Attachment #1

MASTER SERVICES AGREEMENT NO. MSA-*SAMPLE*

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

1. INTRODUCTION

WHEREAS, Customer has established a self-funded employee health benefits plan (the "Plan"), for certain eligible Plan Participants (employees, dependents, beneficiaries, retirees, or members as referenced in the Plan documents, or any term used by the Customer to designate participants in the Plan) pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA") described in Appendix I of this Services Agreement; and

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

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

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

2. TERM

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

3. SERVICES

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

4. STANDARD OF CARE

Aetna or Customer will discharge their obligations under the Services Agreement with that level of reasonable care which a similarly situated Services provider or Plan Administrator under ERISA, as applicable, would exercise under similar circumstances. In connection with fiduciary powers and duties hereunder, if delegated by Customer to Aetna as noted in the Claim Fiduciary section of the applicable SAS, Aetna shall observe the standard of care and diligence required of a fiduciary under ERISA Section 404(a)(1)(B).

5. FIDUCIARY DUTY

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

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

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

6. SERVICE FEES

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

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

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

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

All overdue amounts shall be subject to the late charges set forth in the Service and Fee Schedule(s).

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

7. TERMINATION

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

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

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

(C) **Aetna Termination** -

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

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

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

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

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

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

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

8. BENEFIT FUNDING

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

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

(A) one (1) year following the date Aetna completes its runoff processing obligations; or

(B) five (5) days following Customer's failure to provide requested funds or pay Service Fees due in accordance with Section 7(C).

9. CUSTOMER'S RESPONSIBILITIES

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

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

Sutter Health and Affiliates, the dominant health system in much of northern California, uses its bargaining power to insist on unique requirements to participate in the Aetna network. Aetna's contract with Sutter requires payment of claims that would otherwise be denied, such as those not medically necessary or experimental or investigational (but does not require payment for services the Plan expressly excludes from coverage, such as for cosmetic surgery). Aetna will charge the Plan for these claims in order to be able to continue providing Plan

Participants with access to Sutter's services on an in-network basis. Consult your SPD text to ensure that the description of Aetna's services accommodates such arrangements.

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

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

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

10. RECORDS

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

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

11. CONFIDENTIALITY

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

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

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

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

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

12. AUDIT RIGHTS

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

Audits must be commenced within two (2) years following the period being audited.

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

Aetna is not responsible for paying Customers' audit fees or the costs associated with the audit. Customer shall pay Aetna fees for any audit which, with Aetna's approval, (i) cannot be completed within a five (5) day period, (ii) contains a sample size in excess of 250 claim transactions (or with respect to a Health Fund audit, 250 Plan

Participant(s)), or (iii) otherwise creates exceptional administrative demands upon Aetna. The Customer represents that it has informed its Plan Participants that Plan Participant Confidential Information may be used in connection with audits.

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

(B) **Auditor Qualifications and Requirements** - Customer will utilize individuals to conduct audits on its behalf who are qualified by appropriate training and experience for such work, and will perform its review in accordance with published administrative safeguards or procedures and applicable law against unauthorized use or disclosure (in the audit report or otherwise) of any individually identifiable information. Customer and such individuals will not make or retain any record of provider negotiated rates included in the audited transactions, or payment identifying information concerning treatment of drug or alcohol abuse, mental/nervous or HIV/AIDS or genetic markers, in connection with any audit. Aetna reserves the right to refuse to allow an auditor to conduct an audit in the event Aetna determines the auditor has a conflict of interest. Determination of the nature of a conflict of interest shall be in the sole discretion of Aetna. A conflict of interest includes (but is not limited to) a situation in which the audit agent (a) is employed by an entity which is a competitor of Aetna; or (b) has terminated from Aetna within the past 12 months; or (c) is affiliated with a vendor subcontracted by Aetna to adjudicate claims. The audit firm in complying with state licensure requirements or professional standards with Auditing professional groups (e.g. American Institute of Certified Public Accountants) will meet Aetna's standard for professionalism. If the audit firm is not licensed, or a member of a national professional group or if audit firm has a financial interest in audit findings or results, the audit agent will agree by signature to Aetna's Code of Conduct in performing the audit.

