ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT

THIS ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT, (this "Addendum"), entered into effective as of January 1, 2021 (the "Addendum Effective Date"), is made by and between **RxBenefits, Inc**. ("Administrator"), and **Indian River County Board of County Commissioners** ("Client"). The parties, intending to be legally bound, hereby agree as follows:

1. Administrator and Client are parties to that certain Administrative Services Agreement dated May 1, 2018 (the "Agreement").

2. Administrator and Client hereby execute this Addendum for the purpose of documenting that Exhibit A (Client Application) to the Agreement has been amended and restated to reflect, among other things, new pricing terms. Such amended and restated Exhibit A (Client Application) shall be attached and affixed to the Agreement as Exhibit A (Client Application) in lieu of the prior Exhibit A (Client Application) upon execution of this Addendum by the parties' authorized representatives below and shall be in full force and effect as said Exhibit A from and after the Addendum Effective Date.

3. Except for the amendment and restatement of Exhibit A (Client Application) effected hereby, the Agreement shall not otherwise be modified, altered or amended in any respect and is hereby ratified and incorporated herein.

IN WITNESS WHEREOF, the undersigned parties have entered into and executed this Addendum effective as of the Addendum Effective Date.

EXHIBIT A

CLIENT APPLICATION

January 1, 2021

[IMPORTANT – PLEASE READ CAREFULLY: Client should complete Section A and carefully review this Exhibit A, which has been completed by Administrator, in order to ensure the accuracy and completeness of such information. Client shall promptly notify Administrator of any inaccuracy or omission with respect to such terms and conditions, if applicable (including, without limitation, the Client Information in Section A).]

A. INFORMATION ABOUT CLIENT

Client's Name: Indian River County Board of County Commissioners

Client's Mail Address: 1801 27th Street, Vero Beach, Florida 32960-3365

B. PLAN DESIGN; MEMBER COST SHARE

Member Cost Share:

Please see current Summary of Benefits.

Client represents and warrants that the design of Client's Plan as reflected in a Plan design document for Client ("PDD"), accurately reflects the applicable terms of Client's Plan for purposes of this Agreement. Client shall provide Administrator with ninety (90) days prior written notice of any proposed changes to the design of Client's Plan (including the PDD), which changes shall be consistent with the scope and nature of the services to be provided by Administrator under this Agreement. Client agrees that it is responsible for Losses resulting from (a) any failure to implement Plan design changes which are not communicated in writing to Administrator, or (b) implementation of verbal or written direction regarding exception or overrides to the PDD. In addition, Client shall notify Members of any Plan design changes prior to the effective date of any such changes as required by applicable law.

C. SERVICES; FORMULARY.

1. Base Administrative Services: The following services are the base administrative services made available to Client and its Members pursuant to the Agreement (including this Exhibit A) (the "Base Administrative Services"), as applicable:

- Administration of eligibility submitted via tape or telecommunication
- Eligibility maintenance
- Client support system for on-line access to current eligibility
- Administration of Client's Plan Design
- In-network claims adjudication via on-line claims adjudication system
- Designated Account Team
- Client clinical and plan consulting, analysis and cost projections
- Annual analysis of program utilization and impact of plan design and managed care interventions
- Welcome Package and ID Cards for new Members
- Standard Member communications
- Toll-free telephone access to customer service for the program for use by Members and Client's benefits personnel and representatives

2. **Additional Administrative Services:** Client will pay for additional administrative services (the "Additional Administrative Services") beyond those included in the Base Administrative Services that are requested by Client and provided or made available by Administrator under the program as follows:

2.1 Administrative Fees

Administrative Services	**Fees**
Transaction Fees Payable for Administrative Services (per Article IV.B of the Agreement)	**$0.65 per Prescription Drug Claim** made by Members payable on a bi-monthly basis
Transaction Fees Payable for Administrator's Clinical Advantage Program (individual prices listed in table below)	**$1.45 per claim**
Manufacturer Copay Assistance Programs	**Fees**
• Out of Pocket Protection (Accumulation)	Not Elected
• Out of Pocket Protection + Variable Copay Assistance Program	Not Elected
• SaveOnSP	Not Elected
• Out of Pocket Protection + SaveOnSP	**$0.40 per claim** (Elected)
Reviews and Appeals Management	
• Low Clinical Value Exclusions (LCV)	**$0.30 per claim** (Elected)
• High Dollar Claim Review (HDCR)	**$0.75 per claim** (Elected)
Initial Determinations (i.e. coverage reviews) and Level One Non-Urgent Appeals for the Coverage Authorization Program, consisting of: Prior Authorization Step Therapy Drug Quantity Management	Included in the existing utilization management PMPM charge **OR** Included in the existing PA charge of $55 per initial determination* **OR** **No Charge if Client elects HDCR**
Initial Determinations and Level One Non-Urgent Appeals for benefit reviews. Examples: copay review, plan excluded drug coverage review, administrative plan design review.	$55 per initial determination **OR** **No Charge if Client elects HDCR**
Final and Binding Appeals – Level Two Appeals and/or Urgent Appeals for UM, formulary, and benefit reviews.	$10.00 per review***** **OR** **No Charge if Client elects HDCR**
External Reviews by Independent Review Organizations - for non-grandfathered plans	$800 per review **OR** **No Charge if Client elects HDCR**
Miscellaneous	
Third Party Integration Fees	Charges passed through from provider or mutually agreed upon by Parties

The following terms and conditions apply only if client does not elect HDCR:

- Initial determination – this is the first review of drug coverage based on the plan's conditions of coverage. Initial determinations are also referred to as initial reviews, coverage reviews, prior authorization reviews, UM reviews, or benefit reviews.
- The Level 2 and Urgent Appeal Service is an optional service for Clients to enroll in and there is an incremental fee of $10 per initial determination.
- Level 2 and Urgent Appeals are not included in the UM package fees.
- The Level 2 and Urgent Appeal Service fee is not charged per appeal. It is charged for each initial review. This allows Client to better estimate their appeal costs since it is based on the number of

initial determinations. The fees cover the legal and operational costs involved with handling final and binding appeal reviews, which includes, but is not limited to the following: staffing of clinical professionals and supportive personnel, notifications to patients and prescribers, and maintaining a process aligned with state and Federal regulations.

