COUNTY OF ORANGE

HUMAN RESOURCE SERVICES – EMPLOYEE BENEFITS

Contract

With

OptumRx, Inc

for

Pharmacy Benefit Management and
Claims Administration Program

Contract

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CONTRACT

THIS AGREEMENT to provide a Pharmacy Benefit Management and Claims Administration Program, (hereinafter referred to as "Contract"), is effective by and between the County of Orange, a political subdivision of the State of California, (hereinafter referred to as "County") and OptumRx, Inc., with a place of business at 1600 McConnor Parkway, Schaumburg, IL 60173, (hereinafter referred to as "Contractor"), which are sometimes individually referred to as "Party" or collectively as "Parties".

RECITALS

WHERAS, Contractor responded to a Request for Proposal ("RFP") to provide a Pharmacy Benefit Management and Claims Administration Program as defined herein; and

WHERAS, the Contractor represents that its services shall meet or exceed the requirements and specifications of the RFP; and

WHEREAS, the County's Board of Supervisors has authorized the Purchasing Agent or its *designee* to enter into this Contract with Contractor for a Pharmacy Benefit Management and Claims Administration Program;

NOW, THEREFORE, the Parties mutually agree as follows:

ARTICLES

General Terms and Conditions:

1. **Scope of Contract:** This Contract, including any Attachments and Exhibits, specifies the contractual terms and conditions by which the County will obtain professional services provided by Contractor as further detailed in the Scope of Work, identified and incorporated herein by this reference as "Attachment A".

2. **Compensation:** The Contract price as set forth in "Attachment B" Cost/Compensation, identified and incorporated herein this reference, as full renumeration for (a) performing all Services and furnishing all staffing and materials required, (b) any reasonably unforeseen difficulties which may arise or be encountered in the performance of the Services until acceptance, and (c) risks connected with the Services.

~~3.~~ **Term of Contract:** The Contract shall commence upon January 1, 2021 and shall continue in effect through December 31, 2024~~for a period of three (3) years ("Initial Term"),~~ unless earlier terminated ~~in accordance with this Contract~~ by ~~the~~ County. The Contract may be renewed thereafter for ~~two (2)~~ one (1) additional consecutive one (1) year term ~~periods (each a "Renewal Term"),~~ upon the ~~mutual~~ written agreement of both Parties. Renewal of the Contract may require approval by the County Board of Supervisors. The County does not have to give a reason if it elects not to renew this Contract; however, the County must provide ninety (90) days advance written notice of its intent not to renew this Contract to Contractor. Permitted renewals of the Contract provided in this paragraph 3 shall not result in any change in any other term, condition or provision of this Contract unless agreed to in writing by the Parties. ~~The Initial Term and any subsequent Renewal Term shall collectively be defined as the "Term".~~

4. **Entire Contract:** This Contract, including its Attachments and Exhibits as listed in Section 60 (Incorporation), which are attached hereto and incorporated herein by this reference, contains the entire Contract between the Parties with respect to the matters herein. There are no restrictions, promises, warranties or undertakings other than those set forth or referred to herein. No exceptions, alternatives, substitutes, or revisions are valid or binding on the County unless authorized by the County in writing. Electronic acceptance of any additional terms, conditions or supplemental Contracts by any County employee or agent, including but not limited to installers of software, shall not be valid or binding on the County unless accepted in writing by the County's Purchasing

Agent or his authorized designee. In the event of a conflict between or among the Contract documents, the

order of precedence shall be the provisions of the main body of this Contract (i.e., those provisions set forth in the recitals and articles), and then the attachments and then the exhibits.

5. **Amendments:** No alteration or variation of the terms of this Contract shall be valid unless made in writing and signed by the Parties; no oral understanding or agreement not incorporated herein shall be binding on either of the Parties; and no exceptions, alternatives, substitutes or revisions are valid or binding on the County unless authorized by the County in writing.

6. **Governing Law and Venue:** This Contract has been negotiated and executed in the state of California and shall be governed by and construed under the laws of the state of California without reference to conflict of laws provisions. In the event of any legal action to enforce or interpret this Contract, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure Section 394. Furthermore, the parties specifically agree to waive any and all rights to request that an action be transferred for trial to another venue.

7. **Contingency of Funds:** Contractor acknowledges that funding or portions of funding for this Contract may be contingent upon state budget approval, receipt of funds from, and/or obligation of funds by, the state of California to County; and inclusion of sufficient funding for the services hereunder in the budget approved by County's Board of Supervisors for each fiscal year covered by this Contract. If such approval, funding or appropriations are not forthcoming, or are otherwise limited, County may immediately terminate, upon notice this Contract without penalty.

8. **Taxes:** Unless otherwise provided herein or by law, price quoted does not include California state sales or use tax. Out-of-state Contractors shall indicate California Board of Equalization permit number and sales permit number on invoices, if California sales tax is added and collectable. If no permit numbers are shown, sales tax will be deducted from payment. The Auditor-Controller will then pay use tax directly to the State of California in lieu of payment of sales tax to the Contractor.

9. **Delivery:** Time of delivery of services is of the essence in this Contract. County reserves the right to refuse any services and to cancel all or any part of the services that do not conform to the prescribed Scope of Work.

10. **Independent Contractor:** Contractor shall be considered an independent contractor and neither Contractor, its employees, nor anyone working under Contractor shall be considered an agent or an employee of County. Neither Contractor, its employees nor anyone working under Contractor, shall qualify for workers' compensation or other fringe benefits of any kind through County.

11. **Assignment or Sub-contracting:** The terms, covenants, and conditions contained herein shall apply to and bind the heirs, successors, executors, administrators and assigns of the Parties. Furthermore, neither the performance of this Contract nor any portion thereof may be assigned or sub-contracted by Contractor without the express written notice to the County. Any attempt by Contractor to assign or sub-contract the performance or any portion thereof of this Contract without the express written notice to the County shall be invalid and shall constitute a breach of this Contract. Irrespective of any assignment of subcontracting with respect to any portion of this Contract, Contractor shall remain fully responsible and liable for the performance of all services required herein. Contractor currently does not contemplate utilizing subcontractors specifically in support of the services to be provided by the County. Notwithstanding this paragraph or any other terms or provisions set forth in this Contract or its attachments, none of the work done for the County, its employees, agents, directors, elected officials or their dependents as relates participant interaction may be performed outside the United States of America. Further, no participant specific data will be sent to locations outside the United States of America. To the extent that non-core account team members, special project teams and the like are required to do work for the County outside the United States of America, non-core account team members will not access participant data that will allow for personal identification either as a standalone data element or in combination, for example, including but not limited to social security number, date of birth, personal health information, and home addresses outside the United States of America by Contractor, its affiliates, or their employees, directors, or subcontractors. Contractor is part of a large, multinational entity that has employees around the world, all of whom follow universal policies and procedures. However, Contractor agrees that the services stated in the Contract that directly serves the participants of County and involve access, and/or utilization, to participant

information will only be performed within the borders of the United States of America and its territories (the "U.S."). This restriction does not apply to services that are indirect, administrative, overhead services, or services that are incidental to the performance of this Contract, including but not limited to IT infrastructure, troubleshooting, and support, where such offshore services are performed by badged employees. No County PHI will be stored outside of the U.S.

12. **Non-Discrimination:** In the performance of this Contract, Contractor agrees that it will comply with the requirements of Section 1735 of the California Labor Code and not engage nor permit any sub-contractors to engage in discrimination in employment of persons because of the race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, or sex of such persons. Contractor acknowledges that a violation of this provision shall subject Contractor to all the penalties imposed for a violation of anti-discrimination laws or regulations including but not limited to Section 1741 of the California Labor Code.

13. **Performance:** Contractor shall perform all work under this Contract, taking necessary steps and precautions to perform the work to County's satisfaction. Contractor shall be responsible for the professional quality, technical assurance, timely completion and coordination of all documentation and other services performed by the Contractor under this Contract. Contractor shall perform all work diligently, carefully, and in a good and workman-like manner; shall furnish all labor, supervision, machinery, equipment, materials, and supplies necessary therefore; shall at its sole expense obtain and maintain all permits and licenses required by public authorities, including those of County required in its governmental capacity, in connection with performance of the services; and, if permitted to sub-contract, shall be fully responsible for all work performed by sub-contractors.

14. **Errors and Omissions:** All reports, files and other documents prepared and submitted by Contractor shall be complete and shall be carefully checked by the professional(s) identified by Contractor as Account Manager and key personnel, prior to submission to the County. Contractor agrees that County review is discretionary and Contractor shall not assume that the County will discover errors and/or omissions. If the County discovers any errors or omissions prior to approving Contractor's reports, files and other written documents, the reports, files or documents will be returned to Contractor for correction. Should the County or others discover errors or omissions in the reports, files or other written documents submitted by Contractor after County approval thereof, County approval of Contractor's reports, files or documents shall not be used as a defense by Contractor in any action between the County and Contractor, and the reports, files or documents will be returned to Contractor for correction at no charge to County.

15. **Warranty:** Contractor expressly warrants that the services covered by this Contract: 1) will be performed in a timely, competent and professional manner, in accordance with industry standards by duly qualified and experienced Contractor personnel possessing all relevant certifications, licenses and permits; 2) will conform to the specifications set forth herein and 3) are fit for the particular purpose in which they are intended. Acceptance of this Contract shall constitute an agreement upon Contractor's part to indemnify, defend and hold County and its indemnities, as identified in paragraph 19 below and as more fully described in paragraph 18, harmless from liability, loss, damage and expense, including reasonable counsel fees, incurred or sustained by County by reason of the failure of the services to conform to such warranties, faulty work performance, negligent or unlawful acts, and non-compliance with any applicable state or federal codes, regulations, ordinances, orders, or statutes, including the Occupational Safety and Health Act (OSHA) and the California Industrial Safety Act. Such remedies shall be in addition to any other remedies provided by law.

16. **Patent/Copyright Materials/Proprietary Infringement:** Unless otherwise expressly provided in this Contract, Contractor shall be solely responsible for clearing the right to use any patented or copyrighted materials in the performance of this Contract. Contractor warrants that any software as modified through services provided hereunder will not infringe upon or violate any patent, proprietary right or trade secret right of any third party. Contractor agrees that, in accordance with the more specific requirement contained in paragraph 19 below, it shall indemnify, defend and hold County and County Indemnitees harmless from any and all such claims and be responsible for payment of all costs, damages, penalties and expenses related to or arising from such claim(s), including, but not limited to, attorney's fees, costs and expenses.

17. **Compliance with Laws:** Contractor represents and warrants that services to be provided under this Contract

shall fully comply, at Contractor's expense, with all standards, laws, statutes, restrictions, ordinances, requirements, and regulations (collectively "laws"), including, but not limited to those issued by County in its governmental capacity and all other laws applicable to the services at the time services are provided to and accepted by County. Contractor acknowledges that County is relying on Contractor to ensure such compliance, and pursuant to the requirements of paragraph 19 below, Contractor agrees that it shall defend, indemnify and hold County and County INDEMNITEES harmless from all liability, damages, costs and expenses arising from or related to a violation of such laws.

18. **Indemnification:** Contractor agrees to indemnify, defend with counsel approved in writing by County, and hold County, its elected and appointed officials, officers, employees, agents and those special districts and agencies which County's Board of Supervisors acts as the governing Board ("County Indemnitees") harmless from any claims, demands or liability of any kind or nature, including but not limited to personal injury or property damage arising from or related to Contractor's negligence or willful misconduct in providing the services, products or other performance provided by Contractor pursuant to this Contract. If judgment is entered against Contractor and County by a court of competent jurisdiction because of the concurrent active negligence of County or County Indemnitees, Contractor and County agree that liability will be apportioned as determined by the court. Neither party shall request a jury apportionment.

19. **Limitation on Liability:** In no event shall either Party be liable to the other for any loss of profits, lost business opportunity or any special, indirect, consequential or incidental damages arising out of or in connection with this Contract, regardless of the cause of action.

    Contractor will not be responsible for any claims, losses, or damages sustained as a result of the actions, or failure to act, by any retail pharmacy, pharmaceutical manufacturer or other pharmaceutical providers pursuant to this Contract.

20. **Emergency/Declared Disaster Requirements:** In the event of an emergency or if Orange County is declared a disaster area by the County, state or federal government, this Contract may be subjected to unusual usage. The Contractor shall service the County during such an emergency or declared disaster under the same terms and conditions that apply during non-emergency/disaster conditions. The pricing quoted by the Contractor shall apply to serving the County's needs regardless of the circumstances. If the Contractor is unable to supply the goods/services under the terms of the Contract, then the Contractor shall provide proof of such disruption and a copy of the invoice for the goods/services from the Contractor's supplier(s). Additional profit margin as a result of supplying goods/services during an emergency or a declared disaster shall not be permitted. In the event of an emergency or declared disaster, emergency purchase order numbers will be assigned. All applicable invoices from the Contractor shall show both the emergency purchase order number and the Contract number.

21. **Insurance Provisions:** Prior to the provision of services under this Contract, the Contractor agrees to purchase all required insurance at Contractor's expense including all endorsements required herein, necessary to satisfy the County that the insurance provisions of this Contract have been complied with. Contractor agrees to keep such insurance coverage, Certificates of Insurance, and endorsements on deposit with the County during the entire term of this Contract. In addition, all subcontractors performing work on behalf of Contractor pursuant to this Contract shall obtain insurance subject to the same terms and conditions as set forth herein for Contractor. Contractor shall ensure that all subcontractors performing work on behalf of Contractor pursuant to this Contract shall be covered under Contractor's insurance as an Additional Insured or maintain insurance subject to the same terms and conditions as set forth herein for Contractor. Contractor shall not allow subcontractors to work if subcontractors have less than the level of coverage required by County from Contractor under this Contract. It is the obligation of Contractor to provide notice of the insurance requirements to every subcontractor and to receive proof of insurance prior to allowing any subcontractor to begin work. Such proof of insurance must be maintained by Contractor through the entirety of this Contract for inspection by County representative(s) at any reasonable time. Contractor shall not allow subcontractors to work if subcontractors have less than the level of coverage required by county from Contractor under this Contract. It is the obligation of Contractor to provide notice of the insurance requirements to every subcontractor and to receive proof of insurance prior to allowing any subcontractor to begin work. Such proof of insurance must be maintained by Contractor through the entirety of this Contract.

    All self-insured retentions (SIRs) shall be clearly stated on the Certificate of Insurance. If Contractor' is self-

insured, Contractor, in addition to, and without limitation of, any other indemnity provision(s) in this Contract, agrees to all of the following:

1) In addition to the duty to indemnify and hold the County harmless against any and all liability, claim, demand or suit resulting from Contractor's, its agents, employee's or subcontractor's negligence or willful misconduct in providing the services, Contractor shall defend the County at its sole cost and expense with counsel approved by Board of Supervisors against same; and
2) Contractor's duty to defend, as stated above, shall be absolute and irrespective of any duty to indemnify or hold harmless; and
3) The provisions of California Civil Code Section 2860 shall apply to any and all actions to which the duty to defend stated above applies, and the Contractor's SIR provision shall be interpreted as though the Contractor was an insurer and the County was the insured.

If the Contractor fails to maintain insurance acceptable to the County for the full Term of this Contract, the County may terminate this Contract.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by the Contractor shall provide the minimum limits and coverage as set forth below:

Coverage	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 combined single limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence
Professional Liability Insurance	$10,000,000 per claims made or per occurrence
Network Security & Privacy Liability	$5,000,000 per claims

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (ISO) form CG 00 01, or a substitute form providing liability coverage at least as broad.

The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 0012, CA 00 20, or a substitute form providing coverage at least as broad.

Required Endorsements
The Commercial General Liability policy shall contain the following endorsements, which shall accompany the Certificate of Insurance:

1) An Additional Insured endorsement using ISO form CG 20 26 04 13or a form at least as broad naming the ***County of Orange its elected and appointed officials, officers, agents and employees*** as Additional Insureds, or provide blanket coverage, which will state ***AS REQUIRED BY WRITTEN CONTRACT.***

2) A primary non-contributing endorsement using ISO form CG 20 01 04 13, or a form at least as broad evidencing that the Contractor's insurance is primary, and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing.

The Network Security and Privacy Liability policy shall contain the following which shall accompany the Certificate of Insurance:

1) An Additional Insured naming the ***County of Orange, its elected and appointed officials, officers, agents and employees*** as Additional Insureds for its vicarious liability.
2) A primary and non-contributing endorsement evidencing that the Contractor's insurance is primary, and any insurance or self-insurance maintained by the County of Orange shall be excess and non- contributing.

The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the ***County of Orange, its elected and appointed officials, officers, agents and employees*** or provide blanket coverage, which will state ***AS REQUIRED BY WRITTEN CONTRACT.***

All insurance policies required by this Contract shall waive all rights of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

Contractor shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Contract, upon which the County may suspend or terminate this Contract.

If Contractor's Professional Liability and Network Security and Privacy Liability are "Claims-Made" policies, Contractor shall agree to maintain coverage for two (2) years following completion of the Contract.

The Commercial General Liability policy shall contain a severability of interests clause also known as a "separation of insureds" clause (standard in the ISO CG 0001 policy).

Insurance certificates should be forwarded to the agency/department address listed on the solicitation.

If the Contractor fails to provide the insurance certificates and endorsements within seven (7) days of notification by CEO/Purchasing or the agency/department purchasing division, award may be made to the next qualified vendor.

County expressly retains the right to require Contractor to increase or decrease insurance of any of the above insurance types throughout the Term of this Contract which shall be mutually agreed upon. Any increase or decrease in insurance will be as deemed by County of Orange Risk Manager as appropriate to adequately protect County.

County shall notify Contractor in writing of changes in the insurance requirements. If Contractor does not deposit copies of acceptable Certificates of Insurance and endorsements with County incorporating such changes within thirty (30) days of receipt of such notice, this Contract may be in breach without further notice to Contractor, and County shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit Contractor's liability hereunder nor to fulfill the indemnification provisions and requirements of this Contract, nor act in any way to reduce the policy coverage and limits available from the insurer.