(C) **Audit Coordination** - Customer will provide reasonable advance notice of its intent to audit and will complete an Audit Request Form providing information reasonably requested by Aetna. Further, Customer or its representative will provide Aetna at least four (4) weeks in advance of the desired audit date, with a complete and accurate listing of the transactions to be pulled for the audit, and with identification of the potential auditor. Notification requirements may exceed four weeks for unusual audit requests, including but not limited to audits involving large sample sizes (e.g., greater than 250 transactions). No audit may commence until the Audit Request Form is completed and executed by the Customer, the auditor, and Aetna.

(D) **Identification of Audit Sample** - The sample must be based on a statistical random sampling methodology (e.g., systematic random sampling, simple random sampling, stratified random sampling). Aetna reserves the right to review and approve the sample size, the objectives of the audit and the sampling methodology proposed by the auditors.

(E) **Closing Meeting** - The auditors will provide their draft audit findings to Aetna, in writing, and auditors shall discuss their draft audit findings with Aetna at this stage of the audit process.

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

13. RECOVERY OF OVERPAYMENTS

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

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

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

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

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

14. INDEMNIFICATION

(A) Aetna shall indemnify and hold harmless Customer, its directors, officers, and employees (acting in the course of their employment, but not as Plan Participants) for that portion of any third party loss, liability, damage, expense, settlement, cost or obligation (including reasonable attorneys' fees but excluding payment of plan benefits) caused solely and directly by Aetna's willful misconduct, criminal conduct, breach of the Services Agreement (including, without limitation, Appendix III), fraud, breach of fiduciary responsibility, failure to comply with Section 4 above or infringement of any U.S. patent, copyright, trademark or other intellectual property right of a third party, related to or arising out of the Services provided under the Services Agreement.

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

(C) The party seeking indemnification under (A) or (B) above must notify the indemnifying party within 20 days in writing of any actual or threatened action, suit or proceeding to which it claims such indemnification applies. Failure to so notify the indemnifying party shall not be deemed a waiver of the right to seek indemnification, unless the actions of the indemnifying party have been prejudiced by the failure of the other party to provide notice within the required time period.

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

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

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

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

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

15. DEFENSE OF CLAIM LITIGATION

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

16. REMEDIES

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

17. BINDING ARBITRATION OF CERTAIN DISPUTES

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

18. NON-AETNA NETWORKS

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

1) Aetna does not credential, monitor or oversee the providers or the administrative procedures or practices of any non-Aetna networks;

2) No particular discounts may, in fact, be provided or made available by any particular providers;

3) Such providers may not necessarily be available, accessible or convenient;

4) Any performance guarantees appearing in the Services Agreement shall not apply to services delivered by non-Aetna providers or networks;

5) Neither non-Aetna providers nor non-Aetna networks are to be considered contractors or subcontractors of Aetna; and

6) Such providers are providers in private practice, are neither agents nor employees of Aetna, and are solely responsible for the health care services they deliver.

Customer further agrees that, if Aetna subsequently establishes its own contracted provider network in a geographic area where services are being provided by a non-Aetna network, Aetna may terminate the non-Aetna network contract, and begin providing services through a network that is subject to the terms and provisions of the Services Agreement. Customer acknowledges that such conversion may cause disruption, including the possibility that a particular provider in a non-Aetna network may not be included in the replacement network.

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

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

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

20. GENERAL

(A) **Relationship of the Parties** - It is understood and agreed that Aetna is an agent with respect to claim payments and an independent contractor with respect to all other Services being performed pursuant to the Services Agreement. Aetna makes no guarantee and disclaims any obligation to make any specific health care providers or any particular number of health care providers available for use by Plan Participants or that any level of discounts or savings will be afforded to or realized by Customer, the Plan or Plan Participants.

(B) **Subcontractors** - The work to be performed by Aetna under the Services Agreement may, at its discretion, be performed directly by it or wholly or in any part through a subsidiary, an affiliate, or under a contract with an organization of its choosing. Aetna will remain liable for Services under the Services Agreement. Upon request, Aetna shall provide a written list of Tier 1 subcontractors. Tier 1 subcontractors are defined as a subset of Aetna suppliers for whom a portion of the Services provided may include direct member contact or significant access to Plan Participant-identifiable data. Not all Aetna suppliers on the list provided are utilized in providing services to all customers or plan participants. Aetna shall make an updated Tier 1 Subcontractor list available to Customer, for informational purposes, as requested by Customer but no more frequently than once annually during the term of the Services Agreement. For the avoidance of doubt, neither Aetna's obligation to provide, nor Customer's right to receive, a Tier 1 Subcontractor list under this paragraph shall constitute a right of Customer to pre-approve any Aetna subcontractor or a right to require Aetna to terminate any agreements (or services under any agreements) with any Aetna supplier.