- Charges for the Level 2 and Urgent Appeal Service are billed on the monthly admin invoice for completed initial determination for UM, formulary, and benefit reviews. No subsequent charges are incurred when cases are appealed.
- Appeals can be deemed urgent at Level 1 or Level 2. Urgent appeal decisions are final and binding. If a Level 1 Appeal is processed as urgent, there is no Level 2 appeal.

PBM Services	**Fees**
Advanced Utilization Management (AUM Bundle)	**$0.46 / PMPM** or Passed through from PBM
Member-submitted paper claims processing fee Medicaid or Medicare subrogation claims fee	$3.00 per claim $3.00 per claim
Opioid Program	$0.32 / PMPM (If Elected)
ACA Statin "Trend Management" Program	$0.03 / PMPM (If Elected)
Combined Benefit Management	
Services to manage combined medical-pharmacy benefits that are not a consumer-directed health (CDH) plan. Services include ongoing management of the data exchange platform with the medical vendor/TPA, production monitoring and quality control, and designated operations team. Combined benefit types may include deductible, out of pocket, spending account, and lifetime maximum.	$0.10 PMPM per combined accumulator up to maximum of $0.20 PMPM for existing connection with medical carrier or TPA. Fees to establish connection with new medical carrier or TPA are quoted upon request.
Network Pharmacy Services	
Network Pharmacy Audit Program	20% of audit recoveries

Comprehensive Consumer Driven Health (CDH) Solution	
<u>Technical</u> Bi-directional data exchange; dedicated operations; 24-hour a day, seven-days a week monitoring and quality control; performance reporting; and analytics <u>Decision Support</u> Dedicated CDH member services, Prescription Benefit Review Statements, Retail Pricing Transparency <u>Member Adherence</u> ScreenRx Preventive Medications <u>Member Education</u> Proactive, personalized member communications open enrollment tools and member communications library, robust online features, and preventive care proactive, personalized member communications	$0.48 PMPM *these charges would be in addition to any pricing adjustments if greater than ten percent of Client's total utilization for all Plans is attributable to a CDHC.
ScreenRx for PPO Plans	$0.25 PMPM (If Elected)
Medicare Part D – Retiree Drug Subsidy (RDS)	

Part D subsidy enhanced service (ESI sends reports to CMS on behalf of Client) (i) Notice of Creditable Coverage	$1.12 PMPM for Medicare-qualified Members with a minimum annual fee of $7,500 $1.35/letter + postage
Part D Subsidy standard service (ESI sends reports to Client) A. Notice of Creditable Coverage	$0.62 PMPM for Medicare-qualified Members with a minimum annual fee of $5,000 $1.35/letter + postage
Communication with physicians and/or members (e.g., program descriptions, notifications, formulary compliance, non-Medicare EOBs, etc.	$1.75/letter + postage
Medicare EOB	$1.75/letter + postage
Custom non-standard materials	Priced upon Request
Electronic Pharmacy Benefit Eligibility Verification	
Eligibility confirmation of pharmacy benefit coverage shared with prescribers and other healthcare professionals through their Electronic Medical Records (EMR) or other digital channels. Pass-through charge to Sponsor at ESI's preferred rate with data switch such as Surescripts.	
Miscellaneous	
Coordination of Benefits - Custom reimbursement formula - Setup and ongoing maintenance - Product support	$0.01 PMPM, If Elected
Formulary Services Fee - High Performance Formulary	$10,000 Implementation Fee + $0.05 PMPM, If Elected
Medicare Part B Solution - Integrated Retail & Mail Program - Retail Only Program - Program Introductory Letter	 - $0.42 PMPM - $0.20 PMPM - $1.35/letter + postage

PBM Services – No Additional Fee	
Customer service for Members	Electronic claims processing
Electronic/on-line eligibility submission	Plan setup
Standard coordination of benefits (COB) (reject for primary carrier)	Software training for access to our on-line system(s)
FSA eligibility feeds	
A. Network Pharmacy Services	
Pharmacy help desk	Pharmacy reimbursement
Pharmacy network management	Network development (upon request)
B. Home Delivery Services	
Benefit education	Prescription delivery – standard
Reporting Services	
Web-based client reporting –	Annual Strategic Account Plan report
Ad-hoc desktop parametric reports	Billing reports
Claims detail extract file electronic (NCPDP format)	Inquiry access to claims processing system
Load 12 months claims history for clinical reports and reporting	
Website Services	
Express-Scripts.com for Members — access to benefit, drug, health and wellness information; prescription ordering capability; and customer service	
Implementation Package and Member Communications	
• New Member packets (includes two standard resin ID cards) • Member replacement cards printed via web (For hard-copy cards, charges are passed through from the PBM)	
• Member-requested replacement packets or Client requested re-carding	$1.50 + postage per packet or card
Clinical	
Concurrent Drug Utilization Review (DUR) Overrides a. Sponsor-requested overrides b. Lost/stolen overrides c. Vacation supplies	No Charge

C.