22. **Confidentiality:** Contractor agrees to maintain the confidentiality of all County and County-related records and other Confidential Information pursuant to all statutory laws relating to privacy and confidentiality that currently exist or exist at any time during the Term of this Contract. All such records and information shall be considered confidential and kept confidential by Contractor and Contractor's staff, agents and employees. Similarly, County agreed to maintain the confidentiality of all Contractor and Contractor-related records and Confidential Information pursuant to all statutory laws relating to privacy and confidentiality that current exist or exist at any time during the Term of this Contract.

    a. For purposes of this Contract, "Confidential Information" means any data or information that is proprietary to the Party making disclosure (the "Disclosing Party") and not generally known to the public, whether in tangible or intangible form, whenever and however disclosed, including, but not limited to: (i) any marketing strategies, plans, financial information, or projections, operations, sales estimates, business plans and performance results relating to the past, present or future business activities of such Party, its affiliates, subsidiaries and affiliated companies; (ii) plans for products or services, and customer or supplier lists; (iii) any scientific or technical information, invention, design, process, procedure, formula, improvement, technology or method (iv) any concepts, reports, data, know-how, works-in-progress, designs, development tools, specifications, computer software, source code, object code, flow charts, databases, inventions, information and trade secrets; (v) any and all summaries, analysis, determinations, distillations, excerpts, work product, results or other documents utilizing or incorporating Confidential Information, whether in whole or in part; (vi) any Protected Health Information, as that term is defined by the HIPAA Privacy Rule, 45 C.F.R. Secs. 160 and 164, that is provided by either Contractor or County pursuant to this Contract; (vii) any information that either Party learns or becomes aware of, directly or indirectly, through the disclosure of Confidential Information; and (viii) any other information that should reasonably be recognized as confidential information of the Disclosing Party. Confidential Information need not be novel, unique, patentable, copyrightable or constitute a trade secret in order to be designated Confidential Information. The Party receiving the information (the "Receiving Party") acknowledges that the Confidential Information is proprietary to the Disclosing Party, has been developed and obtained through great efforts by the Disclosing Party and that Disclosing Party regards all of its Confidential Information as trade secrets. All Confidential Information shall at all times, and throughout the world, remain the property of either Contractor or the County (as the case may be), exclusively, and all applicable rights in patents, copyrights, trademarks, service marks, trade names and trade secrets shall remain

vested in the appropriate Party, exclusively.

b. Use of Confidential Information. The receiving Party shall use the Confidential Information it receives pursuant to this Contract for the sole purpose of its obligations under this Contract. Except as specifically provided herein, in no event shall the receiving Party disseminate or communicate the Confidential Information in any form to any other person, firm, corporation or affiliate without the express written consent of the disclosing Party. The receiving Party shall only disclose Confidential Information to any third party who (i) needs to know the Confidential Information in order to accomplish the objectives in connection with this Contract, and (ii) is required to protect and otherwise not disclose or use the Confidential Information except as provided in this Contract. Any third party who receives any Confidential Information shall be subject to written agreement no less restrictive than this Section 22.

c. Derivatives of Confidential Information. Any reports, documents, notes or other information in whatever form or medium that are derived or result from the receipt of Confidential Information shall be governed by the same terms and conditions respecting confidentiality and used as it is the Confidential Information itself.

d. Rights in Confidential Information. All Confidential Information of the disclosing Party shall be and remain the property of the disclosing Party. The receiving Party shall not obtain any rights of any nature whatsoever in or to the Confidential Information as a result of such disclosure. Upon disclosing Party's request, the receiving Party shall promptly destroy or return to the disclosing Party all of the disclosing Party's Confidential Information. An officer of the receiving Party shall certify to the disclosing Party that all Confidential Information has been destroyed or returned to the disclosing Party. Notwithstanding the foregoing, the receiving Party may retain one original or one copy of the Confidential Information and must maintain the confidentiality of such Confidential Information in accordance with the terms of this section.

e. Contractor understand and agrees that the County is governmental agency subject to California and Federal laws regarding disclosure of public records which may include Confidential Information. If such a request for disclosure is made pursuant to these laws, County agrees to give notice to Contractor and allow Contractor an opportunity to file an action preventing such a disclosure.

23. **Contractor Personnel:** Contractor warrants that all Contractor personnel engaged in the performance of work under this Contract shall possess sufficient experience and/or education and the required licenses set forth herein in good standing to perform the services requested by the County. County expressly retains the right to have any of the Contractor personnel removed from performing services under this Contract to the County. Contractor shall effectuate the removal of the specified Contractor personnel from providing any services to the County under this Contract within one business day of notification by County. County shall submit the request in writing to the Contractor's Account Manager. The County is not required to provide any reason, rationale or additional factual information if it elects to request any specific Contractor personnel be removed from performing services under this Contract.

24. **Contractor's Account Manager and Key Personnel**: Contractor shall appoint an Account Manager to direct the Contractor's efforts in fulfilling Contractor's obligations under this Contract. This Account Manager shall be subject to approval by the County and unless the Account Manager leaves the Contractor organization or is promoted within the Contractor organization, shall not be changed

without the written consent of the County's Program Manager, which consent shall not be unreasonably withheld.

The Contractor's Account Manager and key personnel shall be assigned to this project for the duration of this Contract and shall diligently pursue all work and services to meet the project time lines. Key personnel are those individuals who work within the Contractor organization and liaison directly with the Contractor's Account Manager.

25. **Program Manager:** The County shall appoint a Program Manager to act as liaison between the County and the Contractor during the Term of this Contract. The County's Program Manager shall coordinate the activities of the County staff assigned to work with the Contractor. The County's Program Manager shall have the right to require the removal and replacement of the Contractor's Account Manager from providing services to County under this Contract as further described in Section 24. The County's Program Manager shall notify the Contractor in writing of such request for removal of Contractor's Account Manager. The Contractor shall accomplish the removal within thirty (30) days after written notice by the County's Program Manager unless County reasonably expresses that immediate removal is necessary to ensure appropriate performance under this Contract. The County's Program Manager shall review and approve the appointment of the replacement for the Contractor's Account Manager.

26. **Reports/Meetings:** The Contractor shall develop reports and any other relevant documents necessary to complete the services and requirements as set forth in this Contract. The County's Program Manager and the Contractor's Account Manager will meet on reasonable notice to discuss the Contractor's performance and progress under this Contract. If requested, the Contractor's Account Manager and other project personnel shall attend all meetings. The Contractor shall provide such information that is requested by the County for the purpose of monitoring progress under this Contract.

27. **Ownership of Documents:** All documents, reports and other materials furnished hereunder shall become and remain the sole properties of the County and may be used by the County as it may require without additional cost to the County. None of the documents, reports and other incidental or derivative work or furnished materials shall be used by the Contractor without the express written consent of the County.

28. **Title to Data:** All materials, documents, data or information obtained from the County data files or any County medium furnished to the Contractor in the performance of this Contract will at all times remain the property of the County. Such data or information may not be used or copied for direct or indirect use by the Contractor after completion or termination of this Contract without the express written consent of the County. All materials, documents, data or information, including copies, must be returned to the County at the end of this Contract.

29. **Audits/Inspections:** Contractor agrees to permit the County's Auditor-Controller or the Auditor-Controller's authorized representative (including auditors from a private auditing firm hired by the County so long as such private auditor is not an individual or entity that is: a competitor of Contractor, a pharmaceutical manufacturer representative, or any retail, mail or specialty drug pharmacy representative or vendor) to once annually access during normal working hours to all books, accounts, records, reports, files, financial records, supporting documentation, including payroll and accounts payable/receivable records, and other papers or property of Contractor for the purpose of auditing or inspecting any aspect of performance under this Contract. Notwithstanding the foregoing, County's audit of Contractor records is limited to review of Claims transactions for adherence to and accuracy against the approved plan design and pricing under this Contract, for the limited purpose of verifying Contractor's compliance with the

terms of this Contract. Any auditor will be required to sign a non-disclosure agreement with Contractor. The inspection and/or audit will be confined to those matters connected with the performance of the Contract including, but not limited to, the costs of administering the Contract. The County will provide reasonable written notice (not less than thirty (30) days) of such an audit or inspection. The place, time, type, scope, duration, and frequency of all audits must be reasonable. No audits will be initiated or conducted during the months of December and January because of the demands of the annual renewal and implementation period.

All expenses for such audits shall be at the expense of the requesting Party. County acknowledges that it shall not be entitled to audit: (i) documents, in whole or in part, that Contractor deems proprietary, confidential or trade secret; and (ii) documents, in whole or in part, that Contractor is barred from disclosing by law or pursuant to an obligation of confidentiality to a third party. All information and records reviewed pursuant to this section shall be considered Confidential Information for purposes of this Contract. Nothing in this paragraph shall prevent either the County or its third-Party auditor from access to any document or record necessary to ensure the financial and performance obligations made under this Contact are being fulfilled.

A final audit report shall be provided by County (or its auditor) in writing to Contractor within sixty (60) days of the end of the audit. Contractor will have sixty (60) days to respond to the auditor's report. County (or its auditor) shall have thirty (30) days to respond to Contractor's response. If County or its auditor fails to provide a final audit report within sixty (60) days or fails to respond within thirty (30) days of Contractor's response, the audit will be considered closed.

The County reserves the right to audit and verify the Contractor's records before final payment is made. The audit scope will cover a period not to exceed twelve (12) months, unless the audit relates to a financial guarantee for a period exceeding twelve (12) months, in such case, shall be limited to the term of the financial guarantee, unless the audit relates to a significant change in Contractor's programs or claims processing platform that occurred mid-plan year, in which case the audit period may be extended to encompass that change. Requests for audit must be submitted within twelve (12) months of the end of the period to be audited. The audited period may not be re- audited once the audit is complete. Contractor will be liable for agreed upon findings attributable to the audit period and any subsequent claims incurred until the error is corrected. County may not initiate an audit of the Contractor pursuant to this Contract more than once in any twelve (12) month period, nor more than eighteen (18) months after the date of the termination of this Contract.

Contractor agrees to maintain such records for possible audit for a minimum of ten (10) years after final payment, unless a longer period of records retention is stipulated under this Contract or by law. Contractor agrees to allow interviews of any employees or others who might reasonably have information related to such records. Further, Contractor agrees to include a similar right to the County to audit records and interview staff of any sub-contractor related to performance of this Contract.

Should the Contractor cease to exist as a legal entity, the Contractor's records pertaining to this Contract shall be forwarded to the surviving entity in a merger or acquisition or, in the event of liquidation, to the County's Program Manager.

If Contractor changes its claims adjudication platform at any time during the Term of this Contract, Contractor agrees to allow County to conduct an additional audit to ensure that the claims adjudication system is functioning correctly. All expenses for such audit shall be at the expense of the County. Contractor will provide full recovery in the event of a processing error found during an audit.

Notwithstanding the audit limitations set forth in this Section, Contractor shall cooperate in good faith

with County in connection with any request or audit conducted by a federal or state governmental authority for information and documents or any governmental investigation, complaint or other inqui1y. Furthermore, Contractor agrees that any such request or audit required by a federal or state governmental authority will not be considered an audit by County.

Contractor agrees that the County has the right to validate Contractor's self-reported performance metrics set forth in Attachment D annually during the Term of this Contract.

The County shall be responsible for payment of an auditor, but shall not be responsible for any Contractor expenses related to an operational or financial audit, including the provision of necessary records.

30. **Publication:** No copies of schedules, written documents, and computer-based data, photographs, maps or graphs, resulting from performance or prepared in connection with this Contract, are to be released by Contractor and/or anyone acting under the supervision of Contractor to any person, partnership, company, corporation, or agency, without prior written approval by the County, except as necessary for the performance of the services of this Contract. All press releases, including graphic display information to be published in newspapers, magazines, etc., are to be administered only by the County unless otherwise agreed to by both Parties.

31. **Conflict of Interest**: The Contractor shall exercise reasonable care and diligence to prevent any actions or conditions that could result in a conflict with the best interests of the County. This obligation shall apply to the Contractor; the Contractor's employees, agents and relatives, sub-tier contractors and third parties associated with accomplishing services hereunder. The Contractor's efforts shall include, but not be limited to establishing precautions to prevent its employees, or agents from making, receiving, providing or offering gifts, entertainment, payments, loans or other considerations which could be deemed to appear to influence individuals to act contrary to the best interests of the County. Contractor shall not, during the Term of this Contract, employ any County employee for any purpose.

32. **County's Authority Over Plan**: County acknowledges that it has the sole authority to control and administer the Plan. County further acknowledges that Contractor is engaged to perform services as an independent contractor and not as a fiduciary of the Plan or as an employee or agent of the County, or as the Plan administrator. Nothing in this Contract shall be construed or deemed to confer upon Contractor any responsibility for or control over the terms or validity of the Plan. Contractor shall have no discretionary authority over or responsibility for the Plan's administration. Further, because Contractor is not an insurer, Plan sponsor, Plan administrator, or a provider of health care services to Members, Contractor shall have no responsibility for (i) funding of Plan benefits; (ii) any insurance coverage relating to the County, the Plan or the Participants; or (iii) the nature or quality of professional health care services rendered to Members.

33. **Termination:** In addition to any other remedies or rights it may have by law, County has the right to terminate this Contract without penalty immediately with cause or after ninety (90) days' written notice without cause. This Contract may only be terminated without cause after the first year, unless otherwise specified herein. Cause shall be defined as any breach of this Contract or any misrepresentation or fraud on the part of the Contractor. Exercise by County of its right to terminate the Contract shall not relieve County of further obligations, including payment obligations for all services provided through termination. Any accrued and unpaid Rebate amounts will be payable to County after the termination of this Contract if County has met all monetary terms set forth in this Contract and has not terminated this Contract in breach, as long as the Rebate amounts were earned during the term of this Contract as it applies to County and County does not owe any outstanding payments to Contractor. Notwithstanding the foregoing, if County terminates this Contract without

cause during the Initial Term, it shall be required to refund to Contractor in full all credits and allowances provided to County under this Contract.

Contractor agrees to provide County with claims history detail in the standard NCPDP format, open refill files from mail and specialty, prior authorizations and any other non-confidential, non-proprietary information at no cost upon termination.

Contractor shall maintain complete records of all claims and payments for ten years past termination of the agreement or greater as required by law. At the end of this period, records shall either be transferred to the County or destroyed under the County's direction subject to record retention requirements and as required by law.

Termination for Change of Control: Contractor shall promptly notify County, but in no event later than ten (10) business days after the closing date, of any Change of Control by Contractor. County may terminate this Contract upon occurrence of a Change of Control by Contractor and written notice of termination from County within ninety (90) calendar days after County receives notice of such event, with such termination to be effective ninety (90) calendar days after such notice of termination is given to Contractor by County. For purposes of this Contract, "Change of Control" means the merger, consolidation, sale of substantially all of the assets or similar transaction or series of transactions, including without limitation a transaction or series of transactions as a result of which a Party's shareholders before such transaction or series of transactions, own less than fifty percent (50%) of the total number of voting securities of the surviving entity immediately after such transaction or series of transactions.

34. **Breach of Contract:** The failure of the Contractor to comply with any of the material terms, provisions, covenants or conditions of this Contract shall constitute a material breach of this Contract. In such event the County may, and in addition to any other remedies available at law, in equity, or otherwise specified in this Contract:

    a. Terminate this Contract immediately, without penalty to the County; and/or
    b. Afford the Contractor written notice of the breach and ten (10) calendar days or such shorter time that may be specified in this Contract within which to cure the breach;

    Monetary Default by County. If County fails to meet the payment obligations of Section II. I (a) of Attachment B within the time specified for two (2) consecutive payment cycles, then County shall be deemed in breach of the Contract (such breach hereinafter referred to as "Monetary Default") and, notwithstanding Section II. I. (a) of Attachment B of the Contract, or any other provisions contained herein, if County fails to cure such Monetary Default within five (5) business days, Contractor, in its sole discretion, shall have the non-exclusive and cumulative options to: (a) suspend processing of claims, (b) require County to pre-fund a pharmacy spend account in the amount of two (2) times the average monthly prescription drug spend of County, or (c) utilize available deposited or escrowed funds. In addition, if County fails to cure a Monetary Default within sixty (60) days, then Contractor will have the right to terminate this Contract immediately.

    Non-Monetary Default by County. In addition to the right to terminate for Monetary Default as set forth above, Contractor may also terminate this Contract if County fails to perform any significant non-monetary obligations hereunder ("Non-Monetary Default"). Contractor will notify County of such Non-Moneta1y Default and County will have sixty (60) days to cure the Non-Monetary Default. If County fails to cure such Non-Monetary Default within the sixty (60) day cure period, then Contractor may terminate this Contract immediately.

35. **Disputes:** The parties shall deal in good faith and attempt to resolve potential disputes informally. If a dispute concerning a question of fact arising under the terms of this Contract is not disposed of in a reasonable period of time by the Contractor's Project Manager and the County's Project Manager, such matter shall be brought to the attention of the County Deputy Purchasing Agent by way of the following process:

    a. The Contractor shall submit to the assigned agency/department assigned Deputy Purchasing Agent a written demand for a final decision regarding the disposition of any dispute between the parties arising under, related to, or involving this Contract.

    b. The Contractor's written demand shall be fully supported by factual information, and, if such demand involves a cost adjustment to this Contract, the Contractor shall include with the demand a written statement signed by a senior official indicating that the demand is made in good faith, that the supporting data are accurate and complete, and that the amount requested accurately reflects the amount for which the Contractor believes the County is liable. The Deputy Purchasing Agent shall then review Contractor's written demand and the Parties shall agree to meet in good faith to resolve the matter within thirty (30) business days of receipt by Deputy Purchasing Agent of Contractor's written demand.

    c. Pending the final resolution of any dispute arising under, related to, or involving this Contract, the Contractor agrees to diligently proceed with the performance of this Contract, including the delivery of goods and/or provision of services. The Contractor's failure to diligently proceed shall be considered a material breach of this Contract.

    Any final decision of the County shall be expressly identified as such, shall be in writing, and shall be signed by the County Deputy Purchasing Agent or his designee. If the County fails to render a decision within 90 days after receipt of the Contractor's demand, it shall be deemed a final decision adverse to the Contractor's contentions. Nothing in this section shall be construed as affecting the County's right to terminate the Contract for cause or termination for convenience as stated in section 30 herein.

36. **Orderly Termination**: Upon termination or other expiration of this Contract, each party shall promptly return to the other party all papers, materials, and other properties of the other held by each for purposes of this Contract. In addition, each Party will assist the other Party in orderly termination of this Contract and the transfer of all aspects, tangible and intangible, as may be necessary for the orderly, non-disruptive business continuation of each Party.

    At the end of the Term of this Contract or in the event of termination of this Contract by either party, the Contractor agrees to provide County with a computer history tape (in a form and format reasonable acceptable to the County) with claims history detail in the standard NCPDP format, open refill files from mail and specialty, prior authorizations and any other non-confidential, non- proprietary information at no cost upon termination.

    At the end of the Term of this Contract or in the event of termination of the Contract by either Party and upon the request of County, Contractor agrees to continue the administration of claims incurred prior to the effective ending date of this Contract for a period of thirty (30) days after the termination date from Contractor owned or contracted pharmacies for thirty (30) and from Participants no later than sixty (60) days after the termination date. In compensation for this service, County agrees to remit the run-out fees identified in Attachment B.

37. **Force Majeure:** Contractor shall not be in breach of this Contract during any delay beyond the time named for the performance of this Contract caused by any act of God, war, civil disorder, employment strike or other cause beyond its reasonable control, provided Contractor gives written notice of the cause of the delay to the County within 36 hours of the start of the delay and Contractor avails himself of any reasonably available remedies.

38. **Consent to Breach Not Waiver:** No term or provision of this Contract shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and signed by the Party claimed to have waived or consented. Any consent by any Party to, or waiver of, a breach by the other, whether express or implied, shall not constitute consent to, waiver of, or excuse for any other different or subsequent breach.

39. **Remedies Not Exclusive:** The remedies for breach set forth in this Contract are cumulative as to one another and as to any other provided by law, rather than exclusive; and the expression of certain remedies in this Contract does not preclude resort by either Party to any other remedies provided by law.

40. **Notices:** Any and all notices, requests demands and other communications contemplated, called for, permitted, or required to be given herein shall be in writing, with a copy provided to the assigned Deputy Purchasing Agent (DPA), except through the course of the County's Program Manager and Contractor's Account Manager routine exchange of information and cooperation during the terms of the work and services. Any written communications shall be deemed to have been duly given upon actual in-person delivery, if delivery is by direct hand, or upon delivery on the actual day of receipt or no greater than four (4) calendar days after being mailed by US certified or registered mail, return receipt requested, postage prepaid, whichever occurs first. The date of mailing shall count as the first day. All communications shall be addressed to the appropriate Party at the address stated herein or such other address as the Parties hereto may designate by written notice from time to time in the manner aforesaid.

County:	Program Manager, Diana Banzet Human Resource Services/Employee Benefits 333 W. Santa Ana Blvd., 1st Floor, Room 137 Santa Ana, CA 92701
Contractor:	OptumRx Inc 1600 McConnor Parkway Schaumburg, IL 60173 Attn: Vice President – Client Management
With copy to:	Attn: General Counsel at same address

41. **EDD Independent Contractor Reporting Requirements:** Effective January 1, 2001, the County of Orange is required to file in accordance with subdivision (a) of Section 6041A of the Internal Revenue Code for services received from a "service provider" to whom the County pays $600 or more or with whom the County enters into a contract for $600 or more within a single calendar year. The purpose of this reporting requirement is to increase child support collection by helping to locate parents who are delinquent in their child support obligations.

