ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT

THIS ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT (this "Addendum")**,** entered into effective as of January 1, 2019 (the "Addendum Effective Date"), is made by and between **RxBenefits, Inc**. **f/k/a Prescription Benefits, 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.

ADMINISTRATOR:

RxBenefits, Inc.

By: _____

Name: Lauren Simmons

Title: Director of Compliance and Legal Affairs

CLIENT:

Indian River County Board of County Commissioners

By: _____

Name: _____

Title: _____

EXHIBIT A

CLIENT APPLICATION

CONTRACT EFFECTIVE DATE

[IMPORTANT – PLEASE READ CAREFULLY: Client should carefully review Sections A, B and C of this Exhibit A below which have 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). Client should also carefully review and complete Section D of this Exhibit A below.]

A. INFORMATION ABOUT CLIENT

Client Name: Indian River County Board of County Commissioners	**HR/Primary Contact:**	**Phone:**
Mail Address: 1801 27th Street	**HR Contact Email:**	**Fax:** _____
City/State/Zip: Vero Beach, FL 32960-3365	**Billing Contact:**	**Phone:**
Main Phone:	**Billing Contact Email:**	**Fax:** _____
Send Invoices and Confidential Standard Reports to:		
Authorized Website Users of Client (User's Name and E-mail Address): _____ _____ _____		

*** Note: Client may add or delete Authorized Website Users by providing written notice of such changes to Administrator pursuant to the notice provisions of Article VIII.B of the Agreement.**

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 any failure to implement Plan Design changes which are not communicated in writing to Administrator. In addition, Client shall notify Members of any Plan Design changes prior to the effective date of any such changes.

C. SERVICES; FORMULARY; PRICING.

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)	N/A
Manufacturer Copay Assistance Programs • Out of Pocket Protection (Accumulation) • Out of Pocket Protection + Variable Copay Assistance Program • SaveOnSP • Out of Pocket Protection + SaveOnSP	 • No Charge (Not Elected) • No Charge (Not Elected) • $0.40 per claim (Not Elected) • $0.40 per claim (Not Elected)
Reviews and Appeals Management	
• Low Clinical Value Exclusions (LCV)	• $0.30 per claim minimum (Not Elected)
• High Dollar Claim Review (HDCR)	• $0.75 per claim minimum (Not Elected)
Initial Determinations (i.e. coverage reviews) and Level One 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 review

Administrative Services	**Fees**
Initial Determinations and Level One Appeals for the Benefit Review Program, consisting of reviews known as: Plan Design Related Requests Plan Exclusion Reviews (clinical or administrative reviews of non-Covered Drugs) Copay Reviews Plan Limit Reviews (e.g. age, gender, days' supply limits) Plan Rule/Administrative Reviews/Non-clinical Reviews Clinical Benefit Reviews Direct Claim Reject Reviews	$55 per review
Final and Binding Appeals – Level Two Appeals * and/or Urgent Appeals** *Level One for clients with only one level of appeal ** Appeals can be urgent at Level One or Level Two and decisions are final and binding.	$0.00 per review***** (incremental to PMPM fees or the per review fees above) * *This additional fee is applied to each initial determination.*
External Reviews by Independent Review Organizations - for non-grandfathered plans	$800 per review

PBM Services	**Fees**
Advanced Utilization Management (AUM Bundle)	**$0.51** / PMPM
Manual/hardcopy eligibility submission Member-submitted paper claims processing fee Medicaid subrogation claims fee	$10.00 $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	
Consumer Choice Plan Technical Bi-directional data exchange; dedicated operations; 24-hour a day, seven-days a week monitoring and quality control; performance reporting; and analytics Member Advocacy Dedicated CDH member services, open enrollment tools and member communications library, robust online features, and preventive care Health Choices Medication Adherence Monitoring and Outreach and proactive, personalized member communications Drug Choices Benefit Coaching, Prescription Benefit Review Statements, proactive, personalized member communications	All services: $0.65 PMPM • Technical and Member Advocacy: $0.35 PMPM • Health Choices and Drug Choices: $0.30 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.
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

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	

C.

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)	• Implementation support
• **Clinical**	
Concurrent Drug Utilization Review (DUR) Prior Authorization – Administrative a. Non-clinical Prior Authorization b. Lost/stolen overrides c. Vacation supplies	

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 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:
  - 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; or
  - If denied, an appeal process is available.
- Foundational Utilization Management. 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 QL promotes FDA-approved dispensing guidelines by ensuring appropriate quantities are dispensed. 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. 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: Must have HDCR component in place to elect this component. 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[SM] 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. 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).