2.2 Administrator Clinical Programs

- If elected, the ***Low Clinical Value ("LCV")*** exclusion option prevents unnecessary spending by removing LCV medications from the formulary without impact to client rebates while providing equal or more effective medicines at a lower cost. LCV medications are drugs that treat common conditions that do not provide any additional or superior therapeutic value when compared to currently existing therapies already in the marketplace. These medications are excluded in addition to any products that would normally be excluded by PBM Formulary. This exclusion occurs without affecting rebate minimum guarantees or contracted discount rates. Administrator reserves the right to amend, from time to time, the list of low clinical value medications. The list of low clinical value medications may be updated quarterly. Client may request a current list of LCV medications.

- If elected, Administrator's **High Dollar Claim Review, Prior Authorization and Appeals program ("HDCR")**, will provide Client with umbrella protection against high-cost prescription claims for approved

formulary drugs. Prescription claims over the threshold dollar amount are flagged prior to payment and reviewed for clinical appropriateness. This additional level of clinical oversight protects against unnecessary spending, saving clients money and providing improved visibility into claim reviews, decision processes, and cost savings.

- The following may apply to HDCR:
  - RxBenefits manages the clinical review process for high dollar claims, providing oversight of the process. We communicate trends and savings results to clients through detailed reporting and analytics;
  - Review turnaround time is dependent on prescriber activity and whether additional information is required. If additional information is required, the reviewer will attempt to contact physician at least once daily for three days; direct contact with the prescriber will discontinue after the third day. The majority of reviews are completed with a disposition within 24 to 72 hours;
  - Following a clinical review, one of four actions will occur: the medication is ***approved***, the medication claim is ***denied***, the doctor may decide to ***withdraw*** and prescribe a different medication, or the reviewer can ***dismiss*** the claim due to lack of communication from the prescriber;
  - If denied, the appeal process is available.
- If HDCR is elected, the Administrator will also manage all other Prior Authorizations and Appeals.
  - Following a clinical review, one of four actions will occur: the medication is ***approved***, the medication claim is ***denied***, the doctor may decide to ***withdraw*** and prescribe a different medication, or the reviewer can ***dismiss*** the claim due to lack of communication from the prescriber;
  - If denied, the appeal process is available.
- The appeal process:
  - If an initial review is ***denied***, the Member may appeal the decision to have a different pharmacist reviewer evaluate the prior authorization.
  - If the ***denial is upheld*** upon first appeal, a second appeal may be made, which is completed in consultation with a peer physician reviewer from an Independent Review Organization.
  - If the ***denial is again upheld*** upon second appeal, a final appeal for a Federal External Review completed by an Independent Review Organization may be made.
  - If the ***denial is upheld*** by the final review, the appeal process has been exhausted and the decision is final and binding.

- ***Foundational Utilization Management ("UM").*** UM is a bundling of evidence-based clinical programs commonly used to provide appropriate clinical oversight of prescription drug claims. UM ensures the correct clinical evaluation processes are in place. Appropriate quantity limit ("QL") promotes FDA-approved dispensing guidelines by ensuring appropriate quantities are dispense. Step Therapy ("ST") ensures the most clinically appropriate item is used first as part of adhering to accepted guidelines. When faced with two similar agents, the lowest cost option is promoted first. Prior Authorizations ("PA") ensure FDA-approved guidelines with respect to indications are being met. Utilizing the PBM or customized criteria, RxBenefits has carved out the QL/ST exception review process as well as all specialty and non-specialty PA reviews to be independently reviewed and documented utilizing a documentation system that allows for ease of auditing through increased visibility of clinical decisions. This component requires that a client elect a standard Utilization Management Programs promoted by Administrator. NOTE: Client must have HDCR component in place to elect UM. The following may apply:
  - Review turnaround time is dependent on prescriber activity and whether additional information is required. If additional information is required, the reviewer will attempt to contact physician at least once daily for three days; direct contact with the prescriber will discontinue after the third day. The majority of reviews are completed with a disposition within 24 to 72 hours.;

- Following a clinical review, one of four actions will occur: the medication is ***approved***, the medication claim is ***denied***, the doctor may decide to ***withdraw*** and prescribe a different medication, or the reviewer can ***dismiss*** the claim due to lack of communication from the prescriber; or
- If denied, an appeal process is available.

- If elected, PBM's ***Manufacturer Assistance Program for Specialty Medications ("MAP")***, consists of 1 or 2 components when available, dependent on the specific plan design: (1) Accumulator Protection using Manufacturer Copay assistance dollars to help lower member out-of-pocket costs and client costs where funds are not applied to member deductible and member out-of-pocket maximum totals; and (2) Accumulator Protection Plus Variable Cost-Share, where plan changes can maximize available assistance funds to offset plan costs and cover the members' cost-share but does not apply to their deductible and out-of-pocket maximum, yielding high savings potential, or Therapeutic Interchange Programs where the specialty pharmacy will move members to preferred agents in order to allow the usage of copay assistance funds from manufacturers. Requires exclusive specialty pharmacy relationship.
  - If elected, the **SaveOnSP** program is a benefit design change implemented by PBM in conjunction with a third-party vendor, SaveOnSP. Within the SaveOnSP program, certain specialty medications are classified as non-essential health benefits. This means that any funds spent on these drugs no longer apply to the members' accumulators. In addition, the targeted drugs are assigned higher copays. In all cases, SaveonSP helps the member coordinate manufacturer-sponsored copay assistance. SaveOnSP targets drugs in six of the top ten specialty categories.
- If elected, PBM's **Advanced Opioid Management℠ program** reaches out to physicians, pharmacists and patients at key touchpoints to minimize early exposure to opioids and to prevent patients from progressing to overuse and abuse. Patients will be required to start therapy with no more than a 7-day supply of short-acting medications (with certain exceptions). Member Education will start at the first fill. Doctors will be notified at the point of care when specific signs of misuse and abuse are observed.