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

(D) **Communications** - Aetna and Customer shall be entitled to rely upon any communication believed by them to be genuine and to have been signed or presented by the proper party or parties.

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

Address: ***SAMPLE***
SAMPLE

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

(F) **Health Care Reform** - The Patient Protection and Affordable Care Act of 2010 contains provisions that may have a material effect on Customer's benefit Plans. Many of these provisions are subject to further clarification through rulemaking which has not been completed, and may be modified by subsequent legislative or judicial action. Customer is advised to seek its own legal counsel concerning the effect of the Act on Customer's Plans. Aetna reserves the right to modify its products, services, rates and fees, in response to legislation, regulation or

requests of government authorities resulting in material changes to plan benefits and to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

(G) **Miscellaneous** - The Services Agreement shall be governed by and interpreted in accordance with applicable federal law, including but not limited to ERISA. To the extent such federal law does not govern, the Services Agreement shall be governed by Connecticut law and the courts in such state shall have sole and exclusive jurisdiction of any dispute related hereto or arising hereunder. No delay or failure of either party in exercising any right hereunder shall be deemed to constitute a waiver of that right. There are no intended third party beneficiaries of the Services Agreement. This Section and Sections 3 through 13 and 15 through 17 shall survive termination of the Services Agreement. The provisions of Section 14 shall survive termination only to the extent stated therein. The headings in the Services Agreement are for reference only and shall not affect the interpretation or construction of the Services Agreement. This Services Agreement (including incorporated attachments) constitutes the complete and exclusive contract between the parties and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein. No modification or amendment of this Services Agreement shall be valid unless in a writing signed by a duly authorized representative of Aetna and a duly authorized representative of Customer. By executing this Services Agreement, Customer acknowledges and agrees that it has reviewed all terms and conditions incorporated into this Services Agreement and intends to be legally bound by the same. The parties incorporate the recitals (set forth in Section 1 of this Master Services Agreement) into this Services Agreement as representations of fact to each other.

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

CUSTOMER

SAMPLE

By: _____

Name: _____

Title: _____

Date: _____

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

By: _____

Mark T. Bertolini

Chairman, Chief Executive Officer and President

Date: *SAMPLE*

Financial Verification

_____

SELF FUNDED MEDICAL PLAN
STATEMENT OF AVAILABLE SERVICES – PPO BASED PRODUCTS
EFFECTIVE *SAMPLE*
MASTER SERVICES AGREEMENT No. MSA-*SAMPLE*

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

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

II. Claim Fiduciary

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

III. Administration Services:

A. Member and Claim Services:

1. Requests for Plan benefit payments for claims shall be made to Aetna on forms or other appropriate means approved by Aetna. Such forms (or other appropriate means) may include a consent to the release of medical, claims, and administrative records and information to Aetna. Aetna will process and pay the claims for Plan benefits incurred on or after the Effective Date using Aetna's normal claim determination, payment and audit procedures and applicable cost control standards in a manner consistent with the terms of the Plan and the Services Agreement. With respect to any Plan Participant who makes a request for Plan benefits which is denied on behalf of Customer, Aetna will notify said Plan Participant of the denial and of said Plan Participant's right of review of the denial in accordance with ERISA.

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

3. Where the Plan contains a coordination of benefits clause or antiduplication clause, Aetna will administer all claims consistent with such provisions and any information concurrently in its possession as to duplicate or primary coverage. Aetna shall have no obligation to recover sums owed to the Plan by virtue of the Plan's rights to coordinate where the claim was incurred prior to the Effective Date. Aetna has no obligation to bring actions based on subrogation or lien rights, unless Subrogation Services are included herein, in which event its obligations are governed by Article VI of this Statement of Available Services.

B. Plan Sponsor Services:

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

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

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

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

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

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

      (iii) a monthly listing of paid benefits; and

      (iv) online access to monthly, quarterly and annual standard claim analysis reports.

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

      (i) forecast of claim costs;

      (ii) accounting of experience; and

      (iii) calculation of Customer reserve.

