN	36.00%
I.V.I.G.	RHOGAM	17.00%
I.V.I.G.	RHOPHYLAC	17.00%
I.V.I.G.	VARIZIG	17.00%
I.V.I.G.	WINRHO	15.50%
I.V.I.G.	XEMBIFY	25.00%
Infectious Disease	ACTIMMUNE	18.00%
Infectious Disease	ALFERON N	10.50%
Infertility	cetrorelix acetate	MAC
Infertility	CETROTIDE	12.50%
Infertility	CHORIONIC GONADOTROPIN	17.00%
Infertility	FOLLISTIM AQ	16.50%
Infertility	fyremadel	MAC
Infertility	ganirelix acetate	MAC
Infertility	GANIRELIX ACETATE_BRAND	9.25%
Infertility	GONAL-F	16.50%
Infertility	MENOPUR	16.00%
Infertility	NOVAREL	17.00%
Infertility	OVIDREL	17.00%
Infertility	PREGNYL	17.00%

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Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Inflammatory Bowel Disease	CIMZIA	18.25%
Inflammatory Bowel Disease	CIMZIA POW	16.50%
Inflammatory Bowel Disease	ENTYVIO	16.75%
Inflammatory Bowel Disease	ENTYVIO SC	10.00%
Inflammatory Bowel Disease	OMVOH	10.00%
Inflammatory Bowel Disease	RENFLEXIS	19.50%
Inflammatory Bowel Disease	VELSIPITY	10.00%
Inflammatory Bowel Disease	ZYMFENTRA	15.00%
Iron Overload	deferasirox	MAC
Iron Overload	deferiprone	MAC
Iron Overload	deferoxamine	17.00%
Iron Overload	DESFERAL	16.25%
Iron Overload	EXJADE	17.25%
Iron Overload	JADENU	17.25%
Lysosomal Storage Diseases	ALDURAZYME	17.00%
Lysosomal Storage Diseases	CERDELGA	15.25%
Lysosomal Storage Diseases	CEREZYME	17.00%
Lysosomal Storage Diseases	CYSTAGON	17.00%
Lysosomal Storage Diseases	ELAPRASE	15.75%
Lysosomal Storage Diseases	ELELYSO	17.00%
Lysosomal Storage Diseases	FABRAZYME	15.75%
Lysosomal Storage Diseases	KANUMA	17.50%
Lysosomal Storage Diseases	LUMIZYME	17.25%
Lysosomal Storage Diseases	miglustat	MAC
Lysosomal Storage Diseases	NAGLAZYME	15.75%
Lysosomal Storage Diseases	NEXVIAZYME	16.50%
Lysosomal Storage Diseases	OPFOLDA	10.00%
Lysosomal Storage Diseases	POMBILITI	10.00%
Lysosomal Storage Diseases	VIMIZIM	15.75%
Lysosomal Storage Diseases	VPRIV	15.25%
Lysosomal Storage Diseases	XENPOZYME	16.50%
Mental Health Conditions	ZULRESSO	17.00%
Mental Health Conditions	ZURZUVAE	10.00%
Movement Disorders	APOKYN	19.50%
Movement Disorders	apomorphine hydrochloride inj	42.00%
Movement Disorders	AUSTEDO	18.00%
Movement Disorders	droxidopa	MAC
Movement Disorders	DUOPA	17.75%
Movement Disorders	INGREZZA	16.50%
Movement Disorders	KYNMOBI	15.25%
Movement Disorders	NORTHERA	16.75%
Movement Disorders	NUPLAZID	18.00%
Movement Disorders	RADICAVA ORS	15.50%
Movement Disorders	RELYVRIO	13.75%
Movement Disorders	tetrabenazine	MAC
Movement Disorders	XENAZINE	17.00%
Multiple Sclerosis	AMPYRA	14.00%
Multiple Sclerosis	AUBAGIO	18.75%
Multiple Sclerosis	AVONEX	18.75%
Multiple Sclerosis	BAFIERTAM	19.25%
Multiple Sclerosis	BETASERON	18.75%
Multiple Sclerosis	BRIUMVI	14.00%
Multiple Sclerosis	COPAXONE 20	17.50%
Multiple Sclerosis	COPAXONE 40	17.50%
Multiple Sclerosis	dalfampridine	MAC
Multiple Sclerosis	dimethyl fumarate	MAC
Multiple Sclerosis	EXTAVIA	17.75%
Multiple Sclerosis	fingolimod	MAC
Multiple Sclerosis	GILENYA	17.75%