3. **Pricing Terms.** The financial terms set forth are conditioned on such exclusive arrangement and all other specified conditions set forth in Exhibit A of the Agreement. Client will pay to Administrator the amounts set forth below, net of applicable Copayments. The application of Brand Drug and Generic Drug pricing below may be subject to certain "dispensed as written" (DAW) protocols and Client defined plan design and coverage policies for adjudication and Member Copayment purposes. Sales or excise tax or other governmental surcharge, if any, will be the responsibility of Client.

Members will always pay based on the logic below:

- Retail: Lowest of (i) the U&C price, (ii) Plan copayments/coinsurance, or (iii) discounted AWP (including MAC price, when MAC pricing is applicable).

- Mail Order: Lower of (i) Plan copayments/coinsurance or (ii) discounted AWP (including MAC price, when MAC pricing is applicable).

- If no adjudication rates are specified herein, each claim will be adjudicated to Client at the applicable ingredient cost and will be reconciled to the applicable guarantee as set forth herein. The discounted ingredient cost will be the lesser of MAC (as applicable), U&C or the applicable AWP discount. Claims dispensed at ESI Mail Pharmacy will be adjudicated to Client at the applicable ingredient cost and will be reconciled to the applicable guarantee as set forth herein.

3.1 Pricing.

(a) Ingredient Cost. Administrator will offer an average aggregate annual discount as reflected below on Client utilization to be calculated as follows. The pricing below will be implemented as of the Addendum Effective Date. The pricing below will be guaranteed upon the start of Client's Renewal

Term (as described in Article VI(A) of the Agreement) that begins on or after the Addendum Effective Date.

[1-(total discounted AWP ingredient cost (including any retrospective pharmacy payments) but excluding dispensing fees and ancillary charges, and prior to application of Copayments) of applicable Prescription Drug Claims for the annual period divided by total undiscounted AWP ingredient cost (both amounts will be calculated as of the date of adjudication) for the annual period)]. Discounted ingredient cost will be the lesser of MAC (as applicable), U&C or AWP discount.

Notwithstanding anything herein to the contrary: (i) a Prescription Drug Claim that processes at the Brand rates (Participating Pharmacy Reimbursement Rates) and (Mail Pharmacy Reimbursement Rates), as indicated on the ingredient cost field of the Prescription Drug Claim's data record, shall be reconciled as part of the Brand guarantee below; and (ii) a Prescription Drug Claim that processes at the Generic Drug rates (Participating Pharmacy Reimbursement Rates) and (Mail Pharmacy Reimbursement Rates) above, as indicated on the ingredient cost field of the Prescription Drug Claim's data record, shall be reconciled as part of the Generic Drug guarantee below. The only Prescription Drug Claims that may be excluded from the reconciliation of the pricing guarantees are as identified in the "Claims Excluded" paragraph below in addition to claims dispensed in Puerto Rico, Guam, Northern Mariana Islands, Virgin Islands, Hawaii, Massachusetts, and Alaska,. All other Prescription Drug Claims may be included in the reconciliation of the guarantees.

PARTICIPATING PHARMACY	
BRAND	AWP – 19.50%
GENERIC	AWP – 84.50%
RETAIL MAINTENANCE NETWORK (84-90 DAYS' SUPPLY)	
BRAND	AWP – 22.00%
GENERIC	AWP – 84.50%
MAIL SERVICE PHARMACY	
BRAND	AWP – 25.00%
GENERIC	AWP – 87.00%

Claims Excluded: OTC products (excluding insulin, diabetic strips, and test strips), compounds, U&C claims, Member Submitted Claims, Subrogation Claims, Coordination of Benefit Claims, Exclusive and Limited Distribution Products/Claims, vaccines, Specialty Products (other than specialty guarantee) biosimilar products (other than Specialty Product guarantee, if applicable), long term care pharmacy claims and/or claims with ancillary charges and products filled through in-house or 340b pharmacies (if applicable).

(b) Dispensing Fee. ESI will guarantee an average aggregate annual per Prescription Drug Claim dispensing fee on Client utilization to be calculated as follows:

[total dispensing fee of applicable Prescription Drug Claims for the annual period divided by total of applicable Prescription Drug Claims for the annual period which will represent the same underlying claims dataset used to calculate the "Ingredient Cost Guarantee" of this Exhibit A]. Dispensing fees will be calculated using the lesser of MAC (as applicable), U&C or AWP discount adjudication methodology.

PARTICIPATING PHARMACY	
BRAND	$0.50 dispensing fee
GENERIC	$0.50 dispensing fee
RETAIL MAINTENANCE NETWORK (84-90 DAYS' SUPPLY)	
BRAND	$0.50 dispensing fee
GENERIC	$0.50 dispensing fee
MAIL SERVICE PHARMACY	
BRAND	$0.00 dispensing fee
GENERIC	$0.00 dispensing fee

Claims Excluded: OTC products (excluding insulin, diabetic strips, and test strips), compounds, U&C claims, Member Submitted Claims, Subrogation Claims, Coordination of Benefit Claims, Exclusive and Limited Distribution Products/Claims, vaccines, Specialty Products (other than specialty guarantee) biosimilar products (other than Specialty Product guarantee, if applicable), long term care pharmacy claims and/or claims with ancillary charges and products filled through in-house or 340b pharmacies (if applicable).

Dispensing Fees are inclusive of shipping and handling. If carrier rates (i.e., U.S. mail and/or applicable commercial courier services) increase during the Term of this Agreement, the Dispensing Fee guarantees will be increased to reflect such increase(s). Notwithstanding the foregoing, Administrator guarantees that Client will only be responsible for up to a twenty percent increase over the carrier rates of the previous calendar year. At Client's request, Administrator will reimburse Client for any payments made in excess of such twenty percent increase in carrier rates.