The term "service provider" is defined in California Unemployment Insurance Code Section 1088.8, subparagraph B.2 as "an individual who is not an employee of the service recipient for California

purposes and who received Compensation or executes a contract for services performed for that service recipient within or without the state." The term is further defined by the California Employment Development Department to refer specifically to independent Contractors. An independent Contractor is defined as "an individual who is not an employee of the government entity for California purposes and who receives Compensation or executes a contract for services performed for that government entity either in or outside of California."

The reporting requirement does not apply to corporations, general partnerships, limited liability partnerships, and limited liability companies.

Additional information on this reporting requirement can be found at the California Employment Development Department web site located at http://www.edd.ca.gov/Employer_Services.htm.

42. **Change of Ownership/Name, Litigation Status, Conflicts with County Interests:** Contractor agrees that if there is a change or transfer in ownership of Contractor's business prior to completion of this Contract, and the County agrees to an assignment of the Contract, the new owners shall be required under the terms of sale or other instruments of transfer to assume Contractor's duties and obligations contained in this Contract and complete them to the satisfaction of the County.

    County reserves the right to immediately terminate the Contract in the event the County determines that the assignee is not qualified or is otherwise unacceptable to the County for the provision of services under the Contract.

    In addition, Contractor has the duty to notify the County in writing of any change in the Contractor's status with respect to name changes that do not require an assignment of the Contract. The Contractor is also obligated to notify the County in writing if the Contractor becomes a party to any litigation against the County, or a party to litigation that may reasonably affect the Contractor's performance under the Contract, as well as any potential conflicts of interest between Contractor and County that may arise prior to or during the period of Contract performance. While Contractor will be required to provide this information without prompting from the County any time there is a change in Contractor's name, conflict of interest or litigation status, Contractor must also provide an update to the County of its status in these areas whenever requested by the County.

    The Contractor shall exercise reasonable care and diligence to prevent any actions or conditions that could result in a conflict with County interests. In addition to the Contractor, this obligation shall apply to the Contractor's employees, agents, and subcontractors associated with the provision of goods and services provided under this Contract. The Contractor's efforts shall include, but not be limited to establishing rules and procedures preventing its employees, agents, and subcontractors from providing or offering gifts, entertainment, payments, loans or other considerations which could be deemed to influence or appear to influence County staff or elected officers in the performance of their duties.

43. **Precedence:** The Contract documents herein consist of this Contract and its attachments. In the event of a conflict between or among the Contract documents, the order of precedence shall be the provisions of the main body of this Contract, i.e., those provisions set forth in the articles of this Contract, and then the attachments and exhibits.

44. **Headings:** The various headings and numbers herein, the grouping of provisions of this Contract into separate clauses and paragraphs, and the organization hereof are for the purpose of convenience only and shall not limit or otherwise affect the meaning hereof.

45. **Severability:** If any term, covenant, condition or provision of this Contract is held by a court of

competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired or invalidated thereby.

46. **Calendar Days:** Any reference to the word "day" or "days" herein shall mean calendar day or calendar days, respectively, unless otherwise expressly provided.

47. **Attorney Fees:** In any action or proceeding to enforce or interpret any provision of this Contract, or where any provision hereof is validly asserted as a defense, each Party shall bear its own attorney's fees, costs and expenses.

48. **Interpretation:** This Contract has been negotiated at arm's length and between persons sophisticated and knowledgeable in the matters dealt with in this Contract. In addition, each Party has been represented by experienced and knowledgeable independent legal counsel of their own choosing, or has knowingly declined to seek such counsel despite being encouraged and given the opportunity to do so. Each Party further acknowledges that they have not been influenced to any extent whatsoever in executing this Contract by any other Party hereto or by any person representing them, or both. Accordingly, any rule of law (including California Civil Code Section 1654) or legal decision that would require interpretation of any ambiguities in this Contract against the Party that has drafted it is not applicable and is waived. The provisions of this Contract shall be interpreted in a reasonable manner to affect the purpose of the Parties and this Contract.

49. **Authority:** The Parties to this Contract represent and warrant that this Contract has been duly authorized and executed and constitutes the legally binding obligation of their respective organization or entity, enforceable in accordance with its terms.

50. **Health Insurance Portability and Accountability Act (HIPAA):** Contractor understands and agrees that the disclosure of PHI by a health care component of a covered entity is subject to the HIPAA Privacy Rule, Contractor understands and agrees that it is a Business Associate of County for the purposes of the HIPAA Privacy Rule. Therefore, the provisions set forth in Exhibit 1 hereto shall be operative and control the Business Associate relationship of the parties. Nothing in Exhibit 1 shall be considered a waiver of the limitation on subcontracting as set forth in this Contract.

51. **Exclusivity:** County agrees to utilize only Contractor to provide it with any of the services described herein during the Term of this Contract.

52. **Survival:** Notwithstanding any provision to the contrary herein, the provisions of paragraphs 14, 15, 16, 17, 18, and 22 shall survive the termination of this Contract.

53. **Civil Rights:** Contractor attests that services provided shall be in accordance with the provisions of Title VI and Title VII of the Civil Rights Act of 1964, as amended, Section 504 of the Rehabilitation Act of 1973, as amended; the Age Discrimination Act of 1975 as amended; Title II of the Americans with Disabilities Act of 1990, and other applicable State and federal laws and regulations prohibiting discrimination on the basis of race, color, national origin, ethnic group identification, age, religion, marital status, sex or disability.

54. **Lobbying**: On the best information and belief, Contractor certifies no federal appropriated funds have been paid or will be paid by, or on behalf of, the Contractor to any person influencing or attempting to influence an officer or employee of Congress; or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative contract.

55. **Debarment**: Contractor shall certify that neither Contractor nor its principles are presently debarred, proposed for debarment, declared ineligible or voluntarily excluded from participation in the transaction by any Federal department or agency. Where Contractor as the recipient of federal funds, in unable to certify to any of the statements in the certification, Contractor must include an explanation with the bid/proposal. Debarment pending debarment, declared ineligibility or voluntary exclusion from participation by any Federal department of agency may result in the bid/proposal being deemed non-responsible.

56. **Employee Eligibility Verification:** The Contractor warrants that it fully complies with all Federal and State statutes and regulations regarding the employment of aliens and others and that all its employees performing work under this Contract meet the citizenship or alien status requirement set forth in Federal statutes and regulations. The Contractor shall obtain, from all employees performing work hereunder, all verification and other documentation of employment eligibility status required by Federal or State statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, 8 U.S.C. §1324 et seq., as they currently exist and as they may be hereafter amended. The Contractor shall retain all such documentation for all covered employees for the period prescribed by the law. The Contractor shall indemnify, defend with counsel approved in writing by County, and hold harmless, the County, its agents, officers, and employees from employer sanctions and any other liability which may be assessed against the Contractor or the County or both in connection with any alleged violation of any Federal or State statutes or regulations pertaining to the eligibility for employment of any persons performing work under this Contract.

57. **Bills and Liens:** Contractor shall pay promptly all indebtedness for labor, materials, and equipment used in performance of the work. Contractor shall not permit any lien or charge to attach to the work or the premises, but if any does so attach, Contractor shall promptly procure its release and, in accordance with the requirements of paragraph 19 above, indemnify, defend, and hold County harmless and be responsible for payment of all costs, damages, penalties and expenses related to or arising from or related thereto.

58. **Changes:** Contractor shall make no changes in the work or perform any additional work without County's specific written approval.

59. **Terms and Conditions:** Contractor acknowledges that it has read and agrees to all terms and conditions included in this Contract.

60. **Incorporation:** This Contract and its, Attachments A through ~~G~~H and Exhibit 1 are attached hereto and incorporated herein by this reference and made a part of this Contract.

CONTRACT SIGNATURE PAGE

IN WITNESS WHEREOF, The Parties hereto have executed this Contract on the dates shown opposite their respective signatures below.

CONTRACTOR*:

Print Name Title

Signature Date

Print Name Title

Signature Date

**If the contracting party is a corporation, two (2) signatures are required: one (1) signature by the Chairman of the Board, the President or any Vice President; and one (1) signature by the Secretary, any Assistant Secretary, the Chief Financial Officer or any Assistant Treasurer. The signature of one person alone is sufficient to bind a corporation, as long as he or she holds corporate offices in each of the two categories described above. For County purposes, proof of such dual office holding will be satisfied by having the individual sign the instrument twice, each time indicating his or her office that qualifies under the above-described provision.*

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.

****

COUNTY of ORANGE
A political subdivision of the State of California

Print Name Title

Signature Date

Approved by the Board of Supervisors on:_____

APPROVED AS TO FORM:

_____
Deputy, Office of County Counsel
Orange County, California

Attachment A
Scope of Work

Definitions

1. "Average Wholesale Price" or AWP means the average wholesale price of the Covered Drug, on the date dispensed, as set forth in Medi-Span's Master Drug Database (MDDB®) file, if available, or other nationally recognized source determined by Contractor and disclosed to the County.
2. Benefits Administrator means a self-service contractor with which the County has a contract to provide full Benefits administration such as benefits eligibility and enrollment.
3. Compound Prescription means a prescription that meets the following criteria: two or more solid, semi-solid, or liquid ingredients, at least one of which is a Covered Drug, which are weighed or measured then prepared according to the prescriber's order.
4. Concurrent Drug Utilization Review is a series of edits at the point-of-service that are applied to a prescription drug claim comparing member information with the drug dispensed and information in the database related to other medications the member is taking.
5. Covered Prescription Drug Services means those outpatient prescription drugs and pharmacy products, services and supplies as described in a current County Plan Document.
6. County means County of Orange.
7. Drug Classification means the process whereby Contractor shall use the indicators of disclosed nationally available recognized reporting service of pharmaceutical drug information to determine the classification of drugs (i.e., legend vs. over the counter, Brand vs Generic, single source vs. multi-source) for claim adjudication purposes.
8. Enrollee or Participant means eligible subscribers and dependents enrolled in the County's Sharewell Choice, Sharewell Retiree, Wellwise Choice or Wellwise Retiree plan.
9. Explanation of Benefit (EOB) is a periodic summary Statement of Plan and Participant paid amounts sent to Participants.
10. Formulary means the Contractor's preferred drug list developed and maintained by the Contractor's P&T Committee and hereby adopted by the County.
11. Health Plan Administrator or Third-Party Administrator (TPA) is the entity with which County has contracted to administer and process claims for the self-insured PPO health plans.
12. Identification Cards shall mean printed identification cards containing specific information about the prescription drug benefit that will be used by plan Participants. Currently identification cards are issued by the TPA.
13. Limited Distribution Drugs means drugs that are specialty drugs only available through select pharmacy providers as determined by the drug manufacturer.
14. Maximum Allowable Cost or (MAC) consists of a list of off-patent drugs subject to maximum allowable cost payment schedules developed or selected by Contractor. The payment schedules specify the maximum unit ingredient cost payable by the County for drugs on the MAC list.
15. MAC means the maximum allowable cost for a Contractor determined list of retail generic drugs. It is derived from an analysis of several pricing information sources that include Wholesale Acquisition Cost from national wholesalers and Federal Upper Limit prices from the Health Care Finance Administration. The marketplace is continually monitored for price changes that may affect a drug's MAC price; it shall be readily available in the market.
16. Manufacturer Administrative Fee means any fee or other amount paid to Contractor by a pharmaceutical manufacturer for the administration of the formulary rebate program which may be separately classified or calculated apart from "Rebates."

17. Multi-source generic is defined as a generic prescription product available from multiple manufacturers or those prescription products available only from one manufacturer provided, they had been available from multiple manufacturers in the past.
18. New to market Specialty Drugs are Specialty Drugs that are newly introduced for sale by pharmaceutical manufacturers and made available for dispensing at pharmacies, that aren't included on the current Specialty Drug Price List. Once a drug meeting the criteria outlined in section 2.3.24.8 is added to the Specialty Drug Price List, it will be considered a Specialty Drug and no longer considered "new to market".
19. Net Paid Claim means all paid Claims minus reversals for a single prescription fill.
20. Participating Pharmacy means a retail pharmacy that has entered into an agreement with Contractor under which the pharmacy has agreed to provide Covered Prescription Drug Services to Participants and to comply with applicable regulatory requirements.
21. Pharmaceutical Manufacturer means a pharmaceutical, biotech or device company which has entered into an agreement with the Contractor to offer rebates on pharmaceutical products, supplies or services utilized by Participants.
22. Plan Document means the benefit document prepared by the Contractor in conjunction with the County and approved in writing by the County, which is used by the Contractor in processing prescription drug claims in connection with this Contract.
23. Prescription Drug Services means the prescription drug services or supplies that are covered by the Plan as reflected in the County's Plan Document.
24. Program Manager means Director of Human Resource Services, Employee Benefits or his/her designee.
25. Retrospective DUR means a retrospective review of Members' prescription claims to evaluate the appropriateness of each Member's therapy based upon generally accepted current clinical pharmacy practices and clinical rules that focus on gaps in care and unsafe and clinically inappropriate therapy across widely utilized therapy classes.
26. Single-source generic is defined as a generic prescription product with only one generic (non-originator) manufacturer. The originator manufacturer might or might not still be in the market.
27. Specialty Drugs mean medications that can (i) treat unique populations, (ii) require close therapy management and monitoring, (iii) require special handling and/or storage, (iv) are produced through biotechnologies, (v) are expensive and may involve complex reimbursement processes, or (vi) are generally administered as injections or infusions, but can be oral medications, too.
28. Specialty Drug Price List means the list(s) of specialty drugs. The Specialty Drug List is maintained and updated by OptumRx from time to time. The Specialty Drug List(s) applicable to the plan shall be provided to the County of Orange (the County) upon request.
29. Total Rebates will include all compensation or remuneration Contractor receives from pharmaceutical manufacturers (branded and generic), attributable to the purchase or utilization of covered drugs (including Specialty Drugs) by an eligible member. Compensation includes, but is not limited to, discounts; credits; rebates, regardless of how categorized; fees; educational grants received from manufacturers in relation to the provision of utilization data to manufacturers for rebating, marketing and related purposes; market share incentives; commissions; manufacturer administrative fees; administrative management fees; and any/all monies received by Contractor from pharmaceutical manufacturers resulting from price inflation protection negotiations. "Total Rebates" must include all manufacturer administrative fees received by Contractor.
30. Usual and Customary or U&C means the amount a Participating Pharmacy would charge to a cash paying customer for same strength, quantity and dosage form of a covered drug, as of the date the prescription is filled.

Scope of Services

Contractor will be required to provide, at a minimum, the following services, including but not limited to:

I. FINANCIAL/PRICING TERMS

The Contractor shall agree to the following terms regarding the pricing/financial arrangement selected by the County:

1. Contractor will select and disclose to the County, the single source selected for the term of the agreement to price covered drugs at retail, mail order and specialty pharmacy.
2. The AWP used for retail, mail order and specialty pharmacy AWP discount guarantee reconciliation purposes will be the published AWP, as noted above, for actual package size of the 11-digit NDC of the dispensed product on the date dispensed.
3. On March 30, 2009, the US District Court for the District of Massachusetts entered the final order and judgment approving the class action settlement for the First DataBank (FDB) and Medi-Span average wholesale price (AWP) litigation. As a result of this settlement, both FDB and Medi-Span reduced the mark-up factor used to calculate AWP for any drug whose mark-up was in excess of 1.20 to 1.33 times the wholesale acquisition cost (WAC) effective September 26, 2009. Additionally, both FDB and Medi-Span indicated their intention to apply the same adjustments to all other NDCs with a markup factor in excess of 1.20. Contractor agrees that any financial proposal submitted by Contractor shall assume that (a) all pricing terms are reflective of the lower, rolled-back AWP costs and (b) all AWP discounts will apply directly to the actual rolled-back AWP cost with no other adjustment.
4. If the AWP pricing source (e.g., Medi-Span) changes the methodology for calculating AWP in a way that changes the economics of the program, or if the pricing source replaces AWP or you decide to use another pricing benchmark other than AWP or another pricing source (hereinafter "AWP Change or Replacement"), including prior to the Effective Date, the Parties agree to modify the program pricing terms such that the modified program pricing terms are cost-neutral or better for both the County and members. Contractor will provide the County with modified pricing terms with the goal of maintaining the relative economics of both parties.
5. Prior to an AWP Change or Replacement, Contractor shall (1) provide the County with at least ninety (90) days' notice of the effective date of the AWP Change or Replacement, but if the effective date of the AWP Change or Replacement is less than ninety (90) days before Contractor knows that the AWP Change or Replacement will definitely occur, then Contractor shall provide the County with as much advance notice as is reasonably practicable under the circumstances; (2) provide the County with an externally audited written illustration of the financial impact of the AWP Change or Replacement (e.g., specific drug examples) and a written statement of the expected aggregate annual impact of the AWP Change or Replacement at least seventy-five (75) days prior to the effective date of the AWP Change or Replacement, but if the effective date of the AWP Change or Replacement is less than seventy-five (75) days before Contractor knows that the AWP Change or Replacement will definitely occur, then Contractor shall provide the County with the written illustration and statement described above as soon as is reasonably practicable under the circumstances.
6. Contractor agrees that in the event of a pricing methodology change or a change in the Contractor's pricing source, in which the Contractor does not agree to pass through all pricing improvements to the County, or if the change results in a higher gross cost (before member cost share) to the County, then the County, reserves the right to renegotiate financial terms or terminate the contract with ninety (90)

days written notice without penalty, fees, early termination charges, liquidated damages, or loss of rebates.

7. Contractor agrees that if/when AWP-based pricing is replaced in the market it will hold the County harmless from any charges the PBM may incur from (a) making said changes (e.g., IT costs); (b) auditing; or (c) providing required external validation.
8. Contractor agrees to use the same MAC product list at retail and mail such that the MAC unit cost of every individual product on the MAC product list at Mail Order will always be equal to or lower than under the Retail Pharmacy Program. This assessment is solely of MAC unit costs, ignoring retail pharmacy U&C prices.
9. Contractor agrees that all compound drugs dispensed at retail and mail order will be processed using the National Council for Prescription Drug Programs (NCPDP) vD.0 multi-ingredient pricing; compound drugs will not be subject to a mark-up.
10. Contractor has the ability to stop and deny coverage for any compound pharmaceutical that includes ingredient(s) that are comprised entirely or partially of bulk chemicals.
11. Contractor has the ability to administer a separate maximum dollar threshold for compound drugs.
12. If requested by the County, Contractor will monitor, audit and terminate from their network compounding pharmacies that dispense compounded pharmaceuticals that are not in compliance with Contractor's policies and/or network terms and conditions.
13. If requested by the County, Contractor will employ a closed network of certified compounding pharmacies and compounded pharmaceuticals submitted from non-participating compounding pharmacies will be considered an out of network pharmacy claim.
14. The County's agreement to adopt Contractor's formulary/PDL shall not be construed to give Contractor any authority to determine the list of drugs subject to prior authorization or step therapy or excluded from benefit coverage, nor give Contractor any authority to design, amend, or modify, in whole or in part, all or any portion of the Plan, other than determining the list of drugs to be included on the formulary/PDL. The sole purpose of the PDL will be for the assignment of member coinsurance levels.
15. Contractor agrees to provide rebate guarantees based on Contractor's formulary with exclusions AND separate rebate guarantees based on Contractor's formulary without formulary drug exclusions (if requested).
16. If the County accepts formulary drug exclusions, Contractor guarantees that all excluded drugs will have a formulary alternative available.
17. If the County accepts formulary drug exclusions, Contractor will provide its formulary drug list and the County-specific member impact analysis to the County by no later than July 1st preceding the following January 1st effective date. Such list will identify the excluded drugs and the associated covered drug.
18. Contractor agrees that the County will be notified of any negative formulary changes or deletions 60 days in advance of the change, and formulary notices of impacted members will be sent to plan participants at least 30 days before the formulary change Contractor is not required to communicate positive formulary changes.
19. Contractor agrees that all proposed AWP discounts and dispensing fees will be individually guaranteed dollar-for-dollar, with no cross-subsidization, for six-month period of the three-year contract period. Guaranteed AWP discounts and dispensing fees will be measured, reported and reconciled separately by Contractor annually, and Contractor will pay/credit the County 100% of any shortfall between the actual result and the guaranteed results, with no offsets, reductions or adjustments. The County will not accept pricing offers that payout shortfalls based on “Sponsor's net cost”, limited to claims with “Sponsor liability”, or with any ZBD (zero balance due) adjustment. The County will retain 100% of any additional savings achieved above each guarantee, with no cross-subsidization within distribution channel or among distribution channels. Shortfalls in one guarantee may not be offset by overages in

any other guarantee, with the exception of rebates which will be reconciled in aggregate across all channels.