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 next Renewal Term as described in Article VI(A) of the Agreement.

[1-(total discounted AWP ingredient cost (excluding dispensing fees and claims with 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)].

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" column of the table below. All other Prescription Drug Claims may be included in the reconciliation of the guarantees.

Type of Guarantee	Participating Pharmacy	Retail Maintenance Network (84-90 Days' Supply)	Mail Service Pharmacy	Claims Excluded
Brand	AWP – 18.25%	AWP – 21.00%	AWP – 25.00%	OTC, compounds, U&C claims, Member Submitted Claims, Subrogation Claims, Limited Distribution Claims, vaccines, Specialty Products and/or claims with a high-dollar undiscounted AWP value, biosimilar products, long term care pharmacy claims and/or claims with ancillary charges and products filled through in-house or 340b pharmacies (if applicable)
Generic	AWP – 82.25%	AWP – 82.25%	AWP – 85.00%	OTC, compounds, U&C claims, Member Submitted Claims, Subrogation Claims, Limited Distribution Claims, vaccines, Specialty Products and/or claims with a high-dollar undiscounted AWP value, biosimilar products, 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 a maximum average aggregate annual per claim dispensing fee on Client utilization to be calculated as follows:

[total dispensing fee of applicable claims for the annual period divided by total claims for the annual period].

Type of Guarantee	Participating Pharmacy	Mail Service Pharmacy / Retail Maintenance Network*	Claims Excluded
Generic Drug Dispensing Fee/Claim	$0.75	$0.00	OTC, compounds, U&C claims, Member Submitted Claims, Subrogation Claims, Limited Distribution Claims, vaccines, Specialty Products and/or claims with a high-dollar undiscounted AWP value, biosimilar products, long term care pharmacy claims and/or claims with ancillary charges and products filled through in-house or 340b pharmacies (if applicable)
Brand Dispensing Fee/Claim	$0.75	$0.00	OTC, compounds, U&C claims, Member Submitted Claims, Subrogation Claims, Limited Distribution Claims, vaccines, Specialty Products and/or claims with a high-dollar undiscounted AWP value, biosimilar products, 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).

Guarantees will be measured and reconciled on an annual basis within 180 days of the end of each 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. Guarantees for pricing components are measured and reconciled in the aggregate across all pricing components. Any dollar savings generated in excess of one component may be used to offset a short fall for any other 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.

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	$0.75

(b) Pricing for ASES is as follows:

(i) For Specialty Products needing an additional charge to cover costs of all ASES required to administer the Specialty Products, the following standard per diem and nursing fee rates shall apply. Exceptions to the standard per diem and nursing rates are set forth in (ii), below, which list may be updated from time to time by ESI. Pricing for home infusion supplies and services provided at Participating Pharmacies (for example, limited distribution products not then available through ESI Specialty Pharmacy or overrides) will be pass through.

Standard Per Diem	$65/dose
Standard Nursing Fee/ First 2 Hours	$150
Standard Nursing Hourly	$75

(ii) Additional exceptions to AWP Discount Rates and Standard Per Diem & Nursing Fees

Brand Name	AWP Discount	Per Diem
EPOPROSTENOL	1.0%	$65/day
REMODULIN	5.0%	$65/day

The AWP discount includes Phone Support Nursing, Supplies, Pump, first two training visits, and Coordination of In-Person Nursing. In-home nursing that is requested/needed beyond the first two training visits will be charged at a rate of $150 for the first two hours and $75 for every hour after.

(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) Unless otherwise set forth in an agreement directly between ESI Specialty Pharmacy and Client, if a Specialty Product dispensed or ASES provided by ESI Specialty Pharmacy is billed to Client directly by ESI Specialty Pharmacy instead of being processed through ESI and Administrator, Client agrees to timely pay ESI Specialty Pharmacy for such claim pursuant to the rates above and within thirty (30) days of Client's, or its designee's, receipt of such electronic or paper claim from ESI Specialty Pharmacy. ESI Specialty Pharmacy shall have 360 days from the date of service to submit such electronic or paper claim.