Guarantees will be measured and reconciled on an annual basis. The guarantees are annual guarantees - if this Agreement is terminated prior to the completion of the then current contract year (hereinafter, a "Partial Contract Year"), then the guarantees will not apply for such Partial Contract Year. To the extent Client changes its benefit design or Formulary during the Term of the Agreement, the guarantee will be equitably adjusted if there is a material impact on the discount achieved. Subject to the remaining terms of this Agreement, Administrator will pay the difference of Client's cost for any shortfall between the actual result and the guaranteed result. Shortfall payments for financial guarantees, if any, will not be paid until this Agreement is signed. For purposes of measurement of any pricing guarantee in this Agreement or Amendments to this Agreement; over performance in any component will not be used to offset performance in any other measured pricing component.

Notwithstanding anything in this Agreement to the contrary, the Generic average annual ingredient cost discount guarantees set forth above will include only those Prescription Drug Claims that processed to Client for payment where the underlying prescription drug product was identified by Medi-Span as having a Multi-Source Indicator code identifier of "Y" on the date dispensed (or was identified by Medi-Span as having a Multi-Source Indicator identifier of an "M," "N," or "O" on the date dispensed, but was substituted and dispensed by the Mail Service Pharmacy as its "house generic"), unless such Prescription Drug Claim is otherwise excluded above. The Brand average annual ingredient discount guarantees set forth above will include only those Prescription Drug Claims that processed to Client for payment where the underlying prescription drug product was identified by Medi-Span as having a Multi-Source Indicator code identifier of "M", "N", or "O" on the date dispensed (except in cases where the underlying prescription drug product was substituted and dispensed by the Mail Service Pharmacy as its "house generic"), unless such Prescription Drug Claim is otherwise excluded above. The application of brand and generic pricing may be subject to certain "dispensed as written" (DAW) protocols and Client or Plan defined plan design and coverage policies for adjudication and Member Copayment purposes. If Medi-Span discontinues reporting Multi-Source Indicator identifiers, Administrator reserves the right to make an equitable adjustment as necessary to maintain the parties' relative economics and the pricing intent of this Agreement. Notwithstanding anything in this Agreement to the contrary, any rebate guarantees set forth in this Agreement will be reconciled using ESI's proprietary brand/generic algorithm.

Any claim that is considered a single source generic will be included in the generic reconciliation.

3.2 Specialty Products

(a) Exclusive Care. ESI Specialty Pharmacy is the exclusive provider of Specialty Products for the reimbursement rates shown on the Exclusive ESI Specialty Pharmacy Specialty Product List. Any Specialty Product dispensed at a Participating Pharmacy (for example, limited distribution products not then available through ESI Specialty Pharmacy or overrides) will be reimbursed at the standard Participating Pharmacy Specialty Product rates shown below. Upon ESI Specialty Pharmacy acquisition of limited distribution products, Members will obtain prescriptions through ESI Specialty Pharmacy.

	Ingredient Cost	Dispensing Fee*
Exclusive ESI Specialty Pharmacy	See Exclusive Specialty Product List	$0.00
Participating Pharmacy Specialty Products	Participating Pharmacy Specialty Product List	$0.50

* Dispensing Fees are inclusive of shipping and handling. If carrier rates (i.e., U.S. mail and/or applicable commercial courier services) increase during the Term of this Agreement, the Dispensing Fee guarantees will be increased to reflect such increase(s).

(b) ASES. For Specialty Products needing an additional charge to cover costs of all ASES required to administer the Specialty Products, Administrator, ESI or ESI Specialty Pharmacy will bill at the following standard per diem and nursing fee rates set forth below, maintained and updated by ESI from time to time. If ESI elects to bill Client's medical plan for ASES, Administrator will work with ESI to coordinate the invoicing and payment of ASES through Client's medical plan. If Client's medical plan will not cover the cost of ASES billed through ESI or ESI Specialty Pharmacy, Client shall be responsible for the costs of all ASES. If a Specialty Product dispensed or ASES provided by ESI Specialty Pharmacy is billed to Administrator or a Client directly by ESI Specialty Pharmacy instead of being processed through ESI, Client will timely pay Administrator, and Administrator will timely pay ESI Specialty Pharmacy for such claim pursuant to the rates below. ESI Specialty Pharmacy shall have 360 days from the date of service to submit such electronic or paper claim.

Therapeutic Class	Brand Name	Nursing & Per Diem
Immune Deficiency	All Immune Deficiency Drugs requiring Per Diem	$60.00 / Infusion
Enzyme Deficiency	All Enzyme Deficiency Drugs required Per Diem	$60.00 / Infusion
Miscellaneous Specialty Conditions	Duopa	$65.00 / Day
Miscellaneous Specialty Conditions	Soliris	$60.00 Infusion
PAH	Flolan, Veletri, Epoprostenol Sodium (generic-Flolan/Veletri), and Remodulin	$65.00 / Day
PAH	Ventavis	$65.00 / Day
PAH	Tyvaso	$30.00 / Day
Inflammatory Conditions	Remicade	$60.00 / Infusion
Alpha 1 Deficiency	All Alpha 1 Deficiency Drugs requiring Per Diem	$55.00/Infusion
Nursing Rates	All drugs / therapies requiring nursing	$150.00 per initial visit up to two (2) hours/$75.00 per additional hour or a fraction thereof

(c) Specialty Products will be excluded from the non-specialty price guarantees set forth in the Agreement. In no event will the Mail Service Pharmacy or Participating Pharmacy pricing terms specified in the Agreement, including, but not limited to, the annual average ingredient cost discount guarantees, apply to Specialty Products.

(d) **SPECIALTY NET EFFECTIVE DISCOUNT GUARANTEE** - Administrator guarantees that the overall annual net effective discount for the products listed on the Specialty Products List will be as follows for Client (excluding limited distribution products).