20. Contractor's pricing offer is based on and does not require any changes to the proposed Rx plan design(s), clinical programs/rules/edits, outlined in the RFP attachments. Contractor's pricing offer is not contingent upon implementing any additional step therapy, prior authorization, and/or therapeutic switch programs.
21. Contractor will disclose the pricing and guarantee reconciliation methodology that will be applied for the County in its entirety, including but not limited to any pricing methodologies applied during claims adjudication, any definition or any contractual clause that might cause a drug to be billed and filled under different drug classifications, the use of re-bucketing drugs during reconciliation to affect any guarantee (e.g. classifying drugs adjudicated as brands as generic under the GDR guarantee) exclusion of any drugs from the reconciliation calculation, and any other pricing or reconciliation strategy that is not specifically requested or covered within this RFP.
22. All pricing and reconciliation strategies employed by Contractor that are identified during this RFP shall be included in the contract and may not be altered from what was disclosed during the RFP process. In other words, Contractor will include all definitions, pricing and reconciliation methodologies to be employed in the contract and may not change the definitions, pricing or reconciliation methodologies from what was disclosed in this RFP when constructing the contract.
23. Contractor shall not use its “standard” or “book of business” practices when reconciling the County's pricing guarantees unless they are clearly outlined in the County/Contractor contract. If there is a dispute regarding a practice that is not outlined in this contract, Contractor agrees to stop such practice immediately and comply with the terms of the contract.
24. Contractor agrees that if a participant pays 100% of the cost of a prescription, the County will not be billed for any portion of the claim exclusive of any applicable administrative fees. Within sixty (60) days following each contract quarter, Contractor will measure and report to the County its performance for that quarter and year to date for all AWP discount guarantees.
25. Contractor shall uphold contractual pricing for the life of the Contract should the County's claims volume or membership increase or decrease by less than or equal to 20%.
26. Contractor will classify drugs consistently at retail, mail and specialty pharmacy based on data provided by sources such as Medi-Span or First DataBank, pharmaceutical manufacturers, and the Food and Drug Administration, or other sources disclosed to the County.
27. Contractor will select and disclose to the County, the single source selected for the term of the agreement to classify covered drugs consistently at retail, mail order and specialty pharmacy.
28. Brand Drugs and Generic Drugs must be classified as such using the standard designations used by reporting services such as First Databank or other nationally recognized third-party reporting source. Reclassification of any drug using any proprietary methodology or algorithm is not permitted.
29. Neither the availability nor supply of a drug will be used as criteria to classify the drug as a Brand Drug or Generic Drugs.
30. Once a drug has been designated as a Generic Drug, it will remain designated as such unless the original designation was in error.
31. Contractor MUST agree to propose pricing based on its broadest national retail network, where a pharmacy exists and as long as the network does not change, that includes ALL major national and regional pharmacy chains supplemented by independent pharmacies, and that satisfies the minimum network pharmacy access standards outlined in the Ongoing Performance Guarantee section of this Contract.
32. Contractor agrees to provide both a Broad Retail 90 network and a mail order network.

33. Claims filled at retail network pharmacies in rural areas will be treated as any other retail network pharmacy for purposes of all "Retail" pricing guarantees noted below.
34. Contractor will adjudicate all retail claims including specialty and non-specialty at point-of-sale and paper claims at the lowest of: (a) the contracted discount plus dispensing fee; (b) MAC plus dispensing fee or (c) the usual and customary (U&C) price (including the pharmacy's sales price, if any). Contractor agrees that if selected as the winning PBM, the contract language will specify that claims adjudicate at the point of sale using the guaranteed methodology proposed.
35. Contractor must adjudicate all mail order and Specialty Pharmacy claims at the lesser of: (a) the contracted discount plus dispensing fee or (b) MAC plus dispensing fee.
36. Contractor must provide consistent pricing (guaranteed AWP discounts, dispensing fees, administrative fees, and rebates) for all prescriptions filled at Contractor's proposed mail order pharmacy regardless of the days' supply (i.e., Contractor will not apply retail pricing to any mail order claims).
37. For any repackaged products assigned a new NDC number by a re-packager or manufacturer, Contractor will not charge a higher AWP price at mail order or specialty pharmacy than the original manufacturer/labeler AWP price for the same product (drug name, form, and strength).
38. Contractor must adjudicate all retail claims according to the “lowest of” logic such that members always pay the lowest of the applicable coinsurance, the contracted price and/or the pharmacy's U&C amount (including the pharmacy's sale price, if any). Contractor will not be allowed to adjudicate based on “zero balance logic” or on a minimum coinsurance amount, and retail pharmacies will not be allowed to collect a minimum payment.
39. Contractor must adjudicate all mail order and Specialty Pharmacy claims according to the “lower of” logic such that the County members always pay the lower of the applicable coinsurance or the contracted price. Contractor will not be allowed to adjudicate based on a minimum coinsurance.
40. Contractor agrees that the County will not be responsible for any member contributions (e.g., deductible, coinsurance, coinsurances) owed to Contractor. Collecting such fees will be the sole responsibility of Contractor.
41. Contractor will provide minimum aggregate annual Retail Brand AWP Discount Guarantees and a minimum aggregate annual Mail Order Brand AWP Discount Guarantees, inclusive of all single-source brand drugs and all multi-source brand drugs. Brand AWP Discount Guarantees will include all claims with Medi-Span Brand Name Code = “T” with Medi-Span Multi-Source Code = “M”, “N” or “O” on the date dispensed. Contractor's proprietary brand/generic drug algorithm(s) must not be used to classify drugs as Brand or Generic when reconciling Contractor's aggregate annual Brand AWP Discount Guarantees. Contractor will provide annual guarantees. The Brand (Generic) AWP Discount Guarantee includes single-source and multi-source Brand (Generic) drugs. Brand (Generic) drugs are identified by the multi-source code field in Medi-Span containing an M, N, or O. Compound prescription drug claims, 340B claims, Indian Health Services and Tribal claims, direct member reimbursement Claims, claims with ancillary charges such as vaccines, claims filled outside the OptumRx Pharmacy Network and in-house or customer owned pharmacies will be excluded from the guarantees.
42. At retail, this guarantee must include specialty brand drugs dispensed at retail network pharmacies.
43. At retail, this guarantee must include all brand claims priced at U&C. U&C claims will be included based on the adjudicated price, not 100% discount. When calculating the AWP discount guarantee, the ingredient cost for U&C claims will equal the submitted U&C price with a $0.00 dispensing fee.
44. At mail order, this guarantee must exclude specialty brand drugs dispensed at specialty pharmacies.
45. Contractor will measure these guarantees, report on performance and pay/credit the County 100% of any shortfall within ninety (90) days of each annual period, with the County retaining 100% of any

additional savings achieved; shortfalls in one guarantee may not be offset by overages in any other guarantee.

46. Contractor will provide minimum aggregate annual Retail Generic AWP Discount Guarantees and minimum aggregate annual Mail Order Generic AWP Discount Guarantees that are inclusive of all generic drugs (e.g., all MAC'd generics and non-MAC'd generics; all multi-source generics, single-source generics and/or any generic products involved in patent litigations and/or available in limited supply). Generic AWP Discount Guarantees will include: (a) all claims with Medi-Span Brand Name Code = "T" with a Medi-Span Multi-Source Code = "Y" on the date dispensed; and (b) all claims with Medi-Span Brand Name Code = "B" or "G" on the date dispensed. Contractor's proprietary brand/generic drug algorithm(s) must not be used to classify drugs as Brand or Generic when reconciling Contractor's aggregate annual Generic AWP Discount Guarantees. Contractor will provide annual guarantees. The Brand (Generic) AWP Discount Guarantee includes single-source and multi-source Brand (Generic) drugs. Brand (Generic) drugs are identified by the multi-source code field in Medi-Span containing an M, N, or O. Compound prescription drug claims, 340B claims, Indian Health Services and Tribal claims, direct member reimbursement Claims, claims with ancillary charges such as vaccines, claims filled outside the OptumRx Pharmacy Network and in-house or customer owned pharmacies will be excluded from the guarantees.
47. At retail, this guarantee must include specialty generic drugs dispensed at retail network pharmacies.
48. At retail, this guarantee must include all generic claims priced at U&C. U&C claims will be included based on the adjudicated price, not 100% discount. When calculating the AWP discount guarantee, the ingredient cost for U&C claims will equal the submitted U&C price with a $0.00 dispensing fee.
49. At mail order, this guarantee must exclude specialty generic drugs dispensed at Contractor's specialty pharmacies.
50. Contractor will measure these guarantees, reports on performance and pays and credits the County 100 percent of any shortfall within 90 days of each annual period, with the County retaining 100 percent of any additional savings achieved. Shortfalls in one guarantee may not be offset by overages in any other guarantee.
51. Contractor will measure, pay and credit any shortfalls (if applicable) within 90 days of each 12-month period.
52. The calculation of all proposed AWP discount guarantees (Retail Brand, Retail Generic, Mail Brand, Mail Generic and Specialty Pharmacy) must include all zero pay claims (claims where the member pays the full cost of the drug, and the Plan paid zero) based on the actual adjudicated Ingredient Cost; the AWP discount for zero pay claims will not be included at 100% discount.
53. For any the County plans where members must pay the difference between the Brand and Generic gross drug cost when choosing a Brand name drug when a generic alternative is available, such gross drug cost difference (also referred to as MPD Penalty, Coinsurance Penalty, DAW Penalty, or Coinsurance Differential) must not be treated as a discount when reconciling AWP discount guarantees, nor be used in any way to lower the amount otherwise due the County.
54. For any County plans where members are charged a higher cost-share when filling a prescription at retail rather than via mail order or specialty pharmacy, such cost-share must not be treated as a discount when reconciling AWP discount guarantees, nor be used in any way to lower the amount otherwise due the County.
55. Contractor will not dispense any House Generics.
56. County participants may utilize either Contractor's specialty pharmacies or any retail pharmacy to fill specialty medications.
57. Contractor will submit the proposed January 1, 2021 Specialty Drug Price List(s) in Excel by NDC-11, with drug names and associated AWP discounts and dispensing fees. Contractor's Specialty Drug Price

List will clearly identify which, if any, of the list drugs will be excluded from Contractor's aggregate annual specialty pharmacy AWP discount guarantees and/or excluded from Contractor's specialty pharmacy Per Brand Rx Rebate Guarantees.

58. The complete Specialty Drug Price List as of the January 1, 2021 Effective Date, with drug names and AWP discounts, will be included as an exhibit to the agreement.
59. After the January 1, 2021 Effective Date, Contractor will not add any products to the County's Specialty Drug Price List that were previously available a standard non-specialty mail order pharmacy.
60. Only newly FDA-approved and launched drugs, and drugs not on the market as of January 1, 2021 may be considered for addition to the Specialty Drug Price List after this date.
61. Unless there is a change to the specialty distribution or labeling due to regulatory or manufacturer requirement, Contractor will not add any drugs to the County's Specialty Drug Price List that were previously available in the market and delivered through mail order and/or retail (i.e., non-specialty) prior to January 1, 2021.
62. Contractor agrees to adhere to the following additional criteria for Specialty Drugs added to the Specialty Drug Price List after January 1, 2021:
    a. The product must require a customized medication management program that includes medication use review, patient training, coordination of care and adherence management for successful use such that more frequent monitoring and training may be required and must meet at least one of the following four characteristics:
        i. Produced through DNA technology or biological processes
        ii. Target chronic or complex disease
        iii. Route of administration could be inhaled, infused, oral or injected
        iv. Unique handling, distribution and/or administration requirements
63. In addition, a follow-on-biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug and meets the criteria above.
64. All covered drugs that do not meet the above Specialty Drug criteria will be dispensed via mail at the standard Mail Order pricing rates (i.e., discounts, dispensing fees, and rebate guarantees or via retail at the standard retail rates (i.e., discounts, dispensing fees, and rebate guarantees).
65. Contractor agrees that all Limited Distribution Drugs will be billed to the County as specified in their Specialty Drug Price List.
66. Contractor agrees that all existing biosimilars and biosimilars new to market will be priced at a deeper list discount than the original brand.
67. Changes to the Specialty Drug Price List requires ninety (90) days advance written notice to the County along with an explanation of the rationale for such modifications. In making any such modifications, Contractor will provide the County with a revised and complete list noting the effective date for each modification.
68. After the January 1, 2021 Effective Date of the agreement, a copy of the current Specialty Drug Price List will be made available to the County upon request.
69. Contractor will provide aggregate annual Specialty Pharmacy AWP discount guarantees inclusive of all specialty and biosimilar drugs dispensed to the County's members by Contractor's specialty mail order pharmacies.
70. The annual Specialty Pharmacy AWP discount guarantees will exclude the value of rebates, manufacturer coupons, and monies associated with coinsurance assistance programs, and will not be subject to day supply proration or adjustment.
71. Contractor will provide minimum aggregate annual Specialty Discount Guarantees. Contractor will measure the aggregate Specialty Pharmacy discount guarantees and pay/credit the County 100% of any shortfall within ninety (90) days of each Annual period, with the County retaining 100% of any

additional savings achieved; shortfalls in one guarantee may not be offset by overages in any other guarantee.

72. All Specialty Drugs dispensed through a mail order facility will be reconciled against the aggregate Specialty Pharmacy discount guarantee. Contractor will not classify certain mail order facilities as "Retail" specialty pharmacies.
73. Contractor will provide separate aggregate annual per prescription dispensing fee guarantees by channel (retail, mail order, specialty mail order pharmacy).
74. Contractor will measure these guarantees and pay/credit the County 100% of any shortfall within ninety (90) days of each annual period, with the County retaining 100% of any additional savings achieved; shortfalls in one guarantee may not be offset by overages in any other guarantee.
75. Contractor will not increase mail order or specialty pharmacy dispensing fees during the contract term regardless of increases in mailing/postage/shipping fees charged by Contractor's delivery service provider (e.g., UPS, USPS, FedEx).
76. Contractor must quote all base administrative fees on either a PEPM, PMPM, or a per paid claim basis only (e.g., no charge for denied or reversed claims).
77. Contractor will provide drug utilization review (DUR) programs integrated across the retail, mail order and specialty distribution channels as part of the base administrative fees. Additional fees may apply for retrospective DUR, as outlined in Attachment B.
78. Clinical programs subject to a fee or charge must be quoted on an unbundled (ala carte) basis and will include program specific return on investment (ROI) guarantees, as applicable.
79. All proposed clinical programs will return 100% of savings to the County.
80. Any savings achieved in excess from one clinical program will not be used to subsidize short falls in savings resulting from any other clinical program in any contract year.
81. Contractor will exclude savings from Concurrent DUR and administrative edits, including but not limited to "refill too soon", from Contractor's proposed bundled clinical savings guarantee.
82. Contractor will provide quarterly performance reporting for all clinical programs currently in place and recommendations to the County for additions or changes. This analysis shall include the number of members affected, clinical significance and financial impact. It shall further include an assessment of prescription drug issues, trends and new products.
83. Contractor must provide the County with full authority to "turn-off" any point-of-sale edits (e.g., quantity limit, step therapy) that the County does not want to implement or continue. Pricing impact will be documented to aid in decision.
84. Contractor must agree to provide the County the greater of 100% pass-through of actual Total Rebates (as defined below) or the specified minimum Per Brand Rx Rebate Guarantees (as defined below).
85. Contractor agrees to provide quarterly file feeds detailing drug-level rebate information to the County at the time of payment, including, total rebates received by Contractor, total rebates earned by the County and revenue paid to the County. Reconciliation is performed at the aggregate level.
86. Contractor will not assess a rebate management fee to the County.
87. Contractor agrees rebates include:
    a. Base Rebates (negotiated regardless of plan sponsor management requirements such as UM or coinsurance differentials)
    b. Incentivized Rebates (additional rebates for plan sponsor adopting management criteria such as UM or coinsurance differentials, but not limited to those items)
    c. Educational grants
    d. Market Share rebates (additional rebates paid for achieving volume targets as specified in rebate contract)
    e. Price protection clauses

f. Manufacturer Administrative Fees
g. Clinical fees paid by pharmaceutical manufacturers for compliance programs

88. Upon written notice to the County, Contractor reserves the right to modify or amend the financial provisions of the agreement in the event of an external event or industry change impacting Contractor's performance under the agreement, including but not limited to: (a) any government-imposed change in federal, state of local laws or interpretation thereof or industry wide change that makes Contractor's performance of its duties hereunder materially more burdensome or expensive, including changes to the AWP benchmark or methodology; or (b) an unexpected launch of a generic product; or a branded product unexpectedly converted to OTC status, recalled or withdrawn from the market. Contractor will provide documentation of the expected launches and anticipated dates; or (c) changes impacting drug manufacturers which negatively affect Contractor's ability to achieve the economic commitments under this Agreement including the ability to provide or maintain discounts or Rebates. For modifications or amendment made pursuant to (a), (b), or (c) above, Contractor agrees to modify the pricing in an equitable manner to preserve the financial interests of both parties and provide documentation that the revised pricing terms are equitable.

89. With respect to any modifications made as a result of 90, (a), (b) or (c), Contractor or County may initiate a review to determine if/how the current contract will be equitably adjusted as a direct result of the above change(s). Such revision will be limited to an equitable adjustment to the (guaranteed AWP discounts, dispensing fees, administrative fees, other financial guarantees, and/or rebate guarantees), solely as necessary to account for the impact of the triggering event(s) and shall be effective consistent with the effective date of the triggering event. Contractor will provide the County details of and reason for the proposed change, an explanation of the manner in which the proposed change will account for the impact of the event triggering the proposed change, with an illustration that details the impact of the proposed change. The illustration will be specific to County utilization and will show the impact of the County-specific change(s). The illustration will show current utilization and costs based on current County utilization and the impact to Contractor and County as a result of the proposed change. Contractor will disclose any necessary facts and data for County and/or County's benefit consultant to conduct an independent analysis. Such facts will include rebate reports in cases where rebate-ability is compromised. The parties shall then work in good faith to promptly finalize the changes and amend this Agreement to appropriately reflect any such changes. If the changes are accepted, the revision will occur within 30 days after such agreement or otherwise as mutually agreed to by the parties. In the event that the parties are not able to agree on a proposed change then either party can terminate the contract within 90 days and without penalty, fees, early termination charges, or liquidated damages.

90. Contractor reserves the right to modify or amend the financial provisions of the agreement if any of the following occur: (d) a change in the scope of services to be performed under the agreement upon which the financial provisions included in the agreement are based, including a change in the plan specifications or the exclusion of a service line (retail and Home Delivery) from the County's service selection; (e) a reduction of greater than 20 percent in the total number of members from the number provided to Contractor during pricing negotiations upon which the financial provisions included in the agreement are based; (f) implementation or addition of 100 percent member paid claims plan specifications; (g) any substantive change in the County's formulary, exclusions, utilization management programs, or administrative edits, which may impact rebates from drug manufacturers; or (e) Contractor is no longer the exclusive specialty pharmacy provider. For modifications or amendments made pursuant to (d), (e), (f), or (g) above, the County agrees to provide Contractor at least 90 days' notice prior to making any changes. In the event the pricing needs to be modified, within

45 days of the County's notice, Contractor shall provide the County with any modified pricing to ensure the County is aware of pricing modifications prior to implementation.