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

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

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

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

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

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

9. Aetna will provide assistance in connection with the initial set up, design and preparation of Customer's Plan and if requested, [and at Customer's expense] the preparation of draft Summaries of

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

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

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

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

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

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

IV. Aetna Health Connections℠ Services:

1. Utilization Management Inpatient and Outpatient Precertification:

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

Outpatient Precertification (not applicable to Indemnity or PPO Products): A process for reviewing selected ambulatory procedures, surgeries, diagnostic tests, home health care and durable medical equipment. The goals of this process (which may vary based on the requirements of any Aexcel® Product(s) elected) are:

- Assessment of the level and quality of the services provided;
- Determination of the coverage of the proposed treatment;
- Identification of care and treatment alternatives, when appropriate; and
- Identification of Plan Participants for referral to specialized programs.

2. Utilization Management Concurrent Review:

- Concurrent review encompasses those aspects of patient management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.
- Inpatient concurrent review is conducted telephonically or on-site at the facility where care is delivered.
- The concurrent review process includes:
  - Obtaining necessary information from practitioners and providers regarding the care being provided to Plan Participants;
  - Assessing the clinical condition of Plan Participants and the ongoing provision of medical services and treatments to determine benefit coverage;

- Notifying practitioners and providers of coverage determinations in the appropriate manner and within the appropriate timeframe;
- Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting; and
- Identifying Plan Participants for referral to covered specialty programs such as Case Management, Behavioral Health and Disease Management.

3. Utilization Management Discharge Planning:

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

4. Utilization Management Retrospective Review:

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

5. Case Management Program:

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

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

Aetna operates two types of case management programs:

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

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

6. Infertility Case Management:

Aetna operates two types of infertility programs:

- Basic Infertility Program coordinates covered diagnostic services and treatment of the underlying medical causes of infertility, helps Plan Participants understand complex infertility treatments and helps control treatment costs through care coordination and patient education.

- Infertility Case Management Program provides education and information resources for Plan Participants who are experiencing infertility. Depending on the plan selected, the program may guide eligible Plan Participants to a select network of infertility providers for covered or non-covered services. If the services are covered, Aetna's Infertility Case Management Unit issues any appropriate authorizations required under the Plan.

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

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

The Aetna Institutes of Excellence (IOE) transplant network was established to enhance quality standards and lower the cost of transplant care for Plan Participants. It is made up of a select group of hospitals and transplant centers that meet quality standards for the number of transplants performed and their outcomes, as well as access criteria for Plan Participants. IOE facilities have agreed to specific contractual terms and conditions and are selected and recognized by transplant type. The following criteria are applied to each facility prior to being selected for the IOE network:

- Quality – enhanced organ-specific credentialing and quality standards;

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

- Cost – provider contracts reflect lower negotiated rates.

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

Facilities selected for the network met the following criteria:

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

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

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

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

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

8. MedQuery℠

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

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

9. Aetna Health Connections℠ Disease Management:

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

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

10. Beginning Right® Maternity Program:

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

11. Informed Health® Line:

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

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

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

B. **Service Plus.** This includes the following components:

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

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

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

12. **Wellness Counseling:**

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

13. **Healthy Body. Healthy Weight℠:**

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

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

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

14. **Onsite Health Screening Services:**

Aetna's Onsite Health Screening Services help employers engage and educate their employees about wellness at the workplace. These offerings provide turnkey solutions to support employers' overall wellness strategies, increase consumerism and promote informed-decision making. Offerings include:

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

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

15. **Simple Steps To A Healthier Life®:**

Aetna has developed an internet-based comprehensive management information resource, known as "Simple Steps To A Healthier Life" (the "Life Program") and located at www.aetna.com, to be hosted by Aetna and designed for the eligible employees and dependants of subscribing employers (the "Users"). The Life Program is an online service that offers advice relating to disease prevention, condition education, behavior modification and health promotion programs that may contribute to the health and productivity of employees. The Life Program allows Users to create a health assessment profile that generates personalized health reports. Upon completion of the health assessment, Users also have access to an action plan with links to personalized online wellness programs (offered through HealthMedia, Inc.)

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

16. **Personal Health Record:**

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

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

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

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

17. Focused Psychiatric Review (FPR):

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

18. Managed Behavioral Health:

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

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

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

19. Intensive Case Management (Behavioral Health):

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

20. Medical Psychiatric Case Management:

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

21. Depression Disease Management:

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

22. Anxiety Disease Management:

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

23. Alcohol Disease Management:

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

24. Healthy Lifestyle Coaching Tobacco Free:

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

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

• Group coaching support – Led by a health coach and offered in an online/"live-meeting" type of environment for a group of 15 participants with similar focus/goals. These goals may include:

- Eliminating tobacco usage.
- Achieving overall health goals.
- Making positive lifestyle changes.
- Reducing health risk factors.
- Reducing stress.