SPECIALTY DRUGS	
Exclusive	AWP – 21.00%

Within one hundred and eighty (180) days following the end of each Contract Year, Administrator will calculate the actual net effective discount for the products listed on the Specialty Products List to determine if the guarantee has been met. If the actual overall net effective discount is less than the guaranteed net effective discount, Administrator will reimburse Client the full dollar amount of the difference between the actual and guaranteed net effective discounts. Client will retain any amount that the actual net effective discount exceeds the guaranteed net effective discount. The calculation for the actual net effective discount will be as follows: ((Total Ingredient Cost for the products listed on the Specialty Products List) divided by (Total AWP for the products listed on the Specialty Products List)) minus 1. This guarantee is contingent on Client's participation in the National Preferred Formulary or Basic Formulary and an exclusive specialty arrangement.

3.3 Vaccine Claims (NO VACCINE CLAIMS WILL BE INCLUDED IN ANY PRICING OR REBATE GUARANTEE SET FORTH IN THE AGREEMENT).

(a) General Terms applicable to Vaccine Claims

1. "Vaccine Claim" means a claim for a Covered Drug which is a vaccine.

2. "Vaccine Vendor Transaction Fee" means the data interchange fee that ESI is charged by its third party vendor to convert Vaccine Claims submitted electronically by physicians to NCPDP 5.1 format in order for ESI to process the claim.

3. Vaccine Claims shall adjudicate at the lower of U&C or the amounts shown in the table below. In the case of Vaccine Claims, the U&C shall be the retail price charged by a Participating Pharmacy for the particular vaccine, including administration and dispensing fees, in a cash transaction on the date the vaccine is dispensed as reported to ESI by the Participating Pharmacy.

4. The Vaccine Administration Fee for Vaccine Claims for Members enrolled in Client's Medicaid programs, if any, will be capped at the maximum reimbursable amount under the state Medicaid program in which the Member is enrolled.

5. All Vaccine Claims will be subject to any Administrative Fees set forth in the Agreement.

6. Vaccine Claims will be charged a program fee of $2.50 per Vaccine Claim (except for Medicare Part D covered Vaccine Claims, if applicable). The Vaccine Program Fee will be billed separately to Client as part of the administrative invoice according to the billing frequency set forth in this Agreement.

(b) Commercial (Including Medicaid and Exchange, if applicable)

	Participating Pharmacy INFLUENZA	Participating Pharmacy ALL OTHER VACCINES	Member Submitted Vaccine Claims (excluding foreign claims)
Vaccine Administration Fee	Pass-Through (capped at $15 per vaccine claim)	Pass-Through (capped at $20 per vaccine claim)	Submitted amount
Ingredient Cost	Participating Pharmacy Ingredient Cost as set forth in the Agreement	Participating Pharmacy Ingredient Cost as set forth in the Agreement	Submitted amount
Dispensing Fee	Participating Pharmacy Dispensing Fee as set forth in the Agreement	Participating Pharmacy Dispensing Fee as set forth in the Agreement	Submitted amount
Administrative Fee/Vaccine Claim	Administrative Fee per Prescription Drug Claim as set forth in the Agreement		Administrative Fee per Prescription Drug Claim (plus manual claim administrative fee) as set forth in the Agreement
Vaccine Program Fee	$2.50 per vaccine claim		N/A

(c) Medicare Part D Covered Vaccine Claims: Medicare Part D Vaccine Claims shall adjudicate at the lower of U&C or the amounts shown in the table below.

	Participating Pharmacies/ESI Mail Pharmacy/ESI Specialty Pharmacy	Member Submitted Vaccine Claims (excluding foreign claims)	Vaccine Claims Submitted Electronically by Physicians
Vaccine Administration Fee	Pass-Through (capped at $15 for influenza/$20 all other vaccines per Vaccine Claim)	Lower of submitted amount or pharmacy contracted rate (capped at $15 for influenza/$20 all other vaccines if administered at a Participating Pharmacy)	Pass-Through (capped at $15 for influenza/ $20 all other vaccines per Vaccine Claim)
Ingredient Cost	Pass-Through	Lower of submitted amount or pharmacy contracted rate	Pass-Through
Dispensing Fee	Pass-Through	Lower of submitted amount or pharmacy contracted rate	Pass-Through
Vendor Transaction Fee	N/A	N/A	Pass through at ESI cost for Vendor Transaction Fee (currently $3.75, subject to change)

D. REBATES

1. **Rebate Amounts**. Subject to: (i) the conditions set forth in Sections 2 through 4 below and elsewhere in this Agreement; and (ii) Client meeting the Plan Design conditions identified in the table below, the following guaranteed amounts will be payable to Client during the Term of this Agreement:

REBATES PER BRAND Rx	FORMULARY: ESI NATIONAL PREFERRED
NATIONAL PLUS NETWORK	$195.00 per Brand claim
RETAIL MAINTENANCE NETWORK (84-90 DAYS' SUPPLY)	$456.00 per Brand claim
HOME DELIVERY PRODUCTS	$555.00 per Brand claim
SPECIALTY	$1,700.00 per Brand claim

(1) The Extended Days' Supply pricing set forth in this Agreement shall be subject to certain requirements, as follows. Extended Days' Supply shall mean; (1) for all lines of business other than Medicare or EGWP, any supply of a covered drug of 84 days or greater; and (2) for Medicare or EGWP, if applicable, any supply of a covered drug of 35 days or greater. Certain Participating Pharmacies have agreed to participate in the extended (84 – 90) day supply network ("Maintenance Network") for maintenance drugs. Rebate Amounts in the 84 – 90 Days' Supply column in the table set forth above are applicable only if Client implements a plan design that requires Members to fill such days' supply at a Maintenance Network Participating Pharmacy (i.e., Client must implement a plan design whereby Members who fill extended days' supply prescriptions at a Participating Pharmacy other than a Maintenance Network Participating Pharmacy do not receive benefit coverage under the Plan for such prescription). If no such plan design is implemented, Rebate Amounts for such days' supply will be the same as for Prescription Drug Claims for less than an 84 days' supply, and Rebate Amounts for an 84 – 90 days' supply in the table set forth above shall not apply, even if a Maintenance Network Participating Pharmacy is used.