(e) **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 at least AWP (-) minus 19.25% for Client (excluding limited distribution products). Within one hundred and eighty (180) days following the end of each Contract Year, ESI will calculate the actual net effective discount for the products listed on the Specialty Products List that were dispensed through the mail order channel 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 and an exclusive specialty arrangement.

3.3 **Influenza and Other Vaccinations**. Vaccinations shall adjudicate at the lower of:

(a)

	Participating Pharmacy **INFLUENZA**	**Participating Pharmacy** **OTHER VACCINES**
Ingredient Cost +	Participating Pharmacy Ingredient Cost as set forth in the Agreement	Participating Pharmacy Ingredient Cost as set forth in the Agreement
Dispensing Fee +	Participating Pharmacy Dispensing Fee as set forth in the Agreement	Participating Pharmacy Dispensing Fee as set forth in the Agreement
Professional Service Fee (PSF); cost for pharmacist to administer the vaccine	Pass-Through (capped at $15 per vaccine claim)	Pass-Through (capped at $20 per vaccine claim)
Vaccine Program Fee *	$2.50 per vaccine claim	$2.50 per vaccine claim

* The Vaccine Program Fee will be billed separately to Client as part of the administrative invoice according to the billing frequency set forth in the Agreement. This Vaccine Program Fee will apply to any vaccine claims, whether at contracted rates or U&C, and is in addition to any per Prescription Drug Claim administrative fee set forth in the Agreement.

OR

(b) the combined ingredient cost, dispensing fee (if any) and professional service fee (if any) that the Participating Pharmacy generally charges an individual paying cash, without coverage for prescription drug benefits, plus the Vaccine Program Fee set forth above.

Coverage is subject to Plan provisions. No vaccine claims will be included in any guarantees set forth in the Agreement and/or amendments thereto.

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:

Formulary:	**ESI National Preferred**			
	National Plus Network	**Retail Maintenance Network (84-90 Days' Supply)**	**Home Delivery Products**	**Specialty Products**
Rebates per Brand Rx	$157.00 per brand claim	$375.00 per brand claim	$460.00 per brand claim.	$1,150.00 per brand claim

(1) 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, Limited Distribution products, biosimilar products, OTC products (except for insulin and diabetic supplies), 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. Administrator shall pay Client the guaranteed amounts set forth in Section 1 above within approximately thirty (30) days following receipt of the Rebate payments from ESI.

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.

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. 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. ESI'S INFLATION PROTECTION PROGRAM

1. **IP Program**. The Inflation Protection Program ("ESI IP Program"). Subject to the terms and conditions set forth in Section 2 below, under the ESI IP Program Administrator will pay to Client $2.00 per Formulary Brand Drug claim ("Client Inflation Payment"). Subject to the terms and conditions set forth herein, under the ESI IP Program, Administrator will pay Client the Client Inflation Payment within approximately one hundred and eighty (180) days following the end of each calendar quarter for utilization occurring during such calendar quarter. All non-Formulary claims and Generic Drug claims shall be excluded.

2. **Terms and Conditions of ESI's IP Program**.

2.1 Exclusions. The following claims will be excluded from all calculations related to ESI's IP Program:

- Medicare claims, Medicaid claims and any other government health care program claims
- OTCs, member submitted claims, subrogation claims, compounds, Generic Drugs, claims submitted by Client-owned, in-house, or on-site pharmacies, 340B claims, claims submitted through a 100% Member cost-share program, biosimilars, drugs where the quantity or packaging has been changed by the manufacturer from the prior year, and drugs for which there was no utilization in the calendar year prior to the calendar year for which the Client Inflation Payment is being determined.

2.2 **ESI's Right of Equitable Adjustment**. If Client makes material changes to its Formulary or benefit design that negatively impact ESI's ability to control inflation relative to Client's Formulary drug mix, then Client acknowledges that ESI or Administrator reserves the right in ESI's discretion to make an equitable adjustment to the Client Inflation Payment.

2.3 The ESI IP Program, and the underlying economics, is separate and apart from rebates and manufacturer administrative fees, and the amounts described above in this Section E will be paid to Client in addition to any rebate payments to which Client is entitled pursuant to the terms of this Agreement. Client will not be entitled to receive any amounts related to drug price inflation or a related guarantee other than as set forth above in this Section E of this Exhibit A (Client Application).

2.4 No payments will be made to Client unless Client has executed this Agreement.

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, D and E 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.

C**LIENT:**

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: Director of Compliance and Legal Affairs