All Guarantees shall be reported quarterly and paid and reconciled annually against actual results and shall be backed dollar-for-dollar such that the County is made whole if any guarantee fails to be met. Shortfalls in one component guarantee may not be offset by overages in another component guarantee. Contractor will not be allowed to use "aggregate" or "averages" for reconciling discount or dispensing fee guarantees. Rebates will be reconciled in aggregate across delivery channels. Usual and customary and zero balance claims will be excluded from all discount reconciliation methodologies including from the brand, MAC and/ or generic discounts. No cross subsidization of discounts and guarantees are allowed at retail, mail or within the distribution channel, with the exception rebates. Compound prescription drug claims, 340B claims, Indian Health Services and Tribal claims, direct member reimbursement Claims, claims with ancillary charges such as vaccines, claims filled outside the OptumRx Pharmacy Network and in-house or customer owned pharmacies will be excluded from the guarantees.

91. Under Contractor's proposed "Per Brand Rx Rebate Guarantees", specified amounts must apply to all formulary brand, non-formulary brand, single-source brand, and multi-source brand drugs (regardless of DAW coding) dispensed under the Plan; including such covered brand prescriptions where the member paid the full cost of the drug and the Plan paid zero; including brand name drugs dispensed in lieu of a generic equivalent; and including all brand name drugs dispensed as a house generic at Contractor's mail order pharmacy, regardless of DAW coding .. Brand drugs are identified by the multisource code field in Medi-Span containing an M, N, or O. Calculation of the Guaranteed Rebate Amount excludes ineligible claims, such as: (i) claims for plans where, after meeting the deductible, the member's copayment under the applicable benefit plan requires the member to pay more than 50 percent of the claim when evaluated in aggregate, excluding penalty assessments; (ii) vaccines; (iii) Limited Distribution Drugs; (iv) direct member-submitted claims; (v) stale dated claims over 180 days old; (vi) Claims for re-packaged NDCs; (vii) Compounds; (viii) Devices without a prescription drug component or claims that are not for prescription drugs except for insulins or diabetic test strips; (ix) Claims from 340B which typically receive a discount or rebate directly from pharmaceutical manufacturers under section 340B of the Public Health Service Act, or claims from entities eligible for federal supply schedule prices (for example, Department of Veterans Affairs, U.S. Public Health Service, Department of Defense); (x) Long-term care facility claims; (xi) Medicaid managed care claims in states where the state law prohibits Contractor from collecting supplemental rebates; and (xii) for utilization pursuant to a consumer card or discount card program where the plan had no cost liability on the claim or the claims.
92. DAW 1&2 claims that process with a mandatory generic penalty must not be excluded from the calculation of Contractor's proposed "Per Brand Rx Rebate Guarantees". DAW 1&2 are included in the per brand Rx rebate guarantees assuming the claims adjudicate as a brand name product.
93. Per Brand Script Rebate Guarantees must be provided without minimum or average days' supply requirements.
94. Contractor's proprietary brand/generic drug algorithm(s) must not be used to classify drugs as Brand or Generic for determining per Brand Rx Rebate Guarantees.
95. Contractor's proposed Per Brand Rx Rebate Guarantees must be provided regardless of actual generic dispensing rates achieved.
96. Contractor acknowledges that there will be no day supply proration or adjustments to the Per Brand Rx Rebate Guarantees.
97. The Contractor shall offer rebates for all specialty drugs dispensed at retail.

98. Contractor confirms that HIV, PCSK9 and Hep-C products will be dispensed in accordance with the County's plan design, and that the Per Brand Rx Rebate Guarantees will apply to all such products based on channel/network that was used to dispense said product. The Specialty Pharmacy Per Brand Rx Rebate Guarantees will apply to all such products dispensed at Contractor's specialty mail pharmacy.
99. Contractor will pay/credit the County based on the minimum Per Brand Rx Rebate Guarantees on a quarterly basis within ninety (90) days after each contract quarter.
100. 180 days after contract year-end, Contractor will reconcile the guaranteed percent pass-through of Total Rebates against the quarterly rebate payments made in accordance with the minimum Per Brand Rx Rebate Guarantees. The County will retain 100% of any additional savings achieved.
101. In the event that the County's share of "Total Rebates" is greater than the total amount paid to the County via the corresponding quarterly rebate payments, Contractor shall pay/credit any amount due to the County within 180 days after the end of each contract year and will provide supporting standard documents.
102. Contractor will provide the County quarterly reporting, at the time of payment, that clearly itemizes Total Rebate amounts invoiced, amounts paid to the County, and the time frame in which they were earned. Payments will align to 180 days post contract year. If requested, this reporting will be itemized according to the County benefits account structure.
103. Rebates are reconciled and paid quarterly, every 90 days, after the annual reconciliation. The County's share of any Total Rebates for the reconciliation period that are received by Contractor after the annual year-end reconciliation that exceed the total quarterly rebate payments made to the County for the calendar year, will be paid/credited to the County on a calendar quarter basis (every 90 calendar days). Such amounts will not be applied to the next annual rebate reconciliation.
104. Rebates due the County under this Agreement that are received by Contractor after termination or expiration of this Agreement shall be paid to the County by check. Any accrued and unpaid rebate amounts are payable to the County after the termination of the contract if the County has met all monetary terms set forth in the contract and has not terminated the contract in breach, as long as the rebate amounts were earned during the term of the contract as it applies to the County, and the County does not owe any outstanding payments to OptumRx.
105. Contractor shall offer drug-specific point of sale rebate program option (along with any fees, limitations, audit rights, etc.) at the County’s request.
106. With rising Rx costs, it's important to the County to add more transparency in the PBM contract. Contractor will agree to share annual reporting outlining the total revenue Contractor makes on the County's account.
107. Contractor must agree to offer a generic dispensing rate (GDR) guarantee at both retail and mail order. GDR shall be defined as the number of generic prescriptions (single source and multi-source generics) dispensed divided by the total number of prescriptions dispensed (brand and generic). GDR guarantees exclude Specialty Drugs.
108. If Contractor fails to achieve the applicable GDR guarantee in any Contract Year, the number of generic drug prescription claims (including OTC prescription claims) divided by the total number of all prescription claims for such contract year (excluding specialty drug prescription claims). To be eligible for the GDR guarantee, the County must: (a) maintain an average cost-sharing amount differential between Tier 1 and Tier 2 of $15 or more or a 5% coinsurance differential, or meet a minimum deductible to qualify for a Health Saving Account (HSA) with single coverage within each plan specification; (b) adopt OptumRx’s Formulary; (c) implement “Dispense as Written” penalties for DAW 2 claims for the majority of members; and (d) implement all Contractor recommended clinical

programs (for example, prior authorization and step therapy). • Brand cost is defined as: (Brand Drug ingredient cost + Brand Drug dispensing fee - Brand Drug Cost-Sharing Amount - Brand Drug Rebate)

• Generic cost is defined as: Generic Drug ingredient cost + Generic Drug dispensing fee - Generic Drug Cost-Sharing Amount - Generic Drug Rebate, if applicable)

	Year 1	Year 2	Year 3
Mail	84.6	84.7	84.8
Retail	84.2	84.3	84.4

109. If Contractor fails to achieve the applicable GDR guarantee in any Contract Year, the penalty for a missed GDR guarantee will be calculated by taking the total number of prescription claims multiplied by the percentage the GDR was missed by multiplied by the difference between the average cost for a brand drug and the average cost for a generic drug during the measurement period. Penalties will be calculated within 90 days of the close of the full contract year. Annual penalties are capped at $50,000 per year.

110. GDR guarantees shall be reported annually within ninety (90) days from the end of the Contract Year and any amount due the County shall be paid within thirty (30) days of reporting.

111. The County shall have the annual right to evaluate key pricing terms (e.g., AWP discounts, dispensing fees, administrative fees, clinical program fees, and rebates) and all other terms with a financial impact (e.g., generic dispensing rate guarantees, service performance guarantees, trend management guarantees) to ensure that pricing remains competitive in the PBM marketplace throughout the contract term (the "Market Check"). The market check provides a means for the County to determine if pricing terms remain market-leading relative to the marketplace, not just market-leading within Contractor's employer book of business. Annual Market Checks conducted that have any new pricing will become effective January 1 of the following year.

112. The County or its consultant will compare the aggregate value of the current pricing terms provided by Contractor with the aggregate value of the pricing terms then currently available in the marketplace based on the County's consultant's internal benchmark analysis for similarly sized plan sponsors with similar plan designs, pricing structures and mail order penetration as the County.

113. The Market Check report prepared by the County or its designee will be submitted to Contractor and Contractor will provide its comments regarding the report to the County and its designee within ten (10) business days of receipt. If the Market Check results in a finding that current market conditions can yield a one percent (1%) or more savings on gross plan costs (defined as ingredient costs plus dispensing fees plus base administrative fees minus rebates), the parties will discuss in good faith the Market Check analysis and a revision to the pricing terms and other applicable provisions under the Agreement, to be effective no later than January 1 of the upcoming Contract Year.

114. If the parties are unable to reach agreement on revised pricing terms and other applicable provisions within sixty (60) days from the date of the market check report, then the County may terminate the Agreement with no early termination penalty, fee, liquidated damages, or loss of rebates upon ninety (90) days written notice.

115. Any revisions to financial terms resulting from the parties' negotiations are effective the first day of the following contract year, subject to the parties having executed an amendment to the Agreement at least 60 days prior to the effective date.

116. Notwithstanding anything in this Agreement to the contrary, the financial guarantees set forth above apply only if County has received Administrator's services for a full contract year. Furthermore, if this Agreement is terminated prior to the end of a given contract year, then Administrator is not required to meet the financial guarantees set forth above.

II. ACCOUNT MANAGEMENT AND SERVICE SUPPORT

Contractor shall:

1. Agree that all customer service, pharmacy/physician service centers will be staffed within the US. Any services that are offshored must be disclosed in this RFP. If Contractor proposed to offshore any services during the life of the contract, Contractor agrees to give the County at least 90 days' notice and the option to decline offshoring without any impact to pricing.
2. Agree to provide an experienced dedicated account management team that will service the County's, including an appointed clinical pharmacist/clinical program manager, a day-to-day account manager, an account executive, an eligibility file specialist and a benefits analyst. All must be knowledgeable on specific pharmacy benefit program(s) and organizational structure of the County. The experienced, dedicated account manager will assist with member issues and renewals/contract management. The successful Contractor's account management team will provide innovative and proactive consultative support to help the County design programs, resolve outstanding issues, and keep the County informed of prescription drug market trends and issues. The team will be dedicated to the County for the term of the contract (except for change in employment conditions or requested change by the County).
3. Provide a clinical pharmacist and account director (executive) that will be required to provide the County -specific recommendations to control drug trend and improve quality of care, and will present this information at quarterly meetings with the County.
4. Agree that the assigned Account Manager (day to day person), Account Executive/Director and Clinical Resource will be no more than one-time zone away from the County's benefits team. The County's preference is that this person be on Pacific Time (PT).
5. Assign a corporate executive within Contractor's organization with accountability and authority for the quality of service and compliance to the contract. Executive sponsor will attend annual review meetings.
6. Provide the County administration 30 days advance notice of any planned change in the primary account manager.
7. Agree to provide a backup contact person knowledgeable about the County's plan and benefits in the event the dedicated account team is unavailable.
8. Provide open enrollment support that includes call center services, printed pharmacy materials and (upon request) in-person support by Contractor at onsite meetings. This will be provided every year and it will be Contractor's responsibility to communicate appropriate decision timelines to the County to fulfill this requirement.
9. Participate in the following account meetings and calls, at no cost to the County, and adhere to a schedule of in-person meetings and teleconferences that best supports the County's needs.
    a. If applicable, weekly pre- and post-implementation meetings with the County staff to commence no later than five business days after the award of the contract.
    b. Biweekly operations meetings with the County staff to commence post implementation.
    c. Monthly strategic calls
    d. Quarterly onsite meetings with the County staff and at least three key account team members, to report and review program performance results including all services and components of the program such as clinical, financial, contractual reporting requirements, customer service, appeals, and any program recommendations. Quarterly materials must be provided at least a week in advance of the meeting and

no later than 45 days after the close of the quarter; quarterly reports need to tie to general management reports provided monthly/quarterly to the County.

e. Semi-annual review to be held onsite in January/February and July/August of each year to discuss strategic initiatives.

f. Ad-hoc meeting to address urgent or emergent issues

g. As needed, annual onsite visits by the County staff to your operations facilities (mail service, specialty and/or member service).

10. Provide plan design, clinical and utilization management program and formulary modeling services at no charge. Contractor will provide detail to the County on the financial benefit and potential member disruption of any clinical or utilization management rules that it proposes. Contractor must hold quarterly review meetings onsite or via conference call with the County to report and review program performance results.
11. Provide clinical decision support and coordination of care with designated disease or care management programs upon request by the County.
12. Provide upon request and at its own expense, an agreed upon number of materials and staff as determined by the County for annual benefit fairs.
13. Track member inquiries, including provider service and prior authorization inquiries, to provide the County with a de-identified summary of pharmacy-related issues from the member call center issue tracking database upon request. These inquiries include phone calls, email messages and direct mail communications. Tracking and reporting will include case management status and turnaround time.
14. Pay all expenses for two County staff persons to attend the Contractor's annual conference/client meeting.
15. At the request of County, be available to participate in all of County's open enrollment meetings and health fairs throughout the year, a minimum of 6 meetings per calendar year. Attendance and promotional materials shall be provided by Contractor as part of the base administrative fees and at no additional charge to the County.
16. Review the pharmacy section of the County's Plan Documents for accuracy and document any changes that occur each year as part of the base administrative fees and at no additional charge to the County.
17. Agree that the County will be consulted on account management staffing changes (e.g., national account executive, account manager, account coordinator, clinical account executive and financial analyst) and have the opportunity to review the qualifications of potential replacements with final right of approval.
18. Provide replacements on the Account Management team (including the appointed clinical pharmacist/clinical program manager, the day-to-day account manager, account executive, and eligibility file specialist) and/or implementation team, upon the County's request, if dissatisfied with the performance of existing team members. Contractor will comply with the County's request and make every reasonable effort to provide a qualified replacement, subject to the County's approval, within two weeks of such request.
19. Provide appropriate support for the County due to divestitures, mergers and/or acquisitions that may occur during the course of the contract.

III. MEMBER SERVICES

Contractor shall:

1. Have a designated customer service unit (>80% of calls managed through designated center) for the County with real time electronic access to eligibility and claims history from all pharmacy (including specialty) adjudication systems.
2. By October 1, 2020, activate the dedicated toll-free member service line for all the County members. Contractor will provide all member and provider service staff with information and training relative to the County program at least 30 days prior to the activation date.
3. Ensure the County's member service representatives provide the following services to "prospective" members during the annual open enrollment period(s) and year-round services to newly enrolled new hires: locating a participating pharmacy, information on the County's (s), help determining if a drug is on Contractor's formulary, and applicable coinsurance. Contractor will also be expected to provide similar support for prospective members via Contractor's member web site.
4. Ensure the County's member service team will be knowledgeable of the specific pharmacy benefit programs of the County and their integration with medical coverage to respond to member questions. Member/Provider service representatives will always have access to a pharmacist in the event the call requires the attention of a clinician.
5. Provide Immediate Verification Requests (IVR) and web support along with a dedicated toll-free telephone line that will be available24 hours a day, seven days a week, and 365 days a year.
6. Provide the County's members with a single, dedicated toll-free number and a designated team of customer service advocates (CSAs) to support benefit, eligibility, prior authorization status, and other plan-related inquiries for both retail and the Home Delivery Pharmacy Program 24 hours a day, seven days a week. This team of CSAs will have the ability to warm transfer members to the specialty pharmacy call center staff. CSAs will obtain necessary information before making the transfer and conveying that information to the specialty call center, so the member does not have to restate their request.
7. Ensure specialty pharmacy call center staff will have the expertise and training needed to assist members with specialty medication requests and drug inquiries.
8. Provide an option for single sign on access to Contractor's member website through the County's H&W portal(s), at no additional cost to the County.
9. Agree to customize and co-brand Contractor member web site to incorporate other benefit information of the County in an effort to communicate linkages to other Contractors and benefits of the County.
10. Make available to the County's members information about the County's plan design (s) (including if a drug is covered, any coverage limitations and the applicable coinsurance) and Contractor formulary (via phone and web).
11. Provide consistent access to the Contractor's member website that contains claims information for the County, pricing and drug information customized to the benefits of the County and supports consumer knowledge of the prescription drug benefits and choices.
12. Customize open enrollment materials. County logo, plan name, dedicated phone number and website address will be required on forms, and County specific website pages. Standard language that does not apply to the County will need to be removed. This shall be part of the base administrative fees and at no charge to County.
13. Provide enrollment support specific to the County's plan design, including welcome packets, and handbooks, as part of the base administrative fees and at no additional charge to the County.

14. Provide customer service activities to include, but not limited to: one dedicated single front-end, toll-free number with touch tone routing, for County participants with questions concerning their prescription (retail, mail or specialty), to refill a mail order or specialty prescription, to check on a mail order or specialty prescription, etc.; a voice response system with a user-friendly menu and alternative language options (or access to language translation services); and system availability 24 hours a day/7 days a week/365 days a year (excluding scheduled downtime) as part of the base administrative fees with no additional cost to the County.
15. Provide a designated, trained Customer Service Center team for County with electronic access to eligibility, mail order claims, and claims history from all of the claims adjudication systems. At a minimum, this designated team shall be responsible for taking all calls from County participants between the hours of 7:00 AM and 9:00 PM Pacific Time Monday - Friday and 8:00 AM to 5:00 PM Pacific Time Saturday and Sunday. Calls outside of these hours may be taken by CSRs that are trained on County benefits, but not part of the designated team.
16. Develop and use alternate ID numbers for participant identification in a format and style approved by County.
17. Upon the County's request, provide prescribers with electronic access to Member benefit plan information, including (a) Member eligibility status, (b) Member medication history, (c) Formulary status of the prescription drug being prescribed, (d) listing of Generic drug or Formulary Brand alternative medications, (e) Member coverage information where applicable, (f) applicable cost-sharing amount, and (g) drug classification information required by the Centers for Medicare & Medicaid Services or successor governmental authority.
18. Work with medical TPA to provide a single ID card for both the medical and Rx benefit.
19. Agree to provide communication materials (standard or custom) at no additional cost to support the service and delivery of the County prescription drug program.
20. Agree to send out two (2) communications annually, at no additional cost, to promote and educate member on current programs that are offered under the benefit.
21. Agree to not to charge the County for production costs, including postage, for standard communications.
22. Agree to take full accountability and responsibility for all communications it sends to the County's members, the County must be given the opportunity to review and approve all communications pieces (letters, flyers, and inserts) before they are sent to the County's members. Contractor agrees to provide the County two weeks to review and approve all communications before sending to the County's members.
23. Agree to not display Social Security numbers on any member communication materials.
24. Agree to adhere to the County's branding requirements.
25. Agree not to contact plan members for purposes related to promotional campaigns without the County's advance knowledge and written approval.
26. Maintain and provide upon County or member's request, multilingual electronic, print, and telephonic capabilities with no additional charges to the County.

IV. CLINCAL PROGRAMS AND FORMULARY MANAGEMENT

Contractor shall:

1. Agree to adhere to, develop and administer an evidence and clinically based formulary program including ongoing pharmacy and therapeutics committee review and maintenance.