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Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Multiple Sclerosis	glatiramer acetate 20	70.00%
Multiple Sclerosis	glatiramer acetate 40	70.00%
Multiple Sclerosis	glatopa 20	70.00%
Multiple Sclerosis	glatopa 40	70.00%
Multiple Sclerosis	KESIMPTA	19.25%
Multiple Sclerosis	LEMTRADA	17.75%
Multiple Sclerosis	MAVENCLAD	19.25%
Multiple Sclerosis	MAYZENT	17.50%
Multiple Sclerosis	mitoxantrone	17.00%
Multiple Sclerosis	OCREVUS	17.50%
Multiple Sclerosis	PLEGRIDY	18.75%
Multiple Sclerosis	PONVORY	19.25%
Multiple Sclerosis	REBIF	17.25%
Multiple Sclerosis	TECFIDERA	19.25%
Multiple Sclerosis	teriflunomide	MAC
Multiple Sclerosis	TYSABRI	17.00%
Multiple Sclerosis	VUMERITY	18.75%
Multiple Sclerosis	ZEPOSIA	19.25%
Neurological Disorders	ADUHELM	16.00%
Neuromuscular	RYSTIGGO	10.00%
Neuromuscular	VYVGART	18.50%
Neuromuscular	VYVGART HYTRULO	10.00%
Neutropenia	FULPHILA	16.50%
Neutropenia	FYLNETRA	11.00%
Neutropenia	GRANIX	16.00%
Neutropenia	LEUKINE	16.50%
Neutropenia	NEULASTA	17.00%
Neutropenia	NEUPOGEN	16.00%
Neutropenia	NIVESTYM	15.00%
Neutropenia	NYVEPRIA	15.50%
Neutropenia	RELEUKO	12.50%
Neutropenia	ROLVEDON	11.75%
Neutropenia	STIMUFEND	12.75%
Neutropenia	UDENYCA	16.50%
Neutropenia	ZARXIO	15.00%
Neutropenia	ZIEXTENZO	16.25%
Ocular Disorders	SUSVIMO	16.75%
Oncology - Injectable	ABRAXANE	17.00%
Oncology - Injectable	ADCETRIS	17.75%
Oncology - Injectable	ALYMSYS	16.00%
Oncology - Injectable	AVASTIN	16.50%
Oncology - Injectable	azacitidine	48.00%
Oncology - Injectable	BELEODAQ	17.50%
Oncology - Injectable	BELRAPZO	16.25%
Oncology - Injectable	BENDAMUSTINE HYDROCHLORID	17.25%
Oncology - Injectable	bendamustine hydrochloride inj	13.25%
Oncology - Injectable	BENDEKA	17.50%
Oncology - Injectable	BESPONSA	17.25%
Oncology - Injectable	BLINCYTO	13.75%
Oncology - Injectable	BORTEZOMIB	17.00%
Oncology - Injectable	bortezomib for inj	12.75%
Oncology - Injectable	BORTEZOMIB FOR INJ_BRAND	9.25%
Oncology - Injectable	COLUMVI	10.00%
Oncology - Injectable	CYRAMZA	17.25%
Oncology - Injectable	DACOGEN	17.25%
Oncology - Injectable	DARZALEX	17.50%
Oncology - Injectable	decitabine	21.00%
Oncology - Injectable	EMPLICITI	17.50%
Oncology - Injectable	ENHERTU	13.00%