2. **Exclusions.** Member Submitted Claims, Subrogation Claims, Coordination of Benefit Claims, Exclusive and Limited Distribution Products, biosimilar products, OTC products (except for insulin and diabetic strips and test strips), vaccines, claims older than 180 days, claims through Client-owned or 340b pharmacies, and claims pursuant to a 100% Member Copayment plan are not eligible for the guaranteed Rebate amounts set

forth in Section 1 above.

3. Rebate Payment Terms

Subject to the conditions set forth herein, Administrator will receive from ESI the quarterly Rebate payments within approximately one hundred eighty (180) days following calendar quarter adjudicated for Rebates received during the prior calendar quarter. Upon receipt, Administrator will credit Client's account.

4. Conditions

4.1. ESI contracts with pharmaceutical manufacturers for Rebates on its own behalf and for its own benefit, and not on behalf of Client. Accordingly, ESI retains all right, title and interest to any and all actual Rebates received from manufacturers. ESI will pay to Administrator (and Administrator shall pay to Client) amounts equal to the Rebate amounts allocated to Client, as specified above, from ESI's general assets (neither Client, its Members, nor Client's Plan retains any beneficial or proprietary interest in ESI's general assets). Client acknowledges and agrees that neither it, its Members, nor its Plan will have a right to interest on, or the time value of, any Rebate payments received by ESI during the collection period or moneys payable under this Section. No amounts for Rebates will be paid until this Agreement is executed by Client. ESI and Administrator will have the right to apply Client's allocated Rebate amount to unpaid Fees. ESI will retain Manufacturer Administrative Fees on Specialty Products.

4.2 Client acknowledges that it may be eligible for Rebate amounts under this Agreement only so long as Client, its affiliates, or its agents do not contract directly or indirectly with anyone else for discounts, utilization limits, Rebates or other financial incentives on pharmaceutical products or formulary programs for Prescription Drug Claims processed by ESI pursuant to the Agreement, without the prior written consent of ESI. In the event that Client negotiates or arranges with a pharmaceutical manufacturer for Rebates or similar discounts for any Covered Drugs hereunder, but without limiting ESI's right to other remedies, ESI may immediately withhold any Rebate amounts earned by, but not yet paid to, Client as necessary to prevent duplicative Rebates on Covered Drugs. To the extent Client knowingly negotiates and/or contracts for discounts or Rebates on claims for Covered Drugs without prior written approval of ESI, such activity will be deemed to be a material breach of this Agreement, entitling ESI to suspend payment of Rebate amounts hereunder and to renegotiate the terms and conditions of this Agreement.

4.3 Under its Rebate program, ESI may implement ESI's Formulary management programs and controls, which may include, among other things, cost containment initiatives, and communications with Members, Participating Pharmacies, and/or physicians. ESI reserves the right to modify or replace such programs from time to time. Guaranteed Rebate amounts, if any, set forth herein, are conditioned on adherence to various Formulary management controls, benefit design requirements, claims volume, and other factors stated in the applicable pharmaceutical manufacturer agreements, as communicated by ESI to Client from time to time. If any government action, change in law or regulation, change in the interpretation of any law or regulation, or any action by a pharmaceutical manufacturer has an adverse effect on the availability of Rebates, then ESI and Administrator may make an adjustment to the Rebate terms and guaranteed Rebate amounts, if any, hereunder.

4.4 Rebate Acknowledgment; No Representation; Rebate Limitations. Client acknowledges that Administrator is not making any representation, warranty or guaranty of any kind or nature, either express, implied or otherwise, regarding the amount of Rebates to be paid or remitted to Client pursuant to this Agreement, except as specifically set forth in writing herein. In addition, Client waives, releases and forever discharges ESI and Administrator from any Losses arising from a pharmaceutical company's (a) failure to pay Rebates; (b) breach of an agreement related to Rebates; or (c) negligence or misconduct affecting Rebates. Client acknowledges that whether and to what extent pharmaceutical companies are willing to provide Rebates to Client may depend upon a variety of factors, including the content of the PDL, the Plan's design features, Client meeting criteria for Rebates, and the extent of participation in ESI's formulary management programs, as well as

ESI/Administrator receiving sufficient information regarding each Claim for submission to pharmaceutical companies for Rebates. Client acknowledges and agrees that ESI may, but shall not be required to, initiate any collection action to collect any Rebates from a pharmaceutical company. In the event ESI does initiate collection action against a pharmaceutical company to collect Rebates, ESI may offset any reasonable costs, including reasonable attorneys' fees and expenses, arising from any such action. Notwithstanding any provision of this Agreement to the contrary, Administrator shall only be responsible for payment of Rebates to Client pursuant to the terms of this Agreement if such Rebates are actually received by Administrator during the Term of this Agreement. In no event shall Administrator be obligated to pay Rebates to Client until Administrator receives payment for the same Rebates from ESI. In the event Client terminates the Agreement outside the terms and conditions in the Agreement, Client forfeits the right to receive any Rebates received by Administrator on Client's behalf after the date of such termination. Client acknowledges that Administrator shall not be obligated to pay Client any Rebates described herein until this Agreement is signed by Client.

5. Rebate amounts paid to Client pursuant to this Agreement are intended to be treated as "discounts" pursuant to the federal anti-kickback statute set forth at 42 U.S.C. §1320a-7b and implementing regulations. Client is obligated if requested by the Secretary of the United States Department of Health and Human Services, or as otherwise required by applicable law, to report the Rebate amounts and to provide a copy of this notice. ESI will refrain from doing anything that would impede Client from meeting any such obligation.