2. Agree that the County will be notified at least 90 days in advance of any change to the high deductible preventive drug list or clinical program causing member impact. Member communications, that may be customized by the County, will go out 30 days prior to effective date of change.
3. Agree that if the County adopts Contractor's formulary without drug exclusions, Contractor will not exclude drugs from coverage unless required by FDA or the County.
4. Agree that excluded drugs can be obtained through the standard prior authorization process rather than requiring a medical exception process.
5. Confirm administration of OptumRx standard utilization management programs is included at no cost.
6. Develop and maintain customized prior authorization criteria, step therapy programs, and/or quantity limits, if requested by the County. Additional charges may apply as outlined in Attachment B.
7. Provide quarterly reporting on clinical programs elected by the County that will include showing the number of member specific encounters, the impact of such encounters and savings calculated from real vs. inferred data, and overall ROI of implemented programs.
8. Disclose annually (by July 1) all manufacturer-funded clinical or medication adherence programs administered by Contractor at retail, mail, specialty pharmacy or through direct member solicitation, and for which Contractor proposes to include the County and its members for the following calendar year. The County retains the right to decline participation without adversely affecting the financial guarantees applicable for that calendar year.
9. Provide and maintain the Preventive Drug List to be used by any the County High Deductible Health Plan (HDHP).
10. Provide the Concurrent DUR Program as part of the base administrative fees and at no additional charge to the County.
11. Provide a current and complete list of Preventive Drugs effective on the Effective Date and any updates applicable throughout the contract term.
12. Agree that clinical programs subject to a fee or charge will be quoted on an unbundled (a la carte) basis.
13. Provide a Prior Authorization Program which will be administered at the point-of-sale or at mailing and is designed to promote appropriate utilization and safety in the prescribing of prescription drugs.
14. Intentionally omitted.
15. Agree that the County shall have sole authority to determine the benefits to be administered under its Plan and will conduct second level appeals. The County has the sole right to resolve disputed claims under the Plan and shall promptly inform Contractor of such resolution. However, County shall rely primarily on information and recommendations provided by Contractor in resolving such disputed claims.
16. Provide a Retro DUR and direct member outreach program for Enrollees.
17. Respond to members' first level appeals within 30 days. Contractor will also support the County in responding to second level appeals, complaints and grievances in full compliance with healthcare reform rules, with responses provided to the County’s inquiries within two business days of request for information. Contractor will also provide a process for external Independent Review Organization (IRO) appeals.
18. Provide support to the County for appeals within two business days of request for information. In addition to reviewing and responding to first level appeals, the Contractor will coordinate and provide external review services, through its contracted rotating independent review organizations,

on behalf of the County. Currently the County handles all second level Administrative & Grievance Appeals (i.e., co-pay, drugs not covered, quality of service, cost of script) inquiries. The County funnels any first level appeals through Contractor. Contractor shall

19. Confirm that brand-to-brand substitutions resulting from Contractor-initiated intervention programs will only be permitted to promote clinical outcomes and only in circumstances where the substituted product results in a lower plan and member cost, unless otherwise approved in advance by the County. Rebates shall only be considered in instances where the plan has drug-specific rebates reinvested at the point of sale. This paragraph shall not apply to interchanges (a) initiated pursuant to a drug utilization review or for patient safety reasons; (b) required due to market unavailability of the currently prescribed drug; (c) from a brand name drug to its FDA-approved generic equivalent; and (d) required for coverage reasons, where the prescribed drug is not covered by the Formulary or the County's Plan.

V. MAIL ORDER AND SPECIALTY PHARMACY SERVICES

Contractor shall:

1. Be properly licensed, certified or credentialed to operate in the applicable states where dispensing mail order facilities and specialty operations reside.
2. Confirm and represent that product purchasing and inventory control procedures are designed and implemented to prevent the introduction of counterfeit products into the U.S. supply chain, and to create end-to-end audit trails in the event of drug product warnings or recalls. Specifically, upon receipt at Contractor mail order pharmacies, Inventory Control staff verifies that the proper manufacturer NDC number, drug name and expiration dates are received. In addition, Contractor records all lot numbers of products and does not purchase repackaged products, thereby further limiting exposure to counterfeit drugs.
3. Not charge the County or members for expedited delivery if its organization causes the prescription delay.
4. to authorize a short-term fill for a Home Delivery Pharmacy prescription at retail to any member experiencing a delay in the delivery of its order, resulting from extenuating circumstances such as a manufacturer shortage.
5. Be required to collect coinsurance for mail and specialty services with no balance billing to the County of unpaid coinsurance allowed.
6. Agree to transfer mail order prescriptions to a retail pharmacy in the case of emergency, vacation refills or if multiple prescriptions are requested and one is out-of-stock.
7. Not charge the County or members for expedited delivery if its organization causes the prescription delay. Contractor agrees to offer any member experiencing a delay in the delivery of its order the option of filling their prescription at a participating retail pharmacy.
8. Have the capability to accept and store member credit card data in a secure location.
9. Agree to allow the County the flexibility to determine if members can fill specialty drug prescriptions at retail and will include pricing for an Open/voluntary option (open retail network/ no retail refill limit) and an Exclusive/closed network option (specialty pharmacy only).
10. Agree to allow the County the flexibility to determine participation in the Specialty drug distribution and management services on an individual therapy and drug level with no impact to discounts or rebates and no additional charges.
11. Agree that the County may carve-out specialty to another Contractor at any time with one hundred and eighty (180) days' notice.

12. Confirm that should the County elect to utilize alternate pharmacy for Specialty drug distribution and management, it will not affect non-specialty discounts, dispensing fees, rebates, or admin fees or impose additional charges.
13. Be able to apply adjudication logic designating a preferred specialty provider (if the County chooses) as the exclusive provider of the specialty benefit. This will include denying coverage of specialty products (after 1 grace fill) processed under the pharmacy card, when applied at a retail setting.
14. Agree to administer and invoice for rebates at Preferred Specialty Provider; however, there is no requirement for the County to use Contractor's rebating contracts for specialty products administered at a Preferred Specialty Provider.
15. Agree that all non-specialty products dispensed out of the specialty pharmacy will be subject to your proposed standard retail pricing terms (discounts, dispensing fees, and rebates guarantees).
16. Agree that the County and its members are not responsible for the cost of lost, stolen, or damaged traditional or specialty medications delivered to the member. Contractor will expedite and assume the cost of expedited shipping of any replacement medication.
17. At the direction of the County, provide customized letters to participants and providers taking specialty medications to describe the enrollment process and the clinical services offered by the Specialty Pharmacy.
18. Provide on-call support 24 hours a day/7 days a week/365 days a year to pharmacist and registered nurses that are hired by the Specialty Pharmacy and are appropriately trained in dealing with specialty medication inquiries.
19. Monitor specialty drug utilization and refill compliance data to identify opportunities to minimize waste. Such activities shall be reported to the County on a quarterly basis.
20. Upon County's request, provide County with an updated specialty drug list. Notwithstanding the foregoing, an updated specialty drug list, including pricing, shall also be provided to County on a quarterly basis.
21. Ensure that at the time of dispensing or as the product is being prepared for automatic dispensing it is visually inspected by a pharmacist for correct color, shape, and other identifying markings. Contractor will verify that all drugs from primary or secondary Contractors have either been purchased directly from the manufacturer or that the Contractor is capable of showing the trail to assure that they are not buying from secondary markets. Secondary wholesalers will only be used to cover for shortages that have occurred with the primary Contractor and/or for limited distribution products.

VI. DATA, REPORTING, AND SYSTEMS

Contractor shall:

1. Claims Data Retention. Retain complete records of the County claims data for a minimum of ten (10) years, or greater as required by law, from the date the prescription is filled. Thereafter Contractor will dispose of such data in accordance with its standard policies and practices and applicable state and federal law. Disposition of PHI shall be in accordance with the Business Associate Agreement.
2. Data Feeds: Acceptance. If required at implementation or in the future, accept a data feed or interface with third party Contractors at no additional cost, including but not limited to: health plan administrator, benefit administrator, health management Contractor, health risk assessment

Contractor, transparency Contractor, etc. This list is not all inclusive and Contractor agrees to integrate with ANY Contractor of the County's choosing.

3. Upon County's request and at no additional charge, provide regular prescription claims data feeds in Contractor's standard format(s) to up to ten (10) unique Contractors for disease management, flexible savings account (FSA) and other "payment," "treatment" and "healthcare operations" purposes (as defined under HIPAA). Other examples of electronic data feeds are: at least weekly feeds to the County's medical Contractors, data warehouse Contractors, transparency Contractors; financial claims history to consultants; clinical data to health plans; etc. Each data feed could be unique in nature and would range from daily to quarterly transmission intervals.
4. Agree that all data on claims incurred by the County's members belongs to the County. Contractor will not refuse to share data with any Contractor if requested by the County. Each party will retain ownership rights of its own data and confidential information. Claims records are the property of the County while OptumRx shall retain ownership of its operational records.
5. Agree data feeds, incoming and outgoing, for accumulator integration with the medical TPA required under PPACA and will be provided at no additional charge.
6. Provide periodic electronic data feeds at no additional cost and all required information to Contractors such as Livongo, Rx Savings Solutions, etc.
7. Provide: (a) Quarterly electronic summary reports of the County's claims activity and an annual report analyzing the County's prescription drug trend within ten (10) business days from the end of the reporting period; (b) Online access capability to standard reports so that authorized the County users and third-party representatives can view current reports within a day of user access. There will be no limit on the number of authorized users allowed at no additional cost.
8. Collect and report statistics and/or summaries on a monthly, quarterly and annual basis as specified by the County. The reports may be standardized reports provided by the Contractor. If the reports do not adequately meet the County requirements, the Contractor shall customize the reports to the County's specifications. The County's requirements may change from time to time during the life of the Contract. Standard reports shall be provided as part of the base administrative fees; the charge for customized reports shall be noted in the Fee Schedule. For purposes of clarity, a customized report shall be a report that requires IT services and support for development.
9. Provide unrestricted online access to utilization reports and ad-hoc reporting tools to a minimum of six (6) user IDs at no charge to the County and which will include the consultants. Contractor will be required to provide unrestricted online access to utilization reports and ad-hoc reporting tools for consultants.
10. Provide the County (and if requested, their third-party representatives) with sophisticated online reporting and modeling (plan design, clinical and financial) tools at no additional cost for up to ten (10) people. The online reporting tool will include a custom, ad hoc reporting function with access to all data elements captured. Contractor will provide onsite training and ongoing user support to manage the prescription drug program at no additional cost.
11. Provide prescription drug claim level detail, all reports, billings, rebate records, performance measures, service concerns and issues, or any other communication, to the County in a manner mutually agreed upon by both parties.
12. Provide reporting for the purposes of monitoring and reconciling financial and performance guarantees. Sampling techniques and report formats will be defined and mutually agreed upon.
13. Provide reporting for the purposes of monitoring claims paid for ineligible members due to eligibility discrepancies with medical TPA.

14. Financial guarantee true-up will be performed annually (90 days after each 12-month increment of service). Payments of shortfalls, if any, occur within 30 days of customer agreement of the reconciliation findings.
15. Provide Medicare Part D services, specifically providing support for the Retiree Drug Subsidy filing and related activities.
16. Meet all current and future reporting requirements with the Centers for Medicare and Medicaid Services (CMS) for Medicare Modernization Act (MMA) Part D. Contractor shall remove Part B items (e.g., diabetic supplies) from the files to be sent to CMS for the subsidy. Contractor shall ensure that MMA support meets County's compliance, audit, and other standards.
17. Be responsible for administering Coordination of Benefits (COB) as applicable for electronically processed claims. At County's option, the Contractor shall be responsible for administering COB and other functions and services in regards to Medicare Part D subsidy activity including the provision of cost reports and filing. This includes applying the Medicare Allowed Amount to the member's deductible and/or OOPM, as an example.
18. Process subrogate Medicaid claims.
19. In the event of a platform or name change, pay any charges associated with the creation and distribution of new member ID cards by the TPA.
20. Contact County's Benefits Administrator and/or the County's TPA for verification of eligibility of a participant that is shown as ineligible online in the event of participant escalation.
21. Notify County or its designee, if the eligibility file is not received by the due date identified on the file schedule provided by the County's TPA.
22. If requested, agree to process paper claims according to the fee structure detailed in bid form 4.
23. Notify the County immediately upon identification of system-related problems, programming problems or data transfer problems. The Contractor shall make every effort necessary to correct such problems within 48 hours regardless of the time or date in order to minimize any disruption to participants.
24. Capture and report eligibility discrepancies including cost impact for late termed monthly.
25. Agree that the County, County's benefit administrator, and the County's consultant will have access to all reporting systems, view eligibility, enrollment and claims status in real time.
26. Confirm and ensure that the Contractor's online reporting tool must allow reports to be summarized by various plans/groups as designated in the County's account structure.
27. Provide claims review and routine audit functions to detect and prevent mis-billed claims and fraud at retail, mail and specialty pharmacy.
28. Ensure all of the Contractor's processes, systems, and reporting will be in full compliance with federal and state requirements, and compliant with HIPAA for acceptance of claim transactions. Any fines related to non-compliance will be Contractor's sole responsibility.
29. Confirm Contractor uses electronic Coordination of Benefits (COB) for both commercial plans and Medicare Part B covered drugs.
30. Agree that any dollars associated with coinsurance assistance programs and/or coinsurance accumulator programs will not be treated in any way as discounts on claim costs. These dollars will be tracked separately and will never be used to reconcile guaranteed discounts, rebates, or dispensing fees.
31. Confirm there will be no additional fees to the County if the County elects to enroll in Contractor's coinsurance accumulator program.
32. Load clean eligibility data within 24 hours of receipt.
33. Notify County or its designee prior to the eligibility update application, of any material errors or coding problems on the eligibility file that exceeds agreed upon thresholds.

34. Agree that maintenance of eligibility will be compliant with the requirements of the HIPAA standards.
35. Coordinate with the County's medical TPA for eligibility. Contractor must accept various file formats, media and schedules, including daily or even real-time updates. Depending on the frequency and format, additional charges may apply.
36. Be capable of supporting manual eligibility updates and off-cycle files, which may arise from new acquisitions.
37. Provide an eligibility database that will have the capacity to maintain enrollment/eligibility for the County members by each business, segment and plan.
38. Provide immediate online real-time manual eligibility updates for urgent requests by the County. Contractor will also provide medical TPA access to Contractor's eligibility system to allow for urgent, real-time manual eligibility updates.
39. Based on the eligibility files received by the Contractor:
    a. Add coverage for members who have joined the plan within 48 hours of receipt of eligibility data
    b. Update member information (e.g., address changes) within 48 hours of receipt of eligibility data
    c. Notify appropriate party of eligibility issues within 24 hours of receipt of eligibility data

VII. RETAIL NETWORK MANAGEMENT

Contractor Shall:

1. Maintain at least one broad retail network option that includes all chain pharmacies (national and regional) plus independents, available to the County's commercial plan members during the initial term of this agreement and subject to the discount and fee guarantees included in Contractor's pricing offer.
2. Represent that contracts with participating pharmacies require them to be in compliance with all applicable local, state and federal laws and regulations and if a pharmacy is out of compliance with these contractual requirements (i.e., dispensing counterfeit drugs), the pharmacy would be subject to removal from its retail networks.
3. Under no circumstances contact, solicit from or issue point of service messaging to the County members that contain information regarding PBM's contract or rate negotiations with a retail pharmacy. In situations where a retail contract has been terminated, and/or a patient safety issue is noted, then Contractor will work directly with the County to determine the communication strategy and outreach to the affected members.
4. Maintain a disaster recovery plan that contemplates a natural disaster or national emergency, enabling Contractor to continue to fill all prescription requests using alternative sites or locations as reasonably necessary and appropriate.
5. If requested by the County, provide receipts to members that show total cost, amount paid by member, and amount paid by the County for each prescription at no additional cost.
6. Agree that member coinsurance amounts will be collected by the dispensing pharmacy; the County will never be charged for unpaid member balances or coinsurance.
7. Maintain computerized control of ingredient pricing through the use of a single, auditable industry resource such as Medi-Span and applicable to both mail order (including Specialty) and retail prescriptions.

8. Notify the County at least 90 days in advance regarding termination of a current pharmacy chain or independent pharmacy.
9. Provide a toll-free number for pharmacy and physician inquiries that are answered 24/7/365 by Contractor, as part of the administrative fee.
10. Track and monitor pharmacy performance (i.e., generic dispensing, reversals, controlled substance dispensing, etc.) including PBM's management of the network, providing performance reports upon request to the County.
11. Conduct on-site audits with a minimum of 4% of retail pharmacies on an annual basis and 100% of all audit recoveries will be credited to the County within 30 days of audit recoveries.
12. Provide a program to audit 100% of the submitted claims using a sophisticated audit tool to identify submission errors, waste, fraud and abuse at no additional charge to the County. Contractor shall provide supporting reports on a quarterly basis to demonstrate the activity of this network auditing program.
13. Provide network audit reporting on a quarterly basis.

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.

VIII. PERFORMANCE GUARANTEES

Contractor shall:

1. Offer competitive and aggregate Performance Standard Guarantees values in which it's organization takes full financial risk for unsatisfied guarantees.
2. Agree that all performance guarantees, except system availability, shall be measured and reported based on the County's specific data, unless otherwise noted.
3. Report guarantees according to the appropriate measurement either the County-specific or book-of-business, as agreed to by the County. Reports shall show actual results for the current period versus: (a) prior periods and (b) the guaranteed standard. The County shall not be responsible for requesting reports.
4. Place annual penalties at risk for successfully maintaining Service Performance Guarantees as set forth in Bid Form 6. The County reserves the right to allocate the total amount at risk among the various performance categories, with no more than 20% of the total amount allocated to any one guarantee. The County is not obligated to allocate an amount at risk for each and every performance metric; some may have $0 at risk.

5. Be required to allow the County the flexibility to allocate the total amount at risk among the various performance categories outlined in this RFP at least 30 days prior to the start of each contract year.
6. Agree that member satisfaction, account satisfaction, network access and system availability shall be measured and reported to the County within 45 days of each calendar year. All other service performance guarantees shall be measured and reported directly to the County within 45 days from the close of each quarter.
7. Provide a response that discloses any/all proposed nuances to the proposed performance guarantees and Contractor will pay/credit the specified penalty amount to the County if the stated performance guarantee is not met.
8. Pay penalties, if any, annually based upon annual aggregated results no later than 90 days after the end of the Contract year. Annually, County will select a sampling of performance guarantees and request detailed back-up documentation to validate results. If Contractor failed to make timely penalties payment, then all monies due to County for Contractor's failure to meet a Performance Standard set forth below shall be automatically deducted from any monies due or owing to Contractor from County.
9. Agree that the County will select, annually, a sampling of performance guarantee results for validation, and Contractor shall provide detailed back-up documentation to County within sixty (60) days of County's request.
10. Agree that all reporting provided to the County will include the County's aggregated plan experience unless the County requesting reporting to be segregated by business unit or plan.
11. Shall report and reconcile penalties associated with performance guarantees 60 days from the end of the Contract year and penalties, if any, shall be based on annual aggregate results and paid within 90 days after the end of the Contract year, and the County will not be required to request payment.
12. Contractor will agree to provide a corrective action plan within 72 hours of identification of the issue, when performance issues are identified. Once agreed to by the County, the actions and timelines will be adhered to.
13. Agree that payments for Missed Guideline represent County's sole and exclusive remedy for any Guideline set forth herein. Any such performance failure will not be deemed a material breach that gives County right to terminate under the breach of contract article of this Contract.
14. Agree to use the County's provided scorecard (see Attachment E) to rate the performance of the account management team on a quarterly basis.

IX. IMPLEMENTATION

Contractor shall:

1. Agree to fully-fund a pre-implementation or post-implementation audit to be performed by the County or its professional representatives, including but not limited to the audit of ID card production, eligibility, claims processing, and plan design set-up.