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Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Oncology - Injectable	ERBITUX	17.25%
Oncology - Injectable	EVOMELA	17.50%
Oncology - Injectable	FOLOTYN	17.50%
Oncology - Injectable	GAZYVA	17.50%
Oncology - Injectable	HALAVEN	17.00%
Oncology - Injectable	HERCEPTIN	17.00%
Oncology - Injectable	HERCEPTIN HYLECTA	17.00%
Oncology - Injectable	HERZUMA	16.50%
Oncology - Injectable	IMDELLTRA	10.00%
Oncology - Injectable	IMFINZI	17.25%
Oncology - Injectable	IMJUDO	16.25%
Oncology - Injectable	ISTODAX	17.50%
Oncology - Injectable	IXEMPRA	17.00%
Oncology - Injectable	JEMPERLI	16.75%
Oncology - Injectable	JEVTANA	17.00%
Oncology - Injectable	KADCYLA	17.00%
Oncology - Injectable	KANJINTI	16.50%
Oncology - Injectable	KEYTRUDA	17.25%
Oncology - Injectable	KHAPZORY	13.00%
Oncology - Injectable	KYPROLIS	17.50%
Oncology - Injectable	levoleucovorin calcium	13.00%
Oncology - Injectable	LOQTORZI	10.00%
Oncology - Injectable	LUNSUMIO	13.75%
Oncology - Injectable	MARGENZA	17.00%
Oncology - Injectable	MVASI	17.00%
Oncology - Injectable	MYLOTARG	16.25%
Oncology - Injectable	OGIVRI	15.75%
Oncology - Injectable	ONIVYDE	11.00%
Oncology - Injectable	ONTRUZANT	13.50%
Oncology - Injectable	OPDIVO	17.25%
Oncology - Injectable	OPDUALAG	17.00%
Oncology - Injectable	paclitaxel protein-bound	14.00%
Oncology - Injectable	PACLITAXEL PROTEIN-BOUND_BRAND	17.00%
Oncology - Injectable	PADCEV	16.25%
Oncology - Injectable	PERJETA	17.00%
Oncology - Injectable	PHESGO	17.00%
Oncology - Injectable	POLIVY	17.00%
Oncology - Injectable	PORTRAZZA	17.25%
Oncology - Injectable	POTELIGEO	10.00%
Oncology - Injectable	PROLEUKIN	17.75%
Oncology - Injectable	RIABNI	13.75%
Oncology - Injectable	RITUXAN	17.50%
Oncology - Injectable	RITUXAN HYCELA	17.25%
Oncology - Injectable	romidepsin	14.25%
Oncology - Injectable	ROMIDEPSIN_BRAND	16.75%
Oncology - Injectable	RUXIENCE	17.75%
Oncology - Injectable	RYBREVANT	13.75%
Oncology - Injectable	RYLAZE	16.25%
Oncology - Injectable	SARCLISA	13.00%
Oncology - Injectable	SYLVANT	16.50%
Oncology - Injectable	TECENTRIQ	17.00%
Oncology - Injectable	TEMODAR (INJECTABLE)	17.50%
Oncology - Injectable	temsirolimus	32.00%
Oncology - Injectable	TEPADINA	14.00%
Oncology - Injectable	THYROGEN	16.25%
Oncology - Injectable	TIVDAK	16.75%
Oncology - Injectable	TORISEL	17.25%
Oncology - Injectable	TRAZIMERA	16.50%
Oncology - Injectable	TREANDA	17.00%

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Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Oncology - Injectable	TRUXIMA	17.50%
Oncology - Injectable	valrubicin	15.25%
Oncology - Injectable	VALSTAR	17.50%
Oncology - Injectable	VECTIBIX	17.00%
Oncology - Injectable	VEGZELMA	13.75%
Oncology - Injectable	VELCADE	17.00%
Oncology - Injectable	VIDAZA	13.00%
Oncology - Injectable	VIVIMUSTA	13.75%
Oncology - Injectable	VYXEOS	17.00%
Oncology - Injectable	XGEVA	15.75%
Oncology - Injectable	YERVOY	17.50%
Oncology - Injectable	YONDELIS	17.25%
Oncology - Injectable	ZALTRAP	17.25%
Oncology - Injectable	ZEPZELCA	17.00%
Oncology - Injectable	ZIRABEV	16.00%
Oncology - Injectable	zoledronic acid_onc	45.50%
Oncology - Injectable	ZOLEDRONIC ACID_ONC_BRAND	17.00%
Oncology - Injectable	ZYNYZ	13.75%
Oncology - Oral	abiraterone acetate	MAC
Oncology - Oral	AFINITOR	17.25%
Oncology - Oral	ALECENSA	17.25%
Oncology - Oral	AUGTYRO	10.00%
Oncology - Oral	BALVERSA	10.00%
Oncology - Oral	bexarotene cap	MAC
Oncology - Oral	bexarotene gel	MAC
Oncology - Oral	BOSULIF	17.25%
Oncology - Oral	BRAFTOVI	16.50%
Oncology - Oral	CABOMETYX	16.00%
Oncology - Oral	capecitabine	MAC
Oncology - Oral	COMETRIQ	15.75%
Oncology - Oral	COPIKTRA	16.25%
Oncology - Oral	COTELLIC	16.75%
Oncology - Oral	DAURISMO	17.50%
Oncology - Oral	ERIVEDGE	17.25%
Oncology - Oral	ERLEADA	17.50%
Oncology - Oral	erlotinib hydrochloride	MAC
Oncology - Oral	everolimus_onc	MAC
Oncology - Oral	FARYDAK	17.00%
Oncology - Oral	gefitinib	MAC
Oncology - Oral	GLEEVEC	17.50%
Oncology - Oral	GLEOSTINE	12.50%
Oncology - Oral	HYCAMTIN	17.00%
Oncology - Oral	IBRANCE	17.75%
Oncology - Oral	IDHIFA	15.50%
Oncology - Oral	imatinib mesylate	MAC
Oncology - Oral	INLYTA	17.50%
Oncology - Oral	INQOVI	15.50%
Oncology - Oral	INREBIC	15.75%
Oncology - Oral	IRESSA	17.50%
Oncology - Oral	JAKAFI	16.00%
Oncology - Oral	JAYPIRCA	14.00%
Oncology - Oral	KISQALI	17.50%
Oncology - Oral	lapatinib ditosylate	35.00%
Oncology - Oral	lenalidomide	43.00%
Oncology - Oral	LENVIMA	14.25%
Oncology - Oral	LONSURF	16.00%
Oncology - Oral	LORBRENA	17.50%
Oncology - Oral	LUMAKRAS	16.75%
Oncology - Oral	LYNPARZA	17.25%