E. The following pricing assumptions shall apply for purposes of this Agreement:

1. If Client decides to implement a mandatory generic, mandatory mail, step therapy or other program during the Term, ESI has agreed that proposed pricing terms other than rebate guarantees will remain unchanged.

2. ESI must agree to propose pricing based on its broad national retail network that includes all major national and regional pharmacy chains.

DISCOUNTS

3. The proposed "effective" generic discount and the generic discount guarantee calculation INCLUDES the following:

MAC Generics
Non-MAC Generics
Single Source Generics
Multi-Source Generics
Generics in their FDC-granted exclusivity period
Patent litigated claims
Generics with limited supply
Generic medications prescribed and/or dispensed in conjunction with a specialty medication

4. All Claims filled in Most Favored Nation states are INCLUDED in discount guarantees.

5. All Claims filled in rural pharmacies are INCLUDED in discount guarantees.

6. Ingredient Cost (including Member share) is defined as the lesser of the following:

AWP-Discount %;
MAC Price; or
Usual & Customary Price.

7. Discount will always be calculated using this formula (all Claims, including ZBDs): (1- [Ingredient Cost] / [AWP Price]) x 100.

8. "Gross Cost" is defined as: [Ingredient Cost] + [Dispensing Fee] + [Sales Tax].

9. ESI agrees to apply Client-specific guarantees to all pricing components:

Discounts
Rebates
Admin Fees
Dispensing Fees

10. During the Term, contract guarantees will not change unless one of the following items occurs which could change the economics of the pricing arrangement and would need to be evaluated: (i) a change in assumption or plan design; (ii) change in law; and/or (iii) change in pricing benchmarks.

11. There will be NO dispensing fee applied to Reversed/Rejected Claims.

CLAIMS ADJUDICATION

12. There will be no price floors for amount paid on any Prescription Drug Claims.

REBATES

13. Rebate revenue will not have any impact on discount guarantee reporting and/or true up.

14. Rebates will be paid for brand Prescription Drug Claims and at a flat minimum dollar-for-dollar guarantee basis

15. Contract rebate guarantees are not subject to change as a result of known brand patent expirations.

16. The rebate guarantees are not subject to formulary percentage criteria.

DATA

17. Audit files will be supplied to Client and Client's consultant directly from the source system and should include all Prescription Drug Claims processed including, but not limited to, paid, reversed and denied Prescription Drug Claims.

18. ESI will provide the above-mentioned extract at no charge to Client.

19. At no charge, ESI must be able to transfer data to Client's other vendor partners (e.g., medical plan administrator, stop loss vendor, disease management vendor, catastrophic claimant advocate, etc.), with an appropriate non-disclosure agreement in place.

20. ESI can provide the fully identified NCPDP expanded format to Client's consultant on a monthly basis at no additional charge for use by both the InfoLock team and the Pharmacy Analytics Team.

21. InfoLock Data feeds that are in place will be honored even after termination at no cost to Client or Client's consultant. In other words, if the Agreement is not renewed following the Term, InfoLock must still receive the 4th quarter data even though it will not be available until after termination of this Agreement.

AUDITS

22. Third Party Audits- Client may employ a third-party auditor, at Client's sole cost and expense, to conduct audits of the terms of this Exhibit A, including, but not limited to:

Pharmacy Claims transactions
Financial performance guarantees

23. Client's consultant (Lockton) may perform a pre-implementation audit prior to the Effective Date.

MISCELLANEOUS

24. Any costs bidding entities may incur as it relates to attending meetings, site visits or negotiations are the responsibility of Administrator.

25. Client may not terminate this Agreement without cause and may only terminate this Agreement as expressly provided for in Article VI of the Agreement.

26. Coordination of Benefits claims accounted for in the claims data and discount guarantees by a flag indicating that a transaction utilized COB functionality within the RxCLAIM system. COB claims are excluded from pricing guarantees but are assessed an administrative fee if applicable.

F. EXECUTION BY CLIENT

Client hereby represents and warrants that the information contained in Section A of this Client Application is true and correct in all respects and Client hereby agrees to the specific terms, conditions and financial arrangements set out in Sections B, C and D of this Client Application. Client agrees that if any information in Section A changes, Client will give Administrator prompt notice of such changes. Furthermore, Client understands that this Client Application (Exhibit A) is a part of the Administrative Services Agreement between Client and Administrator to which it is attached and incorporated into by reference and that Client is bound by all terms and conditions of such Administrative Services Agreement.

All capitalized terms used in this Client Application but not specifically defined herein shall have the meanings given to such terms in the Administrative Services Agreement to which this Client Application is attached and made a part of.

IN WITNESS WHEREOF, Client has caused this Client Application (Exhibit A to the Agreement) to be executed as of the Effective Date. In the event this Client Application is amended by the Parties after the Effective Date, the Parties may substitute such amended Client Application for the former Client Application, provided the Parties set forth the date from and after which such amended Client Application shall be effective (the "date" line at the bottom of the Administrator's acknowledgment signature block on an amended Client Application shall be such new effective date with respect to such amended Client Application). The Parties further agree that they will attach such amended Client Application to this Agreement and provide a copy of this Agreement with the amended Client Application (Exhibit A) to Administrator and Client for their respective records. Any such amended Client Application must be signed by Client's authorized representative and acknowledged, agreed to, accepted and dated by Administrator's authorized representative.

CLIENT:
Indian River County Board of County Commissioners

By: _____

Printed Name: _____

Its: _____

Acknowledged, agreed to and accepted by:

ADMINISTRATOR:
RxBenefits, Inc.

By: _____

Printed Name: Lauren Simmons

Its: Sr. Director of Compliance & Legal Affairs