X. AUDIT

Contractor shall:

1. Provide operational and financial audit rights including:
    a. audit once annually, during normal working hours, the County claims, customer service, appeals and pricing guarantees, where applicable, at no additional charge.

b. audit of Contractor's pharmaceutical manufacturers as necessary to determine Contractor's compliance with payment of all rebate monies (including pharmaceutical administrative fees) due the County.
c. Appropriate access to MAC rates and the formulary rebate program.
d. Processes for reporting data to manufacturers, accounting for rebates earned and allocating rebate payments to the County. Audits of rebate contracts are allowed, provided that (i) a third-party auditor approved by Contractor must be utilized; (ii) the County pays its own costs associated with the audit; (iii) all audits are subject to confidentiality obligations required of Contractor in its third- party contracts; and (iv) rebate audits include no more than the top ten pharmaceutical manufacturers or 70 percent of rebate spend.
e. Subject to Section 2 of this section, the County's ability to conduct these audits at any time during the contract term upon 30-days written notice to Contractor.
f. Contractor will allow the County or its designee the ability to review the specialty program including any and all paid claims and documented patient and provider interventions to verify comprehensiveness and effectiveness of services provided.
g. Right to audit at any time not more than once per year (excluding the implementation and CMS audits) during term of agreement or within 12 months following termination, unless material discrepancy has not been corrected within 90 days.
h. Contractor will take and complete corrective action within 30 days of audit that shows any discrepancy. If action requires additional training, corrective action should be completed within 60 days.
i. The annual right to audit includes, but is not limited to, the right to audit procedures, internal audits, claims processing systems, performance guarantees, rebate agreements, paid claims data, pricing guarantees, Medicare Part D reconciliation, compliance with Regulatory Requirements (i.e., Medicare Part D), security, claim files, grievance records, and accounting records. This includes the ability to audit onsite and perform call monitoring at Contractor sites and those of its subsidiaries.

2. Agree that if the County has performance concerns and deems it necessary to conduct an audit, the auditors will be selected by the County, with all audit costs incurred by the Contractor. Contractor will be obligated to notify the County immediately if there is a violation of law, regulation or systemic issue affecting all of the Contractor 's clients or all the clients, including the County, with certain plan provisions. Notwithstanding the foregoing, County's audit of Contractor records is limited to review of Claims transactions for adherence to and accuracy against the approved plan design and pricing under this Contract, for the limited purpose of verifying Contractor's compliance with the terms of this Contract. Any auditor will be required to sign a non-disclosure agreement with Contractor
3. Agree that any work to be in compliance with CMS requirements process will not count as an audit.
4. Agree that the County will not be responsible nor assessed a charge for any Contractor expenses related to any operational or financial audits, including the costs to provide necessary records.
5. Agree that the County shall not be responsible for any expenses related to an operational or financial audit, including the provision of necessary records.be responsible for payment of an auditor, but is responsible for the cost of the auditor.
6. Upon the County implementing the Contractor's RDS program, and to the extent the liabilities arose from Contractor's actions, Contractor agrees to "hold harmless" the County for audit liabilities as a result of Contractor's management of the retiree drug program including any penalties imposed by CMS.

7. Upon the County providing reasonable written notice (not less than 30 days), the County has the right to audit performance metrics at any time during the contract term at no additional cost. All expenses for such performance metrics audit shall be at the expense of the requesting party.
8. Allow statistically valid audit results may be extrapolated to the greater population, in part to determine any applicable performance guarantees.
9. Provide full disclosure and undergo an audit by a third party of its contracts/agreements with all pharma manufacturers.
10. Perform annual SSAE 16 (Type II SAS 70) audits and deliver results to the County (with bridge letters as requested) no later than April of the following year.

XI. GENERAL

Contractor shall:

1. Disclose all offshore (non-U.S. based) services the Contractor maintains or contracts with that will be used in the performance or support of services for the County. During the contract period, Contractor will notify the County at least 90 days in advance of any change and the County will have the right to approve or reject the change in offshore services or support.
2. Provide services that allow the County to be in compliance with the appeals process as required by PPACA. Such services will include an enterprise-wide project team consisting of legal, regulatory, compliance, clinical and operations staff members who thoroughly review the Affordable Care Act (ACA) regulations for compliance. The team also updates, approves and implements Policies and Procedures (P&Ps) as well as Standard Operating Procedures (SOPs) pertaining to administering and servicing internal reviews and appeals. Prior Authorization Appeals incur additional fees as outlined in Attachment B.
3. Including subcontracted Contractors, will comply with all HIPAA, PPACA and DOL regulations applicable to prescription benefits managers, including but not limited to: member services, complaints, appeals, timeliness of responses and confidentiality. Any fines related to non-compliance will be the sole responsibility of the Contractor.
4. Agree that as relates to use and disclosure of PHI, electronic transaction standards and security of electronic PHI under the Health Insurance Portability and Accountability Act of 1996, as amended, they are subject to the terms of the Business Associate Agreement negotiated separately between the parties. Notwithstanding the foregoing, the parties acknowledge that in providing services to Members, Contractor Specialty Pharmacy and the Mail Service Pharmacy are acting as separate health care provider covered entities under HIPAA and not as business associates to the Plan covered by the Business Associate Agreement. In providing services, Contractor Specialty Pharmacy and the Mail Services Pharmacy shall abide by all HIPAA requirements applicable to covered entities and shall safeguard, use and disclose Member PHI accordingly.
5. Verify all employees of the Contractor and subcontractors are U.S. citizens or U.S. green card holders (e-verify process).
6. Maintain an insurance policy with the County as the beneficiary to mitigate the harm resulting from unauthorized access to the personal data processed by Contractor's software.
7. Errors & Omissions Insurance. Contractor agrees to hold Errors and Omissions (E&O) insurance. Please confirm and indicate how much your company is insured for.
8. Agree to act in compliance with health care reform regulations. Contractor agrees to notify the County of any changes needed to remain in compliance with health care reform laws.
9. Agree to undertake comprehensive systems testing and quality assurance audits, with results reported to the County, prior to the contract effective date.

10. Understand each party will be required to maintain such policies of general liability, professional liability and other insurance of the types, including self-insurance, and in amounts customarily carried by their respective businesses. Contractor agrees, at its sole expense, to maintain during the term of this Agreement or any renewal hereof, commercial general liability insurance, pharmacists' professional liability insurance for the Mail Service and Contractor Specialty Pharmacy pharmacies, and managed care liability with limits, excess of a self-insured retention, in amounts of not less than $5,000,000 per occurrence and in the aggregate. Contractor does not maintain liability insurance on behalf of any Participating Pharmacy, but does contractually require such pharmacies to maintain a minimum amount of commercial liability insurance or, when deemed acceptable by Contractor, to have in place a self-insurance program.
11. Upon request; provide the County with the prescription medication claims data necessary to allow the County to file its own claim in a class action settlement. This data will be provided to the County during the existing term of the contract and for up to one year following termination of the contract, at no additional charge.
12. Disclose any material litigation or legal actions in your financial statements and make them available on the UnitedHealth Group website: unitedhealthgroup.com. Any liability that may ultimately arise from these actions would not materially affect our consolidated financial position, operational status, cash flow or business prospects.
13. Notify the County within 30 days of any major (defined as in the County's top 100 brand drugs by number of prescriptions) brand drug patent expirations. Manage patent expirations through:
    - Monthly summary of drug news, including first time generics
    - Weekly Medi-Span report with exact dates of new drug availability
    - Press releases soon after release of new high-impact generics
    - Clinical consultants will proactively help customers manage patent expirations and make recommendations to the County. For example, if pricing is high due to exclusivity, the County may place the product at a higher tier until pricing is more competitive.
14. MAC pricing is adjusted frequently to reflect ingredient costs and other changes in the market; therefore, we are unable to notify the County of all changes in advance. We provide a full MAC list by GPI, effective dates and termination dates on a monthly or quarterly basis in order to meet the County's needs. Adjudicate claims based on the County's plan design.
15. Have no authority under any circumstances to exclude prescription drugs and supplies from coverage by the County's self-insured prescription drug plan. Contractor acknowledges that the County is the Plan fiduciary and as such, the County maintains absolute authority to determine the types of coverage funded by the plan for its plan members, coverage rules and enrollment of eligible members. Contractors that are unwilling to agree to this requirement may be eliminated from further consideration. Furthermore, Contractor will agree to make modifications to covered drugs. Modifications are subject to changes in financial guarantees and subject to customization fees. For Premium Formulary rebates, the Guaranteed Rebate Amount is contingent upon the County's adoption, without deviation, of OptumRx's formulary, exclusions and utilization management programs. The County must have a rebate-qualifying benefit design which includes a minimum of $10 difference in member cost between preferred and non-preferred drugs, and that members, after the deducible phase, must not be responsible for more than 50 percent of the ingredient cost (for example, a 50 percent or more co-insurance plan).
16. Provide the County's approval an initial plan design benefit coding document for internal quality control process to ensure accurate and ongoing administration of the County pharmacy benefit program. This document will be provided to the County during the implementation process, but no later than sixty (60) days prior to the effective date. Additionally, Contractor will maintain a

documented quality control and pre-implementation document and provide it to the County for review and approval prior to implementation of any benefit or program change.

17. Administer the days' supply currently allowed for specialty and non-specialty drugs by the County's plan without penalty, additional charges or reduction to rebates.
18. Attempt to load and test 100% of the County's plan design changes within 3-5 business days of receipt of the written requested plan changes. Turnaround times may vary based on the complexity of the request.
19. In the event that a plan design error is identified, agree to correct all issues within 5 business days of identification and will provide the County with a detailed impact analysis identifying all members impacted, amounts due to the County and amounts due to members within 10 business days of issue identification.
20. Have the ability to override retail and mail-order prescriptions and provide up to a 12-month supply for overseas travel/vacation or due to out of stock and/or back ordered medications, as allowed by an override from an appropriate the County representative.
21. Confirm that it will maintain all documents pertaining to plan design decisions and intent. If during an audit Contractor is not able to provide documentation of the County's intent, Contractor will agree to honor the County's intent (verbal or through a member communication document).
22. In the event of Contractor’s error or oversight, Contractor will be prohibited from going back to charge the County after the normal claims and/or administrative fee billing cycles have ended for the contract year.
23. Agree to disclose all subcontractor relationships that will be used in the performance or support of services. During the contract period, Contractor will notify the County at least 90 days in advance of any changes to its subcontracted relationships and the County will have the right to approve or reject any subcontractor change. As a comprehensive PBM with a strong clinical department and in-house home delivery service and specialty pharmacy operations, limited use of outsourcing and subcontracted services will be limited. The County does not have the right to accept or reject any subcontractor through which any good or service is offered. OptumRx is responsible for the services to the same extent that OptumRx would have been had it performed those services without the use of a subcontractor. To verify that business objectives are achieved and the company’s code of conduct is being followed, OptumRx will have a comprehensive oversight program in place for its subcontractors.
24. Agree that the contract agreement will remain in effect for an initial term of three (3) years from the 1/1/2021 Effective Date (the "Initial Term"), and may terminated earlier or extended in accordance with the terms outlined throughout this RFP. Thereafter, the Agreement will automatically renew with the same terms and conditions for successive one (1) year renewal terms, subject to the termination rights otherwise provided herein.
25. Termination Without Cause. Notwithstanding above, the County may terminate the Agreement without cause upon ninety (90) days written notice to Contractor with no early termination penalty, fee, liquidated damages, or loss of rebates. Contractor will pay/credit all rebates earned by the County up to and including the date of termination. The County will be the only party to have the right terminate without cause.
26. Agree that the County has the right to terminate the agreement in the event of a change of ownership of the Contractor. OptumRx shall promptly notify the County, but in no event later than 10 business days after the closing date, of any change of control by OptumRx. The County may terminate the contract upon occurrence of a change of control by OptumRx and written notice of termination from the County within 90 calendar days after the County receives notice of such event, with such termination to be effective 90 calendar days after such notice of termination is given to OptumRx

by the County. For purposes of the contract, "change of control" means the merger, consolidation, sale of substantially all of the assets or similar transaction or series of transactions, including without limitation a transaction or series of transactions as a result of which a party's shareholders before such transaction or series of transactions, own less than 50 percent of the total number of voting securities of the surviving entity immediately after such transaction or series of transactions.

27. Obligations Upon Termination. Contractor agrees that upon termination of the contract, Contractor will provide all necessary documentation, claims files, prescription history and other data needed for the successful transition of the program to the appointed Contractor within a reasonable timeframe and at no additional cost to the County. This includes, but is not limited to, all open mail order and specialty pharmacy refill files, prior authorization histories and at least twelve (12) months of historical claims data. Two sets of each of these files must be supplied. This agreement must be included in your contract if awarded PBM business. County will continue to pay Contractor in accordance with this Agreement for any Fees for PBM Services provided during the term and any run-off period. Contractor will continue filing for Rebates for claims incurred prior to the Termination Date and will, subject to final reconciliation of any outstanding amounts owed by County to Contractor, pay County Rebates for such claims in accordance with the Rebate payment schedule set out herein. In the event that the County elects to terminate pharmacy benefit management services, we agree to provide the County with a computer history tape (in a form and format reasonable acceptable to the County) with claims history detail in the standard NCPDP format, open refill files from mail and specialty, prior authorizations and any other non-confidential, non- proprietary information at no cost upon termination.
28. In the event of any expiration or termination, agree that all monies owed to the County (rebates, performance/GDR guarantees, financial reconciliations, etc.) will be paid to the County with no offsets within ninety (90) days of expiration or termination based on all earned financial credits as of the termination date. Contractor will not charge any termination fees unless the County requests ad hoc services not included in the scope of the PBM contract.
29. Agree that if the Agreement is terminated and no amounts are due to Contractor, then any amounts due to the County under the Agreement shall be in the form of a check to the County, and not an invoice credit.
30. Contractor shall provide reasonable travel arrangements, i.e., transportation and lodging, at Contractor's expense for up to two (2) County staff to travel semi-annually for implementation, stewardship meetings or other business-related purposes, as agreed upon by the Parties.

XII. COVID-19 OTC Diagnostic Test Network

During the COVID-19 public health emergency period and pursuant to the January 10, 2022 Affordable Care Act Implementation Part 51 FAQ and February 4, 2022 Affordable Care Act Implementation Part 52 FAQ jointly issued by the United States Departments of Labor, Health and Human Services, and the Treasury ("Tri-Agency Guidance"), Contractor will establish and maintain product lists and a network of pharmacies to dispense over the counter ("OTC") at-home COVID-19 diagnostic tests with the pricing and limitations set forth in this section. Pricing will be the U & C price submitted by the dispensing pharmacy plus a $0.50 dispensing fee, which will be passed through to the dispensing pharmacy, plus a $2.00 per Claim administration fee, plus any applicable tax. There will be $0 Coinsurance and Members will be limited to eight (8) tests per Member per month. Effective February 2, 2022, Contractor launched a direct coverage offering with a direct-to-consumer shipping option with the Optum Store. The pricing above shall apply, in addition to standard shipping rates, to such direct-to-consumer shipping option. This pricing applies to both traditional and pass- through retail pricing. The per Claim administration fee is an addition

to any other administration fees. Members who purchase such kits outside of this network may submit a Direct Member Reimbursement (DMR) claim form and will only be eligible for reimbursement of the actual cost of the test, taxes, shipping and any other fees up to $12.00 per test. All fees stated in this Section 10(a), as well as any additional agreed upon DMR fees, shall apply. The terms applicable to this network of pharmacies are subject to change, including changes based on updates to the Tri-Agency Guidance. OTC at-home COVID-19 tests are subject to availability. Claims filled pursuant to this section are excluded from performance and financial guarantees under this Agreement, including but not limited to Rebates and discount and dispensing fee guarantees.

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Attachment B
Cost/Compensation for Contractor Services

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

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.

I. COMPENSATION

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

~~Term of contract:~~	~~Year 1:~~	~~01/01/2021 to 12/31/2021~~
-	~~Year 2:~~	~~01/01/2022 to 12/31/2022~~
-	~~Year 3:~~	~~01/01/2023 to 12/31/2023~~

~~Traditional~~ ~~Year 1/Year 2/Year 3~~					
~~Base Administrative Fees~~	~~Retail 30:~~	~~$0.00/$0.00/$0.00~~		~~per Net Paid Claim~~	-
	~~Retail 90:~~	~~$0.00/$0.00/$0.00~~		~~per Net Paid Claim~~	-
	~~Mail Service:~~	~~$0.00/$0.00/$0.00~~		~~per Net Paid Claim~~	-
	~~Specialty:~~	~~$0.00/$0.00/$0.00~~	-	~~per Net Paid Claim~~	-
~~Paper Claim Fees~~	-	~~$2.50~~	-	~~Per Processed Paper Claim plus the Base Admin. Fee~~	
~~PreCheck MyScript with ePrescribing~~	-	~~$1.25~~	-	~~per PreCheck MyScript Transaction~~	-
~~Retail 30 Pharmacy Network~~ ~~Year 1/Year 2/Year 3~~					
~~Brand Drugs~~	~~AWP minus~~	~~19.00%/19.00%/19.00%~~	~~plus~~	~~$0.80/$0.80/$0.80~~	~~dispensing fee~~
~~Effective Overall Generic Guarantee (ingredient cost)~~	~~AWP minus~~	~~83.25%/83.35%/83.45%~~	~~plus~~	~~$0.80/$0.80/$0.80~~	~~dispensing fee~~
~~Retail 90 (>83 day supply) Pharmacy Network~~ ~~Year 1/Year 2/Year 3~~					
~~Brand Drugs~~	~~AWP minus~~	~~21.50%/21.50%/21.50%~~	~~plus~~	~~$0.00/$0.00/$0.00~~	~~dispensing fee~~
~~Effective Overall Generic Guarantee (ingredient cost)~~	~~AWP minus~~	~~84.10%/84.20%/84.30%~~	~~plus~~	~~$0.00/$0.00/$0.00~~	~~dispensing fee~~
~~Mail Service Pharmacy~~ ~~Year 1/Year 2/Year 3~~					
~~Brand Drugs~~	~~AWP minus~~	~~25.25%/25.25%/25.25%~~	~~plus~~	~~$0.00/$0.00/$0.00~~	~~dispensing fee~~
~~Effective Overall Generic Guarantee (ingredient cost)~~	~~AWP minus~~	~~85.35%/85.45%/85.55%~~	~~plus~~	~~$0.00/$0.00/$0.00~~	~~dispensing fee~~
~~Specialty - Open Network~~ ~~Year 1/Year 2/Year 3~~					
~~Specialty Drugs~~	~~AWP minus 19.00%/19.10%/19.20% plus $0.00 dispensing fee~~				
-	-	-	-	-	-
~~Specialty - Exclusive Network with no grace fills~~ ~~Year 1/Year 2/Year 3~~					
~~Specialty Drugs~~	~~AWP minus 20.00%/20.10%/20.20% plus $0.00 dispensing fee~~				

-	-	-	-	-	-
~~Rebates (Premium Formulary)~~ ~~Year 1/Year 2/Year 3~~					
~~Client Estimated Share~~	~~Greater of 100% or~~	-			
~~Retail 30 – Minimum~~	~~$180.00/$195.00/$210.00~~	~~Per Net Paid Brand Claim~~	-	-	-
~~Retail 90 – Minimum~~	~~$420.00/$465.00/$505.00~~	~~Per Net Paid Brand Claim~~	-	-	-
~~Mail Service – Minimum~~	~~$490.00/$545.00/$575.00~~	~~Per Net Paid Brand Claim~~	-	-	-
~~Specialty – Minimum (Exclusive specialty)~~	~~$1,270.00/$1,370.00/$1,430.00~~	~~Per Net Paid Brand Claim~~	-	-	-
~~Specialty – Minimum (Open Specialty)~~	~~$1,180.00/$1,280.00/$1,340.00~~	~~Per Net Paid Brand Claim~~	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
~~Rebates (Select Formulary)~~ ~~Year 1/Year 2/Year 3~~					
~~Client Estimated Share~~	~~Greater of 100% or~~	-			
~~Retail 30 – Minimum~~	~~$120.00/$130.00/$140.00~~	~~Per Net Paid Brand Claim~~	-	-	-
~~Retail 90 – Minimum~~	~~$250.00/$260.00/$275.00~~	~~Per Net Paid Brand Claim~~	-	-	-
~~Mail Service – Minimum~~	~~$285.00/$300.00/$320.00~~	~~Per Net Paid Brand Claim~~	-	-	-
~~Specialty – Minimum (Exclusive specialty)~~	~~$590.00/$630.00/$680.00~~	~~Per Net Paid Brand Claim~~	-	-	-
~~Specialty – Minimum (Open Specialty)~~	~~$560.00/$600.00/$650.00~~	~~Per Net Paid Brand Claim~~	-	-	-

Term of contract:		Traditional Pricing	01/01/2024 to 12/31/2024
Administrative Fee			
Base Admin Fees	Retail 30:	$0.00	PNPC=Per Net Paid Claim
	Retail 90:	$0.00	PNPC
	Mail Service:	$0.00	PNPC
	Specialty:	$0.00	PNPC
Paper Claim Fees		$2.50	Per Processed Paper Claims plus the Base Admin Fee
PreCheck MyScript with ePrescribing		$1.25	Per PreCheck MyScript Transaction

Broad Retail Pharmacy Network			
Brand Drug Discount AWP-19.10%	Brand Drug Dispensing Fee $0.80 PNPC	Generic Drug Discount AWP-83.65%	Generic Drug Dispensing Fee $0.80 PNPC
Broad Retail 90 Pharmacy Network			
Brand Drug Discount AWP-22.00%	Brand Drug Dispensing Fee $0.00 PNPC	Generic Drug Discount AWP-86.65%	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-86.75%	Generic Drug Dispensing Fee $0.00 PNPC

Specialty Pharmacy – Open Network			
Discount AWP-19.30%		Dispensing Fee $0.00 PNPC	
Specialty Pharmacy – Exclusive Network			
Discount AWP-20.30%		Dispensing Fee $0.00 PNPC	
Rebate Management – Premium Formulary 100% Pass-Through			
Retail Pharmacy $330.00 PNPB	Retail 90 Pharmacy $825.00 PNPB	Home Delivery $850.00 PNPB	Specialty $2,750.00 PNPB
The pricing guarantees included in Optum Rx's offer do not account for the financial impact of manufacturer action in response to recent regulatory changes (i.e. the Inflation Reduction Act's AMP Cap provision); accordingly, Optum Rx may invoke certain contractual rights in response to the financial impacts caused by these changes.			