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Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Oncology - Oral	MEKINIST	17.25%
Oncology - Oral	MEKTOVI	16.50%
Oncology - Oral	NERLYNX	15.50%
Oncology - Oral	NEXAVAR	16.00%
Oncology - Oral	NINLARO	16.00%
Oncology - Oral	NUBEQA	15.75%
Oncology - Oral	ODOMZO	17.25%
Oncology - Oral	ONUREG	14.00%
Oncology - Oral	pazopanib hydrochloride	MAC
Oncology - Oral	PIQRAY	17.25%
Oncology - Oral	POMALYST	16.00%
Oncology - Oral	PURIXAN	14.00%
Oncology - Oral	RETEVMO	14.00%
Oncology - Oral	REVLIMID	16.00%
Oncology - Oral	ROZLYTREK	17.25%
Oncology - Oral	RUBRACA	16.25%
Oncology - Oral	RYDAPT	14.00%
Oncology - Oral	sorafenib tosylate	MAC
Oncology - Oral	SPRYCEL	18.75%
Oncology - Oral	STIVARGA	16.00%
Oncology - Oral	sunitinib malate	MAC
Oncology - Oral	SUTENT	17.25%
Oncology - Oral	TABRECTA	17.50%
Oncology - Oral	TAFINLAR	17.25%
Oncology - Oral	TAGRISSO	17.50%
Oncology - Oral	TALZENNA	17.50%
Oncology - Oral	TARCEVA	17.00%
Oncology - Oral	TARGRETIN	17.50%
Oncology - Oral	TASIGNA	17.25%
Oncology - Oral	TEMODAR (ORAL)	17.50%
Oncology - Oral	temozolomide	MAC
Oncology - Oral	THALOMID	15.75%
Oncology - Oral	TYKERB	17.00%
Oncology - Oral	VERZENIO	17.25%
Oncology - Oral	VITRAKVI	16.00%
Oncology - Oral	VIZIMPRO	17.50%
Oncology - Oral	VOTRIENT	17.25%
Oncology - Oral	XALKORI	17.25%
Oncology - Oral	XELODA	16.50%
Oncology - Oral	XOSPATA	15.75%
Oncology - Oral	XTANDI	17.25%
Oncology - Oral	YONSA	16.75%
Oncology - Oral	ZEJULA	13.75%
Oncology - Oral	ZELBORAF	17.25%
Oncology - Oral	ZOLINZA	17.25%
Oncology - Oral	ZYDELIG	14.00%
Oncology - Oral	ZYKADIA	17.25%
Oncology - Oral	ZYTIGA	18.50%
Osteoporosis	EVENITY	14.50%
Osteoporosis	FORTEO	16.00%
Osteoporosis	PROLIA	12.75%
Osteoporosis	RECLAST	10.00%
Osteoporosis	TERIPARATIDE	15.25%
Osteoporosis	teriparatide injection	MAC
Osteoporosis	TYMLOS	16.00%
Osteoporosis	zoledronic acid_ost	MAC
Paroxysmal Nocturnal Hemoglobinuria	SOLIRIS	17.50%
Paroxysmal Nocturnal Hemoglobinuria	ULTOMIRIS	17.50%
Phenylketonuria	KUVAN	16.00%