Additionally, participants can receive peer-to-peer support through our clinically moderated online communities. Each community or online network has a different health focus. Participants may join one, or many, depending on their interests. **25. Healthy Lifestyle Coaching:**

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

26. Enhanced Clinical Review:

The radiology program is to promote the most appropriate and effective use of outpatient diagnostic imaging services and procedures. Aetna will maintain broad and national or regional access and experience interacting with free-standing radiology and/or outpatient network facilities which include the following services: Computed Tomography/Coronary Computed Tomography Angiograph (CT/CTA), Magnetic Resonance Tomography, Magnetic Resonance Angiography (MRIs/MRAs), Nuclear Medicine and Positron Emission Tomography (PET) and/or PET/CT Fusion, Stress Echocardiography (Stress Echo), and Diagnostic Cardiac Catherization, Sleep Studies and Cardiac Rhythm Implantable procedures (Pacemakers, Implantable Cardioverter-Defibrillators, and Cardiac Resynchronization Therapy). The Enhanced Clinical Review program will be administered by Aetna vendors through a clinical prior authorization process. This program should result in the following benefits:

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

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

27. Flexible Medical Model

This program provides the Customer with the option to purchase more clinical resources devoted specifically to their Plan Participant. The Flex Model provides a Single Point of Contact Nurse (SPOC Nurse) and designated team to handle all case management activities for three levels of Flex Model Options, as elected. Aetna will engage in outbound Plan Participant outreach calls to provide case management support based on specific criteria.

For Customers who elect Flex Option 1 only

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

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

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

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

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

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

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

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

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

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

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

28. Aetna Compassionate Care℠ Program ("ACCP")

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

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

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

ACCP Enhanced Hospice Benefits Package
The enhanced hospice benefits package includes the following:

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

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

29. Dedicated Units, Designated Units and Care Advocate Teams
These services were created to help coordinate care, support and resources for Plan Participants under one Care Unit.

- Aetna's Dedicated Unit provides centralized care management services for pre-certification, utilization management and Case Management.
- Aetna's Designated Unit is a unit team that provides centralized care management services for pre-certification, utilization management, and Case Management for a specific set of Customers, and
- Aetna's Care Advocate Team has customized workflows based on Customer needs, vendor integration, specialized outreach, and program integration. The Care Advocate Team will:
  - Help the Plan Participant understand their doctor's diagnosis and treatment plan
  - Coordinate care across all Aetna programs to allow the Plan Participant to get what they need from Aetna,
  - Help the Plan Participant decide what questions to ask the doctor or health care provider,
  - Introduce the Plan Participant to a disability specialist if they need to file a disability claim
  - Support the Plan Participant throughout their treatment and recovery by making follow-up calls and helping them get the support they need, and
  - Suggest other Aetna health and wellness programs that can help.

30. Aetna Health Connections Get Active! SM Program

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

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

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

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

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

31. Aetna Benefits Advisor

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

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

32. Member Health Engagement Plan ("MHEP")

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

MHEP features include:

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

- A Progress Bar added to the "My Health Activities" page, which visually shows the percentage of completed "to-do" list tasks. The Progress Bar is updated when evidence of action is collected from lab data, pharmacy claim data, medical claims data, or self-reported data.

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

33. Mind-Body Stress Reduction Programs:

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

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

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

Customer can choose between the following options:

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

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

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

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

Program includes:

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

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

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

Program features include:

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

34. Aetna Concierge:

Aetna Concierge is a level of customer service that provides a dedicated team of Aetna Concierges to support the delivery of high-touch, tailored service for Customers. Beyond the normal high-level of customer service Aetna provides, the dedicated Aetna Concierges will obtain Customer-specific training in order to serve as a single point of contact across the full-spectrum of plan and benefit offerings available to Plan Participants. Aetna Concierges also receive additional training emphasizing consultative soft-skills that support a more personalized approach