II. PAYMENT

1. **Payment Term-Payment in Arrears:**
   Monthly and semi-monthly invoices are to be submitted in arrears. Contractor shall reference the Contract number on each invoice. Payment will be net 45 days after receipt and approval by County of an invoice in a format acceptable to the County and verified and approved by the agency/department and subject to routine processing requirements.

   Invoices shall cover services not previously invoiced. The Contractor shall reimburse County for any monies paid to the Contractor for services not provided or when services do not meet the Contract requirements.

   Payments made by the County shall not preclude the right of the County from thereafter disputing any items or services involved or billed under this Contract and shall not be construed as acceptance of any part of the services.

2. **Payment – Invoicing Instructions:**
   The Contractor will provide an invoice on the Contractor's letterhead for services rendered. Each invoice will have a number and will include the following information:

   1. Contractor's name and address
   2. Contractor's remittance address, if different from 1 above
   3. Name of County agency/department
   4. Delivery/service address
   5. Contractor/Subordinate Contract or Purchase Order number
   6. Date of order
   7. Type of fees/service
   8. Sales tax, if applicable
   9. Dates of fees/service
   10. Brief description of fees/service
   11. Contractor's Federal I.D. Number

   The Contractor shall be fully responsible for providing an acceptable invoice to the County. Incomplete or incorrect invoices are not acceptable and will be returned to the Contractor for correction.

3. **Invoicing Instructions:**
   Invoices and supporting documentation (Monthly Program Summary) are to be sent to:

Project Manager, Diana Banzet

Human Resource Services/Employee Benefits
Hall of Administration
333 W. Santa Ana Blvd., Room 137
Santa Ana, CA 92701

The County's project manager at HRS/Employee Benefits is responsible for approval of invoices and subsequent submittal of invoices to the County Auditor-Controller for payment processing.

III. Credits and Allowances

1. **Annual Audit Allowance.** Contractor shall reimburse County up to $35,000 during Year 1 of the Contract, and $30,000 during Year 2 and 3, for costs related to auditing expenses. Eligible expenses will include auditing expenses incurred by a third-party transitional consultant. County will be required to submit documentation to support the expenses it may seek reimbursement for. If County terminates the Contract before the end of first year of the Initial Term, County shall refund to Contractor within thirty (30) days after the effective date of such termination the amount of Audit Allowances that have been provided by Contractor to County as of the effective date of such termination. It is the intention of the parties that, for the purposes of the Federal Anti-Kickback Statute, this audit allowance shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C 1320a – 7b(b)(3)(A).

2. **Pharmacy Management Allowance.** County 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 County 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. County will be required to submit documentation to support the expenses for which it seeks reimbursement. If County terminates this Agreement in breach before the end of the Initial Term, County shall refund to OptumRx within 30 days after the 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 within the meaning of 42 U.S.C. 1320a-7b(b)(3)(A). To the extent required by Laws, County 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.

3. **Advanced Pharmacy Audit Services.** Contractor guarantees County Return on Investment (ROI) in the amount of $14,4000 for the first year of the program.

IV. Additional Services

Fees for Additional Services and Clinical Services will be charged, as applicable.

Additional Fees	
PreCheck MyScript ePrescribing	Included in Standard Services
PreCheck MyScript	$1.25 per PreCheck MyScript transaction
Variable Copay Program	$0.15 PMPM
Client Website Additional Users	Ten included, $400 per year per additional user

Direct Member Reimbursement (DMR)	$2.50 per processed paper claim plus the Administrative Fee
Ad-hoc Reporting	$150 per hour, with a minimum of $500
Manual Eligibility Maintenance	$0.50 per record
ID cards - Subsequent mailings, replacements, or additional	$2 per ID card plus postage, shipping and handling
Explanation of Benefits (EOB)	$2 per EOB plus postage, shipping and handling
Custom Mailings	Production plus postage, shipping and handling
Retail Pharmacy Audit Administration	No administrative or retention fees
RxTRACK License Fee	Ten included, $500 per seat annual fee thereafter
RDS Support Services	$1.25 PMPM
Integrated Accumulator - Near Real Time Method	$0.15 PMPM
Clinical Services (some fees are included with no additional charge)	
Drug Recall Reporting: Proactive monitoring to identify product recalls and withdrawals, and notification to affected members when appropriate.	Included
Concurrent Drug Utilization Review: Real time point of sale monitoring for potential medication use conflicts	Included
Basic Fraud, Waste & Abuse Audit: Optum staffs a diverse team of auditors and investigators focused on generating recoveries for, and detecting and deterring, fraud on the behalf of the client.	Included
Administration of OptumRx Standard Formulary: Optum bases formulary decisions on lowest net cost to provide sound clinical coverage while delivering more client savings and balancing member disruption.	Included
Administration of OptumRx Standard UM programs: From quantity limits to prior authorization to step therapy, Optum offers utilization management strategies that balance flexibility, savings, and member disruption. Refer to Benefit Design Forms for specific edits	Included
Standard Clinical Publications: Optum provides regular and timely updates relating to internal programs, CMS memos and more.	Included

Opioid Risk Management - Advanced Point of Sale Edits: Enhanced Drug Enforcement Agency Edit (DEA) Enhanced Concurrent Drug Utilization Review (CDUR): • Drug-Drug Interaction: Opioid/Medication Assisted Therapy (MAT) Treatment • Drug-Drug Interaction: Opioid/Pregnancy • Drug-Drug Interaction: Opioid/Benzodiazepines • THERDOSE APAP • MEDLIMIT: Daily Cumulative limit on all opioids	Included
To assist commercial clients to manage compound prescriptions, the program includes option for clients to select multiple services: • OptumRx National Compound Credentialing Program (required) • Clinical Prior Authorization on Compounds of High Concern • Bulk Chemical Exclusions • Compound Kit Exclusions • Analytics and reporting • Prior Authorization on High-Cost Products	Standard PA fees will apply if client selects Prior Authorization service
Clinical Prior Authorizations	
Technician/Pharmacist Review	$50 per review
State-mandated Physician Review	$135 per review
Prior Authorization Appeals	
Internal Clinical Appeals Not Requiring Physician Review	$140 per review
Internal Clinical Appeals Requiring Physician Review	$325 per review
External clinical appeal	$500 per review
Retrospective Clinical Program Bundle offers all three of these clinical programs: • RDUR Safety Management • RDUR Gaps In Care • Opioid Risk Management: Retrospective Intervention on Abused Meds module	Bundled Cost of $0.17 PMPM
Medication Adherence Program	
Top 3 Conditions + Chronic Non-Specialty and Specialty Medications	$0.19 PMPM
Opioid Risk Management Solution	

Utilization Management	Standard UM/transactional fees
Enhanced cDUR	Standard included. Customization: $1,000 per edit.
Enhanced Benefit Design	
• Adjust Refill Window	Standard included. Customization: $1,000 per edit.
• Enhanced DEA edit by scope of practice	Standard included. Customization: $1,000 per edit.
Opioid Risk Management Solution (Add-On offerings)	
Refill Window 90% Scheduled II-V Controlled Drugs (80% Specialty-Mail)	Included
Comprehensive UM option	Included, PA fees will apply
Diabetes High-Risk Counseling only 100% of diabetics to be identified as high-risk and therefore included in Diabetes Counseling	$195 per counseled member per year
Orphan Drug Programs	$300 per participating member per year
Advanced Pharmacy Audit Services	$0.10 per claim
COVID Anti-Viral Admin Fee*	$1.00 per Rx
COVID Anti-Viral Professional Service Fee, which is passed through to retail pharmacies*	$10.50 per claim
* Claims filled through this section are excluded from performance and financial guarantees under this Agreement, including but not limited to Rebates and discount and dispensing fee guarantees.	
Direct Member Reimbursement (DMR) COVID Test Kit	$4.50 per claim ($2.00 Admin Fee and $2.50 processing fee)

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ATTACHMENT C
Staffing Plan

1. Primary Staff to perform Contract duties

Name	Classification/Title	Experience/Qualifications
Carolyn Jalbert	Account Executive	Carolyn has been a valued member of the County of Orange's (the County) client management team for four years. Prior to being promoted to the County's account executive in November 2018, she served as the designated client service analyst.
Nissa Osuna	Client Service Manager	Nissa has served as the County's client service manager since 2019.
Dr. Amy Speakman	Clinical Consultant	Amy has provided the County clinical consultation services since 2017.
Shannon C. Ross	Director of Client Management	Shannon has supported the County's client management team since 2011. She previously served as the County's account executive before being promoted to her current position.
Dr. Ellen Nelson	Executive Sponsor	Dr. Nelson has over 10 years of experience in the PBM industry. She is the lead executive responsible for government and reform market relations and strategies. She is an expert on health care reform and oversees related new business initiatives including the CO-OPs.

2. Alternate staff (for use only if primary staff are not available)

Name	Classification/Title	Experience/Qualifications
Shannon C. Ross	Director of Client Management	Shannon has served as a member of the County's client management team since joining the organization in 2011. In the event that the primary staff is not available, she will serve as the interim support pending a new assignment.

Substitution or addition of Contractor's key personnel in any given category or classification shall be allowed only with prior written approval of the County's Project Manager.

The Contractor may reserve the right to involve other personnel, as their services are required. The specific individuals will be assigned based on the need and timing of the service/class required. Assignment of additional key personnel shall be subject to approval by the County's Project Manager. County reserves the right to have any of Contractor's personnel removed from providing services to County under this Contract. County is not required to provide any reason for the request for removal of any Contractor personnel.

3. Sub-contractor(s)

In accordance with Article 11 "Assignment or Sub-Contracting", listed below are Sub-contractor(s) anticipated by Contractor to perform services specified in Attachment A, Scope of Work.

As a comprehensive PBM with a strong clinical department and in-house home delivery service and specialty pharmacy operations, Contractor makes only limited use of outsourcing services. Contractor does not contemplate utilizing subcontractors specifically in support of the services to be provided to the County. Contractor is responsible for the services to the same extent that Contractor would have been had it performed those services without the use of a subcontractor. To verify that business objectives are achieved and the company's code of conduct is being followed, Contractor has a comprehensive oversight program in place for its subcontractors. Contractor currently does not contemplate utilizing subcontractors specifically in support of the services to be provided by the County. If the contractor intends to utilize a subcontractor, Contractor will provide 90-day notice of the use of the subcontractor and receive approval from the County.

Company Name	**Staff Name**
N/A	

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ATTACHMENT D
CONTRACTOR
PERFORMANCE GUIDELINES

Contractor shall adhere to the terms outlined in the Statement of Work regarding Performance Guarantees. Upon the later of the Effective Date OR the date that the Contract is executed by both parties, Contractor will measure its performance guidelines (the "Guidelines") quarterly, and report results to County. The maximum payment for missed Guidelines shall not exceed $75,000 annually, with no more than 20% of this maximum for any missed Guideline annually. Penalties associated with Performance Guarantees shall be reported and reconciled 60 days from the end of the Contract year and penalties, if any, shall be passed on annual aggregate results and paid within 90 days after the end of applicable contract year, subject to County's adherence to payment obligations under this Contract. Payments for Missed Guideline represent County's sole and exclusive remedy for any Guidelines set forth herein. Any such performance failure will not be deemed a material breach that gives County the right to terminated under Section 33 of this Contract.

Service	Performance Guideline	Contractor or Client Book of Business	Standard
Eligibility processing – Timeliness	At least 99 percent of usable eligibility files will be loaded and active in OptumRx's on-line claims adjudication system within 24 hours of OptumRx's receipt. Eligibility files must be transmitted in a mutually agreed upon format and with a mutually agreed upon file naming convention. Eligibility files must not exceed the mutually agreed upon file "edit" threshold, must not arrive during scheduled system maintenance/ downtime and cannot contain a "critical" error or failure that would prevent OptumRx from loading the file into its online claims adjudication system.	County Specific	99% within 1 business day
Eligibility - Accuracy	Electronic eligibility records will be loaded with 100% accuracy. This standard is contingent upon receipt of clean eligibility data delivered in an agreed upon format and Contractor incorrectly loaded the eligibility.	County Specific	Loaded with 100% accuracy
Eligibility error report	As long as the Client eligibility provider continues to accept electronic error reports, Contractor shall produce and transmit an error report on eligibility file updates to the firm-designated eligibility provider within 48 hours of the Contractor receiving a clean and complete eligibility file.	County Specific	100%
System availability	The percent of time the claims processing system will be available to retail pharmacies as measured by the number of hours the system is available, divided by the total number	Contractor Book of Business	>= 99.5%

	of hours within the reporting period excluding regularly scheduled maintenance or telecommunication failure outside of Contractor's control. Measured on Contractor's book-of-business.		
Network pharmacy access	As measured by the number of Client members with access to a retail network pharmacy within one (1) mile urban, three (3) miles suburban or ten (10) miles rural of their home zip code (where a pharmacy exists within the specified standard), divided by the total number of Client members.	County Specific	≥ 98.5%
On-site pharmacy audits	As measured by the number of network pharmacies audited onsite each year divided by the total number of network pharmacies.	Contractor Book of Business	3.00%
Welcome booklets	The amount of time that elapses between when a clean eligibility file or transmission identifying the applicable member is received by the Contractor to when welcome booklets are mailed to the member, provided the communication materials have been approved and the clean eligibility file was provided 20 business days prior to the County's effective date.	County Specific	99% within five (5) business days *prior to the County's effective date.*
Call center average speed of answer (ASA)	Percent of all calls answered within 30 seconds or less. Calculated as the amount of time that elapses once a call is placed into the customer service queue to the time the call is answered by a live customer service representative (CSR). Measurement excludes calls routed to interactive voice response (IVR) system.	Contractor Book of Business	100% within an average of 30 seconds
Pharmacist/clinical support ASA	Measured as the time elapsed once a member requests to speak to a pharmacist from a CSR or selects this option from the IVR menu to the time the call is answered by a pharmacist.	Contractor Book of Business	< 45 seconds
Specialty care call center average speed of answer (ASA)	Percent of all calls answered within an average of 30 seconds. Calculated as the amount of time that elapses once a call is placed into the customer service queue to the time the call is answered by a CSR. Measurement excludes calls routed through an interactive voice response (IVR) system. Excludes calls to the general toll-free telephone line separately established	Contractor Book of Business	100% within an average of 30 seconds

	for non-Specialty Drugs		
Call center abandonment rate	Percentage of calls that are not answered by PBM (caller hangs up before call is answered). Calculated as the number of incoming telephone calls to the member service telephone line that are not answered divided by the number of calls received. Measurement excludes calls routed to IVR and includes calls abandoned within the first 20 seconds. Excludes calls to the toll-free telephone line separately established for Specialty Drugs.	Contractor Book of Business	<= 2.0%
First call resolution	Percent of the County member calls resolved during the first point of contact. First call resolution means the call is resolved and the member does not call back regarding the same inquiry. Calculated as the percent of calls resolved during the first call divided by the total number of calls answered by a CSR. Excludes calls to the toll-free telephone line separately established for Specialty Drugs.	Contractor Book of Business	≥ 95.0%
Responsiveness to written inquiries from members received by designated email box.	Contractor will respond to at least 99% of the County's member written inquiries (including email) which require a response within five (5) business days of receipt and 100% within ten (10) business days of receipt. Response time for all member-written inquiries will be based on the number of business days subtracting the date received from the date answered.	Contractor Book of Business	≥ 99.0% within 5 business days and 100% within 10 business days
Responsiveness to non-specialty written inquiries from members via designated email box and received via U.S. mail.	Contractor will respond to all written inquiries from members accordingly: Email: within 5 business days of email receipt date received via designated email box. All mail: including email and U.S. mail, within an average of 10 business days from date of receipt for inquiries received via designated email box and received via U.S. mail.	Contractor Book of Business	≥ 95.0% of email inquiries within 5 business days: 100% of all written inquiries (written and mail): an average of 10 business days
Member appeal response time	Contractor will respond to 99% of all formal written first level appeals within 30 calendar days, measured from the date of appeal receipt to date response mailed to member. Response to appeal is defined as a thorough	County Specific	≥ 99.0% within 30 calendar days

	review of all information related to the appeal followed by a detailed explanation of the final determination in writing, citing specific reasons for denials		
Member satisfaction survey for members utilizing the pharmacy benefit	Overall member satisfaction survey results will be “Satisfied” or greater for at least 90% of respondents. Member satisfaction results will be measured by the responses to Contractor’s member post-call "Voice of the Customer" satisfaction survey. County specific measurement contingent upon a statistically valid response rate.	County Specific	≥ 90.0%
Specialty medication member satisfaction survey	Optum Specialty Pharmacy guarantees 90% or greater overall customer satisfaction measured by the responses to OptumRx’s member post-call "Voice of the Customer" satisfaction survey. Measured and reported annually and based upon Optum Specialty Pharmacy book of business data.	Optum Specialty Pharmacy book of business data.	≥ 90.0%
Claims processing accuracy	Percent of claims processed and paid accurately based on the applicable coverage, pricing and plan design. Calculated as: (1) the number of retail claims, mail claims, specialty drug claims and directly submitted paper claims adjudicated by Contractor that do not contain a material adjudication error (i.e., any inaccuracy relating to the processing of the claim that results in an incorrect charge to Client or its members), divided by (2) the total number of all such claims adjudicated.	County Specific	> 99.7%
Mail order/specialty pharmacy dispensing accuracy	Percent of all mail order and specialty pharmacy claims dispensed accurately with no errors according to the prescription written and the Client's plan design(s). Calculated as the total number of prescriptions dispensed, less the total number of prescriptions dispensed with the incorrect drug, strength, form, patient name, directions, address (resulting in the medication being delivered incorrectly) or packaging non-conformances, divided by the total number of prescriptions dispensed.	County Specific	≥ 99.99%
Retail paper claims processing time	Contractor will process at least 95% of Client member submitted clean	County Specific	At least 95 % of all clean direct member

	claims within ten (10) business days ~~of~~ from receipt.		reimbursement claims will be processed within 10 business days from receipt.
Mail order turnaround time (clean Rx)	Measured in business days from the date the prescription is received by the Contractor (either via paper, phone, fax