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Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Phenylketonuria	PALYNZIQ	16.00%
Phenylketonuria	sapropterin dihydrochloride	MAC
Psoriasis	BIMZELX	15.00%
Psoriasis	COSENTYX	17.25%
Psoriasis	ILUMYA	17.25%
Psoriasis	OTEZLA	14.75%
Psoriasis	SILIQ	15.50%
Psoriasis	SKYRIZI	19.75%
Psoriasis	SOTYKTU	19.75%
Psoriasis	STELARA	19.00%
Psoriasis	STELARA (SOLN)	18.25%
Psoriasis	STELARA IV	17.00%
Psoriasis	TALTZ	14.25%
Psoriasis	TREMFYA	17.75%
Pulmonary Arterial Hypertension	ADCIRCA	15.25%
Pulmonary Arterial Hypertension	ADEMPAS	15.50%
Pulmonary Arterial Hypertension	alyq	MAC
Pulmonary Arterial Hypertension	ambrisentan	MAC
Pulmonary Arterial Hypertension	bosentan	MAC
Pulmonary Arterial Hypertension	epoprostenol	14.50%
Pulmonary Arterial Hypertension	FLOLAN	14.50%
Pulmonary Arterial Hypertension	LETAIRIS	16.25%
Pulmonary Arterial Hypertension	LIQREV	21.00%
Pulmonary Arterial Hypertension	OPSUMIT	15.50%
Pulmonary Arterial Hypertension	OPSYNVI	10.00%
Pulmonary Arterial Hypertension	ORENITRAM	14.75%
Pulmonary Arterial Hypertension	REMODULIN	14.00%
Pulmonary Arterial Hypertension	REVATIO	16.50%
Pulmonary Arterial Hypertension	sildenafil citrate	MAC
Pulmonary Arterial Hypertension	tadalafil	MAC
Pulmonary Arterial Hypertension	TADLIQ	21.00%
Pulmonary Arterial Hypertension	TRACLEER	14.75%
Pulmonary Arterial Hypertension	treprostinil sodium	24.00%
Pulmonary Arterial Hypertension	TYVASO	13.00%
Pulmonary Arterial Hypertension	UPTRAVI	16.00%
Pulmonary Arterial Hypertension	VELETRI	13.00%
Pulmonary Arterial Hypertension	VENTAVIS	12.00%
Pulmonary Arterial Hypertension	WINREVAIR	10.00%
Pulmonary Disorders	ESBRIET	16.75%
Pulmonary Disorders	OFEV	16.00%
Pulmonary Disorders	pirfenidone	MAC
Rare Disorders	CRYSVITA	15.75%
Rare Disorders	DOJOLVI	15.50%
Rare Disorders	ENSPRYNG	17.00%
Rare Disorders	LITFULO	10.00%
Rare Disorders	VIJOICE	17.25%
Rare Disorders	ZOKINVY	11.00%
Renal Disease	cinacalcet hcl	MAC
Renal Disease	FILSPARI	15.75%
Renal Disease	PARSABIV	15.25%
Renal Disease	RIVFLOZA	10.00%
Renal Disease	SENSIPAR	14.75%
Renal Disease	tiopronin	37.00%
Retinal Disorders	BEOVU	14.75%
Retinal Disorders	BYOOVIZ	12.00%
Retinal Disorders	CIMERLI	8.25%
Retinal Disorders	EYLEA	17.25%
Retinal Disorders	ILUVIEN	17.25%
Retinal Disorders	LUCENTIS	15.25%