when providing service to Plan Participants. The dedicated team provided by Aetna Concierge is staffed with more customer service representatives than Aetna's traditional Customer Service Model, without call handle time guidelines, thereby allowing for longer, more relevant Plan Participant interactions. Aetna Concierges use their skills and training to listen for opportunities to educate and empower Plan Participants by sharing key insights, providing useful information, and offering guidance through the use of Aetna tools and resources so that Plan Participants become more informed health care consumers. The dedicated Aetna Concierge team serves as a single point of contact across the full-spectrum of available benefits and programs offered by a Customer, even if they are external to Aetna. The Aetna Concierge teams are trained on Customer-specific offerings so that they can facilitate person to person transfers of Plan Participants to external vendors and benefit carriers, creating a simplified Plan Participant experience and reducing the fragmentation that accompanies multiple benefit programs with multiple benefit carriers and vendors.
Additionally, there is an added emphasis on adult learning and motivational interviewing to drive positive behavior modifications that will support improved health care consumerism as it relates to the Customer-specific benefits and population health goals and strategies. This training is delivered within the context of Customer-specific cultural training to ensure a tailored, personalized Plan Participant experience. Because Aetna Concierge provides a dedicated team, individual Aetna Concierges will serve as an extension of the Customer benefits team, and as an available single point of contact for Plan Participants via a dedicated, toll-free 800-number, as well as via live web chat through Aetna Navigator®.

35. Aetna FitnessSM Reimbursement Program:

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

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

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

36. Metabolic Health in Small Bytes:

Available to Plan Participants and other eligible employees, as determined by Customer, not otherwise covered under Products provided under this Services Agreement ("Employee"). Metabolic Health in Small Bytes is an innovative program, supporting metabolic syndrome risk reduction and reversal. Obesity is the greatest risk factor for developing Metabolic Syndrome. This program targets the root cause of obesity by using a holistic approach (mental, emotional, and physiological) to help Employees identify underlying reasons for their weight and what barriers may exist which impede weight loss. This program was created through a collaborative effort with Aetna, Duke Diet and Fitness, Duke Integrative Medicine and eMindful.

Metabolic Health in Small Bytes uses a virtual online classroom setting, conducted via the Internet in real time. Employees need a PC with Internet access to participate. Employees engage via streaming video and can hear, speak to and interact with both the live expert instructor as well as other class participants.

Customer can choose between the following options:

Weekly option:

- A more intensive offering

- Best suited for employees with three or more metabolic syndrome risk factors, but also beneficial for employees with one or more risk factor.
- Class meets one hour per week for twenty weeks, same time and day each week.

Monthly option:

- Features consecutive monthly classes covering similar materials and curriculums as the weekly option.
- Participant attends one class a month for twelve months. Class is one hour.
- This option is best suited for a plan sponsor's full population, regardless of metabolic syndrome risk factors*

Combined option:

- Includes both the weekly class for individuals needing the more intensive sessions and the monthly program (12-month total) for those with low metabolic syndrome risks*.

Metabolic Health in Small Bytes is available to an employer's employees (both Aetna medical and non-medical) and their spouses and adult dependents (18 and over). Additionally, there is capability for incentive tracking, integrated with Aetna's incentive management system, for a participant's program completion.

*There are pre-set measurement thresholds for determining appropriate course assignments.

V. **Network Access Services:**

A. Aetna shall provide Plan Participants with access to Aetna's network hospitals, physicians and other health care providers ("Network Providers") who have agreed to provide services at agreed upon rates and who are participating in the Network covering the Plan Participants (which, for any Aexcel product(s) elected, may be subject to further criteria depending on the Product model).

B. When a claim is submitted for services incurred after the Effective Date, covered by the Plan, and performed by a Network Provider, Aetna will issue a payment on behalf of Customer for those services in an amount determined in accordance with the Aetna contract with the Network Provider and the Plan benefits. Retroactive adjustments are occasionally made to Aetna's contract rates (e.g., because the federal government does not issue cost of living data in sufficient time for an adjustment to be made on a timely basis, or because contract negotiations were not completed by the end of the prior price period or due to contract dispute settlements). In all cases, Aetna shall adjust Customer's payments accordingly. Customer's liability for all such adjustments shall survive the termination of this Services Agreement.

C. In addition to standard fee-for-services rates, contracted rates with network providers may also be based on case rates, per diems and in some circumstances, include performance-based contract arrangements, risk-adjustment mechanisms, quality incentives, pay-for-performance and other incentive and adjustment mechanisms. These mechanisms may include payments to physicians, physician groups, health systems and other provider organizations, including but not limited to organizations that may refer to themselves as accountable care organizations and patient-centered medical homes, in the form of periodic payments and incentive arrangements based on performance. Such payments may be more specifically described in an addendum to this Services Agreement, or made available upon request of Customer.

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

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

VI. Subrogation Services:

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

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

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

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

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

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

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

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

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

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

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

VIII. Performance Guarantees

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

IX. Fees

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