Amendment Number Three
To Contract with Optum Rx, Inc.
For Pharmacy Benefit Management and
Claims Administration Program

THIS AMENDMENT Number Three (hereinafter "Amendment"), is made and entered into, upon execution of all necessary signatures, by and between the County of Orange, a political subdivision of the State of California (hereinafter "County"), and OptumRx, Inc., with a place of business at 1600 McConnor Parkway, Schaumberg, Illinois, 60173 (hereinafter "Contractor"), which are sometimes individually referred to as "Party" or collectively referred to as "Parties".

WHEREAS, County and Contractor executed Contract for Pharmacy Benefit Management and Claims Administration Program for the County of Orange, effective January 1, 2021, through December 31, 2023 (hereinafter "Contract"); and

WHEREAS, the Parties entered into Amendment Number One of the Contract to amend Attachment A, B, and D of the Contract effective January 1, 2021; and

WHEREAS, the Parties entered into Amendment Number two of the Contract to amend Attachments A, and D of the Contract effective January 1, 2022, and Attachment B of the Contract effective October 1, 2021; and

WHEREAS, both Parties desire to amend Attachment A and B of the Contract, and to include Attachments F effective January 1, 2023;

NOW THEREFORE, in consideration of the mutual obligations set forth herein, both County and Contractor agree as follows:

1. Attachment A – Scope of Work, Section IV - Clinical Programs and Formulary Management, Item14 is hereby amended as follows:
   "Intentionally omitted"

2. Attachment A – Scope of Work, Section VII, Retail Network Management is hereby amended to include:

   "14. **Advanced Pharmacy Audit Services.** For the fees in Section IV (Additional Services) table of Attachment B – Cost/Compensation for Contract Services, Contractor will perform Pharmacy Network audits consistent with Attachment D (Contractor Performance Guidelines). Contractor will provide reports detailing audit findings and recoveries by line of business and credit recoveries to County at least quarterly. In addition, Contractor will, in accordance with its pharmacy audit program, for the fees set forth in Section IV (Additional Services) table of Attachment B – Cost/Compensation for Contract Services, provide Advanced Pharmacy Audit Services (APAS) including designated audit staff focused on County's Participants' claims to determine whether Participating Pharmacies are submitting appropriate billings for payment by County or Members. Also included with APAS, Contractor will provide quarterly and monthly reports on the specific results of the audits to County as well as a quarterly business review. Contractor will reimburse recovered amount to County as a credit to invoices payable by County or as an adjustment to County claims file.

3. Section IV (Additional Services) table of Attachment B – Cost/Compensation for Contract Services, is hereby amended to include:

Orphan Drug Program	$300 per participating member per year
Advanced Pharmacy Audit Services	$0.10 per claim

4. Attachment D – Contractor Performance Guidelines, is hereby amended to include:

   APAS Performance Guarantee

   To ensure the value to County of the APAS program, Contractor will provide an APAS performance guarantee (APAS PG), as in accordance with applicable law. The APAS PG will be measured initially after the end of the second full year (1st measurement period covers 24 months) of the program then annually (each 12 months) thereafter (Measurement Period). For existing clients under the APAS PG, the audit savings and recoveries from network pharmacies will increase over the actual recoveries and savings achieved (baseline) in the calendar year prior to implementation of APAS. For clients new to Contractor, where prior year recoveries and savings don't apply, an imputed baseline recovery and savings amount will be used based on peer per-claim averages applied to <client name>'s actual net paid claim counts. In addition to including a baseline recovery amount, the APAS PG target will include an amount equal to 100% (PG percentage) of the APAS fees paid to Contractor in the measurement period.

   The APAS PG amount for County will be calculated as follows:

   APAS PG target = APAS Fees (Net Paid Claims multiplied by the APAS per-claim fee) paid in measurement period (initial period = 24 months then each 12 months thereafter) multiplied by 100% plus prior year audit recovery and savings baseline amount or imputed baseline recovery and savings amount

   If total savings and recoveries are less than the APAS PG target amount in any given measurement period (underperformance), Contractor will compensate County for the underperformance up to the full amount of the APAS fees paid in the measurement period, through either a waiver of fees in the amount of the underperformance in following measurement period, or through a credit to County at Contractor's option.

5. Attachment F – Employer Group Waiver Plan (EGWP) Services Addendum is hereby added in its entirety as set forth in Attachment F, attached hereto and incorporated by reference.

6. Attachment F -1 -Fees for EGWP Services is hereby added in its entirety as follows:

"Attachment F-1
Fees for EGWP Services

This is a fixed fee Contract between the County and Contractor for services provided in Attachment A, Scope of Work and Attachment F, EGWP Services Addendum.

In accordance with the provisions of Article 2 of the General Terms and Conditions, the Contractor shall only be compensated as set forth herein below for work performed in accordance with the Scope of Work and Attachment F.

I. COMPENSATION

1. The County will pay Contractor for the services provided herein pursuant to the following table:

Term of contract:			01/01/2023 to 12/31/2023
Administrative Fee			
Base Admin Fee	$1.50 PNPC	PNPC=Per Net Paid Claim	
EGWP Admin Fee	$8.50 PMPM	EGWP=Per Member Per Month	
Broad Retail Pharmacy Network			
Brand Drug Discount AWP-19.00%	Brand Drug Dispensing Fee $0.80 PNPC	Generic Drug Discount AWP-83.45%	Generic Drug Dispensing Fee $0.80 PNPC
Broad Retail 90 Pharmacy Network			
Brand Drug Discount AWP-21.50%	Brand Drug Dispensing Fee $0.00 PNPC	Generic Drug Discount AWP-84.30%	Generic Drug Dispensing Fee $0.00 PNPC
Home Delivery Pharmacy			
Brand Drug Discount AWP-25.25%	Brand Drug Dispensing Fee $0.00 PNPC	Generic Drug Discount AWP-85.55%	Generic Drug Dispensing Fee $0.00 PNPC
Specialty Pharmacy – Open Overall Aggregate Guarantee			
Discount AWP-19.20%		Dispensing Fee $0.00 PNPC	
Rebate Management – Silver Rebate Guaranteed Amount			
Retail Pharmacy $185.00 PNPB	Retail 90 Pharmacy $480.00 PNPB	Home Delivery $550.00 PNPB	Specialty $1,200.00 PNPB
Generic Dispense Rate Guarantee			
Retail 85.00%		Home Delivery 86.00%	

For each channel referenced with a Generic Dispense Rate (GDR) guarantee above (i.e., retail and mail), the Generic Dispense Rate (GDR) guarantee means for any full Contract Year, the number of Prescription Claims for Generic Drugs, as adjusted below ("Adjusted Total Prescription Claims"), i.e., [GDR=GDR Utilization for Contract Year/Adjusted Total Prescription Claims for Contract Year]. The GDR guarantee will be expressed as a percentage. GDR Utilization and Adjusted Total Prescription Claims will be adjusted by excluding: (i) all Prescription Claims from the categories listed as exclusions o the discount and dispensing fee guarantees; and (ii) all Prescription Claims for Specialty Drugs.

To be eligible for the GDR guarantee, Client must comply with each of the following for each Client Benefit Plan:

- Maintain an average copayment differential between tier 1 and tier 2 Formulary products of $15 or more.
- Adopt clinical programs associated with the Formulary; and
- Implement dispense as written penalties for DAW 2 claims for the majority of Members.

The GDR guarantee will be measured and reconciled for each channel referenced with a GDR guarantee in the table above in the aggregate on an annual basis. Overachievement in one channel may be used to offset underperformance in another channel. The penalty for failure to achieve GDR guarantee for a Contract Year will be calculated as product of:
[Adjusted Total Prescription Claims] x (GDR guarantee-GDR achieved (each expressed as a percentage) x (average cost to Client for non-Specialty Brand Drugs for Contract Year minus average Member Cost Share Amount minus average applicable Rebate guarantee)- (average cost to Client for non-Specialty Generic Drugs for Contract Year minus average Member Cost Share Amount)]

The final penalty shall never exceed more than $1.50 per Member per Contract Year.

The GDR guarantee reporting will be provided in conjunction with the pricing discount and dispensing fee guarantee reporting.

Credits and Allowances – Pharmacy Management Allowance

Client shall receive a pharmacy management allowance (PMA) of up to $5.00 per Member annually, which must be utilized within the applicable year and will not carry over to the following year. This PMA allowance is to be used by Client to offset the cost of actions intended to maximize the value of the pharmacy program. Funds may be used for items including, but not restricted to, programming for customization, design and implementation of clinical or other programs, communications, documented expenses related to staff education and industry conference attendance, auditing, data integration and analytics, consulting fees (excluding market checks), and engagement of relevant vendors that impact the pharmacy program strategy and results. Client will be required to submit documentation to support the expenses for which it seeks reimbursement. If Client terminates this Agreement for any reason before the end of the Initial Term, Client shall refund to OptumRx within 30 days after effective date of such termination the full PMA allowance applicable to the year of termination. It is the intention of the parties that, for the purposes of the Federal Anti-Kickback Statute, this PMA allowance shall constitute and shall be treated as a discount against the price of drugs with the meaning of 42 U.S.C 1320a-7b(b)(3)(A). To the extent required by Laws or contractual commitment, Client agrees to fully and accurately disclose and report any such discount to Medicare, Medicaid or other government health care programs as a discount against the price of the Prescription Drugs provided under this Agreement.

General Financial Terms

Except where stated in this section, all terms set forth in Attachment A of this Agreement, where applicable, are incorporated herein by reference. Furthermore, all pricing and financial terms under this Attachment F-1 shall apply uniquely to the EGWP Services in Attachment F and be independently measured and reconciled from Client's commercial population.

- This Amendment must be signed at least 90 days before the effective date of the EGWP Services pricing in this Attachment F-1.
- The effective date of the EGWP Services pricing in this Attachment F-1 will be January 1, 2023, with prior notice of award 120 days before the effective date of this Amendment.
- The EGWP Services pricing in this Attachment F-1 is for a one (1) year contract term, subject to the terms and conditions in this Amendment.
- The pricing in this Exhibit F-1 is for a minimum of 1,531 total EGWP Members as of the effective date of this Amendment.
- Under the Pass-Through Pricing Model, Client shall pay the actual retail pharmacy rates paid by OptumRx for Prescription Drugs electronically processed and dispensed to a Member through OptumRx's retail Pharmacy Network, which are estimated to be the effective rates set forth above. OptumRx's compensation for its services shall be the Claims Administration Fees set forth above and a fee in an amount agreed to by the parties for any additional services authorized by Client.
- Optum Specialty Pharmacy shall be specialty providers under this Agreement and Members will receive Specialty Drug Covered Prescription Services only from a Network Pharmacy, including Specialty Pharmacy. Specialty dispensing fees and Specialty Drug pricing shall apply for any Specialty Drugs filled at retail and Home Delivery. The Specialty Drug List will be provided to Client upon request may be updated from time to time.
- Core Silver Formulary: The Guaranteed Rebate Amount is contingent upon Client's adoption, without deviation, of OptumRx's Formulary and utilization management programs. Clients must have a Rebate qualifying benefit design which includes a minimum of $10 difference in member most between preferred and non-preferred drugs, and that Members, after the deductible phase, must not be responsible for more than 50 percent of the ingredient cost (e.g., a 50% or more co-insurance plan).

EGWP Services and Fees as Applicable

EGWP Services	
• Enrollment/Finance Functions	Included in EGWP Fee
• Standard Client Reporting	Included in EGWP Fee
Explanation of Benefits (EOB)	
• CMS compliant document monthly print and mail (where applicable) • Spanish translated EOB, per Eligible Participant's request • Client variable information (plan logo, hours of operation, customer service information)	Standard Package included in EGWP fee. Customization requirements may incur additional fees for production and postage.

• Programming changes as required for CMS requirements • Data management and processing • Application to enter formulary change information and message to appear on EOBs • Viewer tool for OptumRx call center	
Transition Member Services	
• Eligible Participant and Physician letter	Included in EGWP Fee
• Daily Transmission Claims Data file	Included in EGWP Fee
• Programming changes as required by CMS requirements	Included in EGWP Fee
• Data management and processing	Included in EGWP Fee
• Daily transition file(s), critical error if applicable	Included in EGWP Fee
• Eligible Participant or customer inquiry support	Included in EGWP Fee
1.	
PDE Management	
• CMS Attestations	Included in EGWP Fee
• PDE Creation	Included in EGWP Fee
• Error oversight, trend analysis, and prevention	Included in EGWP Fee
• Error resolution support and best practices	Included in EGWP Fee
• PDE reprocessing as required	Included in EGWP Fee
• CMS report distribution (i.e., P2P, Accum)	Included in EGWP Fee
• Programming as needed for CMS required changes	Included in EGWP Fee
• Reports (i.e., summary, statistics, pre-edit errors)	Included in EGWP Fee
• Report Catalog of CMS generated files	Included in EGWP Fee
2.	
Clinical Programs	
• CDUR & Level 1 (THEDOSE)	Included in EGWP Fee
• Medicare Drug Management Program	Included in EGWP Fee
• Overutilization Monitoring System	Included in EGWP Fee
• RDUR Star Focused	Included in EGWP Fee
• EGWP Medication Therapy Management	Included in EGWP Fee
• Basic Medication Adherence (Late to refill IVR) is not required under Part D, but we automatically include it in our standard EGWP offering.	Included in EGWP Fee
• Medicare Fraud, Waste, and Abuse Program	Included in EGWP Fee
• Medication Error Identification and Reduction (MEIR)	Included in EGWP Fee
• E-Prescribing Services	Included in EGWP Fee
• Opioid Risk Management – Medicare Member Education Program	Included in EGWP Fee
• Prior Authorization (includes clinical Prior Authorization and B vs. D coverage determinations)	$50 per Prior Authorization
• Grievances (pharmacy benefit related grievance)	Included in EGWP Fee
• Re-determination of coverage (second level appeals) – Medical of Administrative	Included in EGWP Fee
• OptumRx Base Formulary	Included in EGWP Fee
Print Fulfillment (as applicable)	Standard Package included in EGWP Fee.
• ID Cards	Customization requirements may incur additional fee.
• Welcome Kits	Standard Package included in EGWP Fee. Customization requests must be approved by OptumRx-EGWP and may incur additional fees.
• ANOC/Evidence of Coverage (EOC) Mailing/Fulfillment	Standard Package included in EGWP Fee. Customization requirements may incur additional fees
• Summary of Benefits & Opt Out letter	Included in EGWP Fee
• Geo-Coded Pharmacy Directories	Included in EGWP Fee
• Formulary Drug List	Included in EGWP Fee
• Payment distribution to Eligible Participants and	Included in EGWP Fee

LTC's for adjustments that identified previous overpayment of the Eligible Participant cost share/Drug Refund Checks	
• Other Eligible Participants or physician communications	Production and Postage at cost
• Eligible Participant requested materials	
• Medicare Secondary Payer Letter/Survey	Production and Postage at cost
• All CMS-required CMS Transaction Reply Code (TRC) letter (post enrollment: including disenrollment, LEP, LIS, etc.	Included in EGWP Fee Included in EGWP Fee
• Return Mail Charge	Included in EGWP Fee
Add-On Medicare Part D Services	
• Specialized support for Medicare Post-enrollment Calls (Benefits, eligibility, EOB review, letters, claim resolution)	Included in EGWP Fee
• Manual Eligibility Data entry	$0.50 per record
• Loading of the required 306 months of pharmacy data	Included in EGWP Fee
• Website with standard design: Access for Eligible Participants and Physicians	Included in EGWP Fee
• Custom Website Development	$250 per Hour
• PBP And Plan Changes	Included in EGWP Fee
• Batch processing of client-caused/initiated adjustments (includes analysis and preparation of data files for processing, adjustment of TrOOP/Drug Spend balances and creation of overpayment and underpayment report as appropriate	Included in EGWP Fee Included in EGWP Fee
• Coordination of Benefits with SPAP's or other mandated programs	$5.000 per Report
• GeoAccess report (in excess of one annually provided in Core Services)	
• DMR Coverage letter (paper claim)	Included in EGWP Fee"
This is not an inclusive list. OptumRx may charge for any products or services not specifically represented herein	

7. Except as amended herein, all other terms and conditions, including those terms of the Contract and any amendments/modifications are incorporated by this reference as if fully set forth herein and shall remain in full force.

(Signature page to follow)

The Parties hereto have executed this Amendment on the dates shown opposite their respective signatures below.

OptumRx, Inc.

By: Ellen Nelson	President, Public Sector and Government Market Segment
Print Name	Title
Ellen Nelson DocuSigned by: DC76EAE0A0394E7...	6/27/2022
Signature	Date
By: Katie Carey	CFO
Print Name	Title
Katie Carey DocuSigned by: 1B8C38DC82EB477...	6/27/2022
Signature	Date

*** If the Contractor is a corporation, signatures of two specific corporate officers are required as further set forth.**

The first corporate officer signature must be one of the following: 1) the Chairman of the Board; 2) the President; 3) any Vice President.

The second corporate officer signature must be one of the following: a) Secretary; b) Assistant Secretary; c) Chief Financial Officer; d) Assistant Treasurer.

In the alternative, a single corporate signature is acceptable when accompanied by a corporate resolution demonstrating the legal authority of the signature to bind the company.

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County of Orange, a political subdivision of the State of California

Print Name	Title
Signature	Date

****

Approved by Board of Supervisors on: Date_____

APPROVED AS TO FORM: DocuSigned by: A1E6C10B06324FE...

Deputy, Office of County Counsel
Orange County, California

Attachment F

Employer Group Waiver Plan (EGWP) Services Addendum

This Employer Group Waiver Plan ("***EGWP***") Services Addendum (the "***EGWP Addendum***") is entered into on July 19, 2022, between OptumRx, Inc. and Optum Insurance of Ohio, Inc. ("***Administrator***") and County of Orange ("***Client***"). Administrator shall commence processing claims under this EGWP Addendum on January 1, 2023, (the "***EGWP Commencement Date***").

WHEREAS, Administrator has entered into an EGWP 800 Series Contract with the Centers for Medicare & Medicaid Services ("***CMS***") dated October 3, 2006, as amended (the "***CMS Contract***"); and

WHEREAS, Administrator is a Medicare Prescription Drug Plan (PDP) Sponsor and provides, through itself and its downstream entities, EGWP services to those retired employees or dependents of such retired employees who have met CMS regulations and guidance requirements to enroll in the EGWP; and

WHEREAS, Client is a union or employer group or trustee(s) of a fund who desires to contract with Administrator for EGWP services for its retired employees or dependents of such retired employees who have not opted out of enrollment in Client's EGWP and who have met CMS regulations and guidance requirements to enroll in the EGWP;

NOW THEREFORE, the parties agree as follows:

Defined terms used throughout the Prescription Drug Benefit Administration Agreement between Administrator or its affiliate and Client (the "***Agreement***") within this EGWP Addendum and terms of the Agreement, to the extent not otherwise addressed herein, are incorporated herein by reference. Any term capitalized in this EGWP Addendum and not defined shall be defined as it is in the CMS Medicare Part D Prescription Drug Benefit Manual ("***Guidance***") and/or the CMS Medicare Managed Care Manual.

1. OBLIGATIONS OF ADMINISTRATOR

1.1 **EGWP PBM Services.** Administrator shall provide, through its affiliated PBM providing services to Client, claims processing, retail, home delivery pharmacy, Specialty pharmacy, and Rebate services as detailed in **Attachment B** (PBM Services) of the Agreement and additionally in accordance with CMS requirements for Client's EGWP Eligible Participants. "***Participants***", "***Eligible Members***", "***Members***", "***Eligible Members***" or "***Enrollees***" shall mean those retired employees or dependents of such retired employees who have met CMS regulations and guidance requirements to enroll in the EGWP and have not opted out of enrollment in Client's EGWP. The parties agree to the Compensation for the EGWP PBM Services as set forth on Attachment **F-1** (Fees for EGWP Services).

1.2 **Pharmacy Network.** Administrator will maintain a pharmacy network, which shall meet the pharmacy access requirements set forth in 42 C.F.R §423.120, as applicable to EGWPs, or other requirements as mandated by the CMS Contract.

1.3 **EGWP Formulary Services; CMS Approved EGWP Standard Formulary.** Administrator shall create and publish a CMS-approved EGWP standard Formulary (the "***EGWP Standard Formulary***") which shall be compliant with the Medicare Part D prescription drug program requirements and other applicable rules and regulations promulgated by CMS. Such EGWP Standard Formulary will be solely managed by Administrator and will include monthly management to accommodate new products to the marketplace.

1.4 **Pharmacy and Therapeutics ("P&T") Committee.** The Administrator P&T Committee is an

external advisory committee comprised of healthcare professionals (physicians, pharmacists, nurses, etc.) that is responsible for managing and administering the EGWP Standard Formulary, including utilization management strategies. The P&T Committee will develop, maintain, and review the EGWP Standard Formulary and other Administrator formularies at least annually to ensure that the formularies are appropriate based on existing pharmacy practices and CMS requirements. Any requested customization of the EGWP Standard Formulary must be reviewed and approved by the Administrator Pharmacy & Therapeutics Committee, shall be subject to additional fees and may impact Rebates.

1.5 **EGWP Specific Clinical Services.** Administrator will provide Concurrent Drug Utilization Review, Prior Authorization, and Clinical Communication services described in **Attachment B** (PBM Services) of the Agreement. Client acknowledges that Administrator may contact prescribers, as appropriate, to obtain approval for substitution of formulary drugs and contact Participants regarding medication adherence, education or similar programs. The EGWP Clinical Services below will be provided under this EGWP Addendum, which are subject to change in the event of changes in CMS requirements, which may result in changes in Compensation:

1.5.1 **Administrator Medication Therapy Management Program.** The Administrator Part D Medication Therapy Management ("***MTM Program***") consists of Administrator (in conjunction with necessary third parties) performing a MTM review designed to meet the CMS MTM Program requirements set forth in 42 CFR §423.153(d) and subsequent sub-regulatory guidance. This set of guidance outlines requirements designed to ensure that medications prescribed to Participants meet specific clinical criteria appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events. Administrator will identify Participants based on the criteria submitted to CMS and will, if applicable, recommend changes in such Participants' drug regimens to the prescribing physicians and/or the dispensing pharmacists, and outreach to Participants to complete the Comprehensive Medication Review (CMR) consultation. The Administrator Part D MTM Program consists of rules and support features offered by Administrator to optimize therapeutic outcomes, including those rules that assist in optimizing certain performance measures set by CMS in its Five-Star Quality Rating System. This is a mandatory program in order to comply with CMS regulations.

1.5.2 **Administrator Basic Retrospective Drug Utilization Review (DUR) Program.** The Administrator Retrospective DUR Program consists of Administrator (in conjunction with necessary third parties) performing a retrospective review of Eligible Participants' prescription claims and, if available and agreed to by the parties, medical data, to evaluate the appropriateness of each Eligible Participants' therapy based upon generally accepted current clinical pharmacy practices and guidelines. In the event Administrator identifies clinical concerns regarding an Eligible Participant's drug regimen, Administrator will communicate its findings to the prescribing physician and/or the dispensing pharmacist. Client acknowledges that services under this program shall be limited to basic retrospective review. This is a mandatory program in order to comply with CMS regulations.

1.5.3 **Administrator Medicare Part D Retrospective Opioid Overutilization Program.** The Administrator Medicare Part D Retrospective Opioid Overutilization Program consists of Administrator (in conjunction with necessary third parties) performing a retrospective review of Eligible Participants' prescription claims and, if available and agreed to by the parties, medical data, to identify Eligible Participants filling multiple prescriptions written by different prescribers and dispensed at different

pharmacies as it relates to opioid narcotic medications that exceed all medically-accepted norms of dosing. In the event Administrator identifies clinical concerns regarding an Eligible Participant's drug regimen, Administrator will communicate its findings to the prescribers. Administrator will provide case management which will include the necessary outreaches to the prescriber, referral for any identified fraudulent activity, implementation of point-of-sale edits, and beneficiary and prescriber notifications. These programs may be subject to change based on CMS requirements.

1.5.4 **Administrator Basic Medicare Quality (Stars) Program.** Administrator creates and manages a set of programs designed to maximize Medicare Star ratings. The Medicare Five Star program was established by CMS to provide plan-to-plan comparisons of several critical measures of health plan quality and performance. These Star ratings monitor performance on several operational, compliance, and clinical measures. Examples of programs to support Stars include medication adherence programs, therapeutic interventions for specific disease states, and member satisfaction programs. These programs require written or telephonic contact with Participants in Client's plan and/or their prescribing physicians. Administrator will provide Client with de-identified copies of any messaging communicated to Participants.

1.5.5 **Electronic Prescribing (E-prescribing) Services.** Administrator shall provide E-prescribing services, which shall be limited to eligibility information, medications history, and formulary benefit management. "***E-prescribing***" program shall mean the electronic transmittal of prescriptions and certain other information required for drugs prescribed for Eligible Participants with designated uniform standards as set forth under Chapter 7 of the Guidance. This is a mandatory program in order to comply with CMS regulations.

1.6 **Actuarial Equivalence Requirements.** Administrator will not be subject to the actuarial equivalence requirements set forth in 42 C.F.R §423.104(e)(5) with respect to the EGWP and may provide coverage deemed to be actuarially less than defined standard Medicare prescription drug coverage between the deductible and initial coverage limit. Administrator affirms that its basic prescription drug coverage under the EGWP will satisfy all of the other actuarial equivalence standards set forth in 42 C.F.R §423.104, including but not limited to the requirements set forth in 42 C.F.R §423.104(e)(3) that the EGWP has a total or gross value that is at least equal to the total or gross value of defined standard coverage.

1.7 **Client Group Enrollment Process.**

1.7.1 Administrator shall enroll and disenroll Participants into the EGWP in accordance with applicable CMS regulations and guidance. Client will enroll Part D eligible individuals eligible for its EGWP through a group enrollment process (i.e., Client provides electronic files) and in accordance with Client's eligibility requirements for participation in the EGWP; as such, Administrator will not be subject to the individual enrollment requirements (i.e., paper, online, broker, fax, telephonic enrollment) set forth in 42 C.F.R §423.32(b). Administrator agrees that all Part D eligible individuals eligible for the EGWP will be advised that Client intends to enroll Participants into the EGWP through a group enrollment process unless the individual opts out of such enrollment. The parties acknowledge that the information must include a summary of benefits offered under the EGWP, an explanation of how to get more information on such plan, and an explanation of how to contact Medicare for information on other Part D plans that might be available to the individual. The parties acknowledge that, except in cases of retroactive enrollment, all such individuals will be provided this information at least ninety (90) days in advance of the individuals enrollment in the EGWP in order

to comply with CMS requirements for notifying individuals at least twenty-one (21) days prior to the effective date of the individual's enrollment in the EGWP, provided Administrator has timely received a full/complete and accurate application for the Participant(s) via Client's electronic Eligible Participant File. The parties agree that enrollment information shall be submitted to CMS only by Administrator. All CMS enrollment requirements are managed by Administrator (e.g., Opt Out, Returned Mail, Out of Area, etc.) in order to support compliance with CMS requirements and are not subject to delegation to Client. In addition, Client must provide Client's initial Participant full file no less than sixty (60) days prior to the EGWP Commencement Date.

1.7.2 Administrator shall submit the Participant File received from Client (as set forth in section 2.3 of this EGWP Addendum) to CMS for enrollment or disenrollment in the Plan within the time frame specified by CMS. Upon receipt of confirmation of acceptance, denial or rejection of an individual from CMS, Administrator shall load the accepted Eligible Participants into (and rejected or disenrolled Participants from) the Plan and report the rejected or denied members back to Client for correction or other action. Client agrees to review and process all Participant file load errors upon initial return of the file from Administrator. Such review, processing and resubmission must take place no later than seven (7) days following notification from Administrator to Client of any Participant File load errors. If Client is utilizing the services of a third-party eligibility vendor to provide the eligibility services, or to review and correct the reject/denial reporting provided by Administrator, Client affirms that it has policies and procedures in place to ensure such third party submits accurate, complete, and timely files to ensure Participants are timely enrolled or disenrolled pursuant to CMS regulations. Client maintains accountability for overseeing Client's third-party eligibility vendor and shall work with Administrator to address and remediate any issues associated with such third-party eligibility vendor. Administrator shall not be liable for any prescriptions filled or processed for any ineligible persons due to incorrect or untimely eligibility data provided to Administrator by Client.

1.8 **CMS Reporting.** Administrator shall produce and submit prescription drug event (PDE) files, HPMS reporting, and other required reporting to CMS as part of Administrator's obligation as a PDP Sponsor. Client must address all eligibility-related rejections in a timely manner to ensure Administrator meets all CMS timeframes for submitting corrected PDE files during the plan year and prior to the end of the annual CMS reconciliation process in in June.

1.9 **Eligible Participant Services.**

1.9.1 **Eligible Participant Customer Service.** Eligible Participant customer service provides Participants with information regarding pharmacy locations, eligibility, drug coverage, copays/deductibles/out-of-pocket maximums, coverage determinations, appeals process in accordance with any applicable CMS regulations and guidance, direct member reimbursement instructions, claims status and general information regarding the Participant's prescription benefit plan as established by the Client. Where applicable, customer service support may include outreach to Participants to obtain required information needed to continue processing the Participant enrollment into the EGWP, or to confirm such information. Participant customer service is available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year (including for TTY and non-English speaking Participants). Administrator also utilizes a third-party vendor for CMS enrollment activities including enrollment inquiries, updating COB and address change information, LEP inquiries and attestations, enrollment communications, etc. that are separate and distinct from

Administrators call center.

1.9.2 **Participant Materials.** Administrator shall develop and mail Participant materials (except for the SPD if Client is governed by ERISA) as required by 42 C.F.R 423.128 unless Client is subject to ERISA. If Client is subject to ERISA, Client attests that it is in full compliance with all applicable ERISA laws and regulations and agrees to provide attestation or reasonable documentation to support compliance upon reasonable the written request of Administrator or CMS including the provision of Client's current Summary Plan Description ("***SPD***") including any material modifications if applicable for review to ensure consistency with CMS required Participant Materials. Administrator shall post the SPD to the Client's portal for review by Participants at Client's request. Such materials will consist of CMS compliant model templates. These materials may only be customized using Client branding, Client contact information (where required) and Client variable paragraphs that explain any Client-specific eligibility/plan rules. Administrator may update materials from time to time to comply with CMS requirements or due to changes in Administrator processes. Administrator will provide Client with template copies of such materials, including any updated materials. Should Client send any additional materials to Participants, such materials must first be approved by Administrator. As set forth under the CMS Contract, the parties agree that, with respect to the EGWP, Administrator will not be subject to the information requirements set forth in 42 C.F.R §423.48 and the prior review and approval of marketing materials and enrollment forms requirements by CMS set forth in 42 C.F.R §423.2260. Administrator will be subject to all other dissemination requirements contained in 42 C.F.R §423.128 and in CMS guidance, including Guidance Chapter 2 "Medicare Marketing Materials Guidelines for Medicare Advantage Plans (MAs), Medicare Advantage Prescription Drug Plans (MA-PDs), Prescription Drug Plans (PDPs), and 1876 Cost Plans" as amended (hereinafter "***Chapter 2***"),Chapter 12 "Employer/Union Sponsored Group Health Plans" as amended (hereinafter "***Chapter 12***"), and Guidance Chapter 3 Eligibility, Enrollment, Disenrollment" as amended (hereinafter "***Chapter 3***"). Additionally, as set forth in the CMS Contract, the dissemination requirements set forth in 42 C.F.R §423.128 will not apply with respect to the EGWP if Client is subject to alterative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("***ERISA***") and fully complies with such alternative requirements. Compensation for such Participant materials are further detailed in the EGWP Compensation **Attachment.** In the event that Client makes modifications to Participant Materials subsequent to final approval and implementation, any costs associated with the revision and mailing of such updated materials shall be billed to Client unless due to Administrator error.

1.10 **Ancillary Services.** If Client requests additional or ancillary EGWP services, including consultative services, other than those described herein, Administrator shall attempt to accommodate Client at a mutually agreed upon rate under a separate Agreement or amendment signed by the parties prior to the performance of services.

2. CLIENT OBLIGATIONS

2.1. **Plan Design Specifications.** Client will provide a Plan Design Document for the EGWP plan administered by Administrator in sufficient detail to permit Administrator to perform its duties and obligations under this EGWP Addendum. Client shall have the ultimate responsibility for approving any pharmacy benefit plan design; however, Client's Plan Design must be compliant with CMS requirements. If Administrator determines that any aspect of Client's Plan Design does not meet CMS requirements, Administrator will notify Client to discuss changes needed

to bring the Plan Design into compliance. Administrator retains sole authority for determining whether Client's Plan Design meets CMS compliance requirements. Administrator shall provide reasonable support in pharmacy benefit plan development, set up and administration on behalf of Client. If requested by Client, Administrator shall provide actuarial services to Client for the purpose of plan design recommendations and development at a mutually agreed upon fee. Administrator will establish and maintain pharmacy benefit plan designs as requested by Client via plan implementation documents provided and approved in writing by Client. Client and Administrator shall mutually agree on the format of the implementation documents. Any changes to the Plan Design Document will be submitted by Client to Administrator through a revised Plan Design Document no less than one hundred twenty (120) days prior to the intended implementation by Client to permit a timely implementation and minimal disruption of services to Eligible Participants. Client acknowledges that nothing in this EGWP Addendum shall be deemed to confer upon Administrator the status of fiduciary as defined in the Employee Retirement Income Security Act of 1974, as amended. All reasonably necessary Client documents (e.g., implementation form, benefit design specifications, etc.) must be signed by Client before any plan benefits will be implemented. Once the plan design document has been approved for the upcoming plan year, no additional changes shall be permitted. Should there be any plan design changes after approval and implementation, the Client shall be responsible for any costs associated with such changes, if applicable including changes to Participant Materials noted in section 1.9.2 above.

2.2. **Enrollment of Participants.**

2.2.1. Enrollment in the EGWP shall be restricted to those Part D Eligible Participants (and/or their Part D eligible spouses and/or dependents) for Client's employment-based retiree prescription drug coverage. Administrator agrees to provide basic prescription drug coverage, as defined under 42 C.F.R §423.100, under the EGWP, in accordance with Subpart C of 42 C.F.R Part 423.

2.2.2. By submitting a Participant to PBM for enrollment, Client validates and attests that all Participants permanently reside within the United States, District of Columbia, U.S. Virgin Islands, American Samoa, Northern Mariana Islands or the Territories of Puerto Rico or Guam. Client agrees that prior to submitting a Participant to Administrator for enrollment, Client must validate that Participant is Part D eligible and that Participant meets Client's plan requirements for an Eligible Participant. Client agrees Participant enrollment and disenrollment requests will be submitted to Administrator prospectively and must be accurate and complete records (included all Medicare required information such as the Participant's Medicare ID/HICN/MBI and EGWP Commencement Date). Administrator requires Client to comply with the enrollment and eligibility requirements set forth in Chapter 3 of the Guidance that ensure the timely submission of enrollment and disenrollment requests to mitigate or reduce the need for retroactivity and to help avoid errors pursuant to CMS regulations. Refer to Chapter 3, Section 60.5 of the Guidance for reference. Client agrees Participant re-enrollment requests will be submitted to Administrator via request to Client's PBM account management team and not via the Eligible Participant File. Client will comply with Administrator's enrollment processes for Participant ID changes, retroactive enrollments/disenrollment's, and other administrative matters. Should Client elect to change Participant identification numbers (e.g., for surviving spouse), Client will be required to confirm that the ID change is valid and accepts the risk associated with the movement of claims under the former ID to the new ID, required to ensure the Participants benefits remain in sync for the remainder of the plan year of the change. If the Client is using a third-party eligibility vendor to perform this service, Client will ensure that such third party will complete the attestation upon written authorization by

Client, and Client agrees to so authorize such third party. Client further acknowledges, that any ID change or reenrollment requests must be approved in writing prior to Administrator taking further action.

2.2.3. Client agrees to attest to Administrator that each Participant submitted to Administrator upon initial enrollment has a creditable coverage history satisfying any potential uncovered months on file at CMS (which will be used to assess a late enrollment penalty ("***LEP***")). Alternatively, if agreed on by the parties, Client agrees that Administrator will contact Participants directly to obtain attestations to some/all uncovered months. Client agrees that either Client will attest as to Participants, or Administrator will reach out to Participants, not a combination of the two (2). Client agrees that Administrator cannot attest to uncovered months on Client's or Participant's behalf. Client agrees to either adjust Participant premiums or pay the LEP on behalf of the Participant as/when applicable for any late enrollment penalty assessed by CMS and must be consistent for all individuals enrolled in the EGWP. Administrator does not provide for direct invoicing of the LEP to Participant's.

2.2.4. Client agrees to inform the Administrator's enrollment department upon initial enrollment if any Participants have other health coverage so that Administrator may provide CMS with any applicable information on other insurance coverage for the purposes of coordination of benefits.

2.2.5. Client (directly or through its third-party eligibility vendor) will review and process/correct all items in enrollment related reports provided by Administrator before submitting any subsequent Eligible Participant File (as hereinafter defined) to Administrator. Such review, processing, and submission must take place no later than seven (7) days following receipt of such reports.

2.3. **Participant File**. Client will provide Administrator with a full file (each an "***Eligible Participant File***") on electronic media acceptable to Administrator of all applicable Eligible Participants Benefit Plan to be serviced by Administrator hereunder. Each Eligible Participant File will include the valid enrollment effective dates per individual record for each new Eligible Participant, which effective date shall be for the current calendar month or not more than three (3) months following the current calendar month. Under CMS requirements, all enrollment effective dates must be effective on the first day of a calendar month and all terminations must be on the last day of the calendar month. If Client provides any retroactive enrollment effective date for an individual record, Client represents and warrants to Administrator that Client has the original signed application from the Eligible Participant, that the date on such signed application is the same as the retroactive effective date and that Client will provide a copy of such original signed application to Administrator upon request. The parties acknowledge that CMS will determine eligibility of Participants for CMS Part D subsidies. The parties further acknowledge that Participants are not enrolled in or disenrolled from the Administrator until CMS determination/approval is received. Additionally, Client will promptly furnish Administrator, on electronic media acceptable by Administrator, files containing records for all Eligible Participants whose enrollment has been terminated with termination dates and each new Eligible Participant for enrollment into the EGWP. Client acknowledges that Administrator does not perform Participant terminations or cancelations via "term by absence". Administrator shall not be liable for any prescriptions filled or processed for any ineligible persons due to incorrect or untimely eligibility data provided to Administrator.

2.4. **Participant Subsidy**. Administrator and Client acknowledge that Client may determine how much of a Participant's Part D monthly beneficiary premium it will subsidize, subject to any

restrictions imposed by the CMS Contract set forth below, and CMS and other federal regulations, including all premium regulations set forth in Chapter 12.

2.4.1. Participants will not be permitted to make payment of premiums under 42 C.F.R §423.293(a) through withholding from the Participant's Social Security, Railroad Retirement Board, or Office of Personnel Management benefit payment.

2.4.2. Client can subsidize different amounts for different classes of Participants in the EGWP provided such classes are reasonable and based on objective business criteria, such as years of services, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for the Low-Income Subsidy.

2.4.3. Client cannot vary the premium subsidy for individuals within a given class of Participants.

2.4.4. Client cannot charge Participants for prescription drug coverage provided under the EGWP more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any). Client must pass through direct subsidy payment received from CMS to reduce the amount the Participant pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays).

2.4.5. For all those Participants eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce any portion of the monthly beneficiary premium paid by the Participant (or in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a low income eligible spouse or dependent, the amount the subscriber or participant pays), with any remaining portion of the premium subsidy amount then applied toward the portion of any monthly beneficiary premium paid by Client. However, if the sum of the Participant's monthly premium (or the subscriber's/participant's monthly premium, if applicable) and Client's monthly premiums (i.e., total monthly premium) are less than the monthly low-income premium subsidy amount, any portion of the low-income subsidy premium amount above the total monthly premium must be returned directly to CMS. Similarly, if there is no monthly premium charged to the Participant (or subscriber/participant, if applicable) or Client, the entire low-income premium subsidy amount must be returned directly to CMS and cannot be retained by Administrator, Client, or the Participant (or the subscriber/participant, if applicable).

2.4.6. Administrator and Client may agree that Client will be responsible for reducing up front the premium contribution required for Participants eligible for the Low-Income Subsidy. In those instances where Client is not able to reduce up front the premiums paid by the Participant (or the subscriber/participant, if applicable), Administrator and Client may agree that Client shall directly refund to the Participant (or the subscriber/participant, if applicable) the amount of the low-income premium subsidy up to the monthly premium contribution previously collected from the Participant (or the subscriber/participant, if applicable). Client is required to complete the refund on behalf of Administrator within forty-five (45) days of the date Administrator receives from CMS the low-income premium subsidy amount payment for the Participant eligible for the low-income subsidy. Client, upon request from Administrator, will provide an attestation to Administrator regarding its compliance with the terms of this section.

2.4.7. If Administrator does not or cannot directly bill a Client's Participants, CMS will permit Administrator to directly refund the amount of the Low-Income Subsidy to the Participant. This refund must meet the above requirements concerning beneficiary premium contributions; specifically, that the amount of the refund may not exceed the amount of the monthly premium contribution by the Participant and/or Client. In addition, Administrator must refund these amounts to the Participant within a reasonable time period. However, under no circumstances may this time period exceed forty-five (45) days from the date that Administrator receives the Low-Income Subsidy amount for that Participant from CMS.

2.4.8. The parties agree that Administrator shall obtain written agreements from Client which provides that Client may determine how much of a Participants' Part D monthly beneficiary premium it will subsidize subject to the restrictions set forth in II. B.3(a) through (g) of the CMS Contract. Administrator agrees to retain these written agreements with Client, including any written agreements related to items (d) through (f) of the CMS Contract, and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with requirements of 42 C.F.R 423.504(d) and 423.505(d) and (e).

2.4.9. If the low income subsidy premium amount for which a Participant is eligible is less than the portion of the monthly Participant premium paid by the Participant (or subscriber/participant, if applicable), then Client should communicate to the Participant (or subscriber/participant) the financial consequences of the low income subsidy eligible Participant enrolling in the EGWP as compared to enrolling in another Part D plan with a monthly Participant premium equal to or below the low income premium subsidy amount.

2.4.10. Client attests that it has eligibility requirements and policies and procedures in place to manage and process reinstatement requests in accordance with CMS guidance. Upon Administrator's written request, Client will provide to Administrator documentation (including but not limited to Client policies and procedures) demonstrating Client's compliance with CMS guidance for the handling of reinstatement requests.

2.4.11. If Client is unable to determine or provide the amount of the annual premium that is solely related to the prescription drug benefit, Client agrees to provide Administrator with the amount of the illustrative premium and an actuarial certification annually to be used for CMS audit purposes and Administrator compliance oversight. For purposes of this attestation, the illustrative premium is equal to the premium Client would have paid if they had purchased an equivalent product offered by Administrator.

2.5. **Coordination of Benefits.**

2.5.1. If the parties agree to include additional benefits in the EGWP, these benefits will be considered non-Medicare Part D benefits and that such additional benefits may not reduce the value of basic prescription drug coverage (e.g., additional benefits cannot impose a cap that would preclude Participants from realizing the full value of such basic prescriptions drug coverage).

2.5.2. Any additional non-Medicare Part D benefits offered under the EGWP will always pay primary to the subsidies provided by CMS to low-income individuals under Subpart P of 42 C.F.R Part 423 (the "***Low Income Subsidy***").

2.5.3. Client is solely responsible for any and all coordination between plans should Client choose to allow Participants to enroll in a separate 800 series Medicare Advantage (MA) plan.

2.5.4. Client agrees that Administrator accepts and loads other comprehensive Primary and/or Secondary insurance information provided by CMS and claims for Participants with other Primary coverage from this process will reject, informing the submitting pharmacy to first bill the Participant's primary coverage. Administrator will mail surveys to these Participants upon initial receipt of the information from CMS, and then annually after that, to request the Participant report any updates in the other coverage(s) directly to Administrator. Administrator will then report these updates to CMS.

3. **PAYMENT. - See Attachment B, II.1 and 2.**

3.1. **Administrative Payments to Administrator**. Administrator shall invoice Client for the Claims Administration fees set forth on Attachment F-1. Payment terms for EGWP Services will be as set forth in Attachment B, Sections II.1 and II.2 of the Contract and shall be incorporated herein by reference.

3.2. **EGWP Participant per Month Fee**. On a monthly basis, Administrator shall invoice Client for the EGWP per Participant per month fee as set forth on Attachment F-1.

3.3. **Network Claims Funding**. On a monthly basis, Administrator shall invoice Client for the Network Claims Funding (as hereinafter defined).

3.4. **CMS Subsidy Payment Reporting**. Administrator shall issue to Client, on a monthly, quarterly, and annual basis, reporting via direct check or Electronic Funds Transfer (EFT) related to CMS subsidies that are payable along with a detailed report by Client at the Member level that substantiates the total amount of the CMS subsidy. Notwithstanding the foregoing, Client acknowledges that it will be responsible for payment of Administrative Fees, EGWP Participant per Month fees, and the Network Claims Funding even if CMS determines that a Participant is not eligible for the CMS Subsidy subsequent to a prior eligibility determination. To the extent CMS subsidies are issued for a Participant, who is subsequently determined to be ineligible by CMS, Administrator shall have the right to recoup such amounts from Client. "***CMS Subsidy***" shall mean the monthly Part D Direct Subsidy, Coverage Gap Discounts, Low-Income Cost Sharing Subsidy, Low-Income Premium Subsidy, and Catastrophic Reinsurance payments for each Participant from CMS as governed by the rules of Subpart G of 42 C.F.R Part 423 and the CMS Contract.

3.5. **Enhanced/Other Health Insurance (OHI) WRAP Coverage (Commercial/Non-Medicare).** Client has elected to enhance the coverage offered under Client's EGWP through commercial WRAP drug coverage to provide a more comprehensive benefit to Client's retirees enrolled under the EGWP. Such additional coverage may include Medicare Part D excluded drugs such as ED, DESI, Cough and Cold products, commonly used OTC products and/or Medicare Part B drugs or products (other than those covered under the Medicare Part D benefit). Under the EGWP Standard Formulary option, the Medicare Part D Excluded and/or Medicare Part B drug Bonus lists are not customizable.

4. **TERM AND TERMINATION.**

4.1. **EGWP Term**. This EGWP Addendum will become effective on the date hereof and continue for three (3) years after the EGWP Commencement Date (the "Initial Term"). Thereafter, this

EGWP Addendum automatically renews for successive twelve (12)-month renewal periods on each applicable anniversary date (each a "Renewal Term"), unless either party provides the other party with written notice of non-renewal of this EGWP Addendum at least one hundred twenty (120) days before the end of such Initial or Renewal Term.

4.2. **EGWP Termination.** Termination of this EGWP Addendum will be as set forth in Sections 33 and 36 of the Contract and shall be incorporated herein by reference.

5. **RECORD MAINTENANCE AND CMS ACCESS**

5.1. **Client Audit.** Client shall have audit access under this EGWP Addendum for the limited purpose of verifying pricing and compliance as further described in the Agreement.

5.2. **Record Maintenance.** For the longer of (1) the period required by law or (2) ten (10) years from the date of rendering any covered Prescription Drug Services, and as further required under 42 C.F.R §§423.505(b)(10) and 423.505(i)(2), the parties will maintain records related thereto, including, but not limited to, prescription records and other documentation related to healthcare services provided to Participants.

5.3. **Administrator and/or CMS Audit.** Administrator and Client acknowledge that CMS may audit records under this EGWP Addendum. Client shall maintain records, including but not limited to, any data related to enrollment (i.e., enrollment data validation reports), disenrollment, eligibility, Participant communications, and other areas covered by this EGWP Addendum. Client agrees it will provide Administrator and CMS with prompt access to such records to the extend required by and in accordance with 42 C.F.R 423.504(d) and 423.505(d) and (e) as well as Chapter 2, Chapter 3, and Chapter 12 of the Guidance. To the extent allowed under law, all information and records reviewed pursuant to this section shall be considered Confidential Information for the purposes of this EGWP Addendum.

6. **NOTICES.** All notices and other communications required or permitted under this Agreement will be in writing and sent to the addresses set forth below (or at other addresses as specified by a notice). All notices will be deemed to have been received either: (a) when delivered, if delivered by hand or commercial courier, sent by United States registered or certified mail (return receipt requested); or (b) on the next business day, if sent by a nationally recognized commercial overnight courier.

If to OptumRx:
OptumRx, Inc.
1600 McConnor Parkway
Schaumburg, IL 60173-6801
Attn: Vice President, Client Management

Copy to:
OptumRx, Inc.
1600 McConnor Parkway
Schaumburg, IL 60173-6801
Attn: General Counsel

If to Client:
County of Orange
333 W. Santa Ana Blvd. Suite 137
Santa Ana, CA 92701
Attn: Employee Benefits

7. **EXCLUSIVITY.** Client agrees to utilize only Administrator to provide EGWP services during the term of this EGWP Addendum.

8. **SURVIVAL.** Termination of the Agreement shall not mean automatic termination of this EGWP Addendum. Unless either party terminates this EGWP Addendum in accordance with section 4.1 or 4.2, this EGWP Addendum shall survive as a stand-alone agreement and incorporate those provisions

from the Agreement cited in this EGWP Addendum to the extent such provisions do not contradict the terms set forth in this EGWP Addendum.

9. **EGWP ADDENDUM.** This EGWP Addendum, and any attachments, and any documents incorporated by reference constitute the entire agreement between the parties regarding the EGWP services to be provided. It supersedes any prior agreement, negotiations or representations, either oral or written, relating to the subject matter of this EGWP Addendum. Should there be any conflict between this EGWP Addendum, the Agreement or CMS rules or regulations, the order of precedence of interpretation with respect to EGWP services shall be: (1) CMS rules and regulations; (2) the Agreement and (3) this EGWP Addendum. This EGWP Addendum may be modified only by a writing executed by both parties.

The parties have accepted and agreed to this EGWP Addendum.

Optum Insurance Ohio, Inc.

By: Ellen Nelson — President, Public Sector and Government Market Segment

Print Name — Title

Docusigned by: Ellen Nelson — 6/27/2022

Signature — Date

By: Katie Carey — CFO

Print Name — Title

Docusigned by: Katie Carey — 6/27/2022

Signature — Date

County of Orange, a political subdivision of the State of California

By: _____

Print Name — Title

_____

Signature — Date