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Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	Drug Name	AWP Discount
Retinal Disorders	OZURDEX	14.75%
Retinal Disorders	RETISERT	17.50%
Retinal Disorders	VABYSMO	14.75%
Retinal Disorders	VISUDYNE	11.75%
Rheumatoid Arthritis	ABRILADA	15.00%
Rheumatoid Arthritis	ABRILADA_NS	15.00%
Rheumatoid Arthritis	ACTEMRA	16.25%
Rheumatoid Arthritis	ADALIMUMAB-AACF	15.00%
Rheumatoid Arthritis	ADALIMUMAB-AATY	15.00%
Rheumatoid Arthritis	ADALIMUMAB-ADAZ	15.00%
Rheumatoid Arthritis	ADALIMUMAB-ADBM	15.00%
Rheumatoid Arthritis	ADALIMUMAB-FKJP	15.00%
Rheumatoid Arthritis	ADALIMUMAB-RYVK	15.00%
Rheumatoid Arthritis	AMJEVITA	19.50%
Rheumatoid Arthritis	AMJEVITA_NS	12.00%
Rheumatoid Arthritis	AVSOLA	15.50%
Rheumatoid Arthritis	CYLTEZO	15.00%
Rheumatoid Arthritis	ENBREL	18.25%
Rheumatoid Arthritis	HADLIMA	15.00%
Rheumatoid Arthritis	HULIO	15.00%
Rheumatoid Arthritis	HUMIRA	18.00%
Rheumatoid Arthritis	HUMIRA_CORDAVIS	18.00%
Rheumatoid Arthritis	HYRIMOZ	15.00%
Rheumatoid Arthritis	HYRIMOZ_CORDAVIS	15.00%
Rheumatoid Arthritis	IDACIO	15.00%
Rheumatoid Arthritis	INFLECTRA	16.00%
Rheumatoid Arthritis	INFLIXIMAB	16.00%
Rheumatoid Arthritis	KEVZARA	15.75%
Rheumatoid Arthritis	OLUMIANT	16.75%
Rheumatoid Arthritis	ORENCIA	18.00%
Rheumatoid Arthritis	OTREXUP	11.50%
Rheumatoid Arthritis	RASUVO	9.00%
Rheumatoid Arthritis	REDITREX	17.00%
Rheumatoid Arthritis	REMICADE	17.00%
Rheumatoid Arthritis	RINVOQ	19.00%
Rheumatoid Arthritis	SIMLANDI	15.00%
Rheumatoid Arthritis	SIMPONI	17.75%
Rheumatoid Arthritis	TOFIDENCE	10.00%
Rheumatoid Arthritis	TYENNE	15.00%
Rheumatoid Arthritis	XELJANZ	16.75%
Rheumatoid Arthritis	YUFLYMA	15.00%
Rheumatoid Arthritis	YUSIMRY	15.00%
RSV	SYNAGIS	18.00%
Seizure Disorders	EPIDIOLEX	15.00%
Seizure Disorders	HP ACTHAR GEL	16.25%
Seizure Disorders	SABRIL	17.00%
Sickle Cell Disease	ADAKVEO	16.75%
Sickle Cell Disease	ENDARI	13.50%
Sickle Cell Disease	OXBRYTA	15.00%
Sleep Disorder	LUMRYZ	17.00%
Sleep Disorder	tasimelteon	MAC
Sleep Disorder	WAKIX	15.25%
Systemic Lupus Erythematosus	BENLYSTA	16.50%
Systemic Lupus Erythematosus	SAPHNELO	14.50%
Thrombocytopenia	ALVAIZ	15.00%
Thrombocytopenia	DOPTELET	16.25%
Thrombocytopenia	MULPLETA	17.50%
Thrombocytopenia	NPLATE	17.50%
Thrombocytopenia	PROMACTA	17.50%

Specialty Fee Schedule

PSUID

City of Olathe		Exclusive
Drug Therapy	**Drug Name**	**AWP Discount**
Urea Cycle Disorders	BUPHENYL	15.75%
Urea Cycle Disorders	carglumic acid	MAC
Urea Cycle Disorders	RAVICTI	16.25%
Urea Cycle Disorders	sodium phenylbutyrate	MAC
Wilson's Disease	clovique	MAC
Wilson's Disease	CUPRIMINE	18.00%
Wilson's Disease	DEPEN TITRA	17.50%
Wilson's Disease	penicillamine	MAC
Wilson's Disease	SYPRINE	17.75%
Wilson's Disease	trientine hcl	MAC
	Default Rate:	17.00%
	Dispensing Fee:	$0.00

NOTES:

- New to Market Brand Specialty Products will be priced at: AWP – 16.00%
- New to Market Generic Specialty Products will be Priced at AWP - 35.00%
- New to Market Limited and exclusive distribution drugs will be priced at AWP – 15.00%
-MAC: Certain dosage forms and strengths may not be included on the MAC list and shall be priced at the specialty default rate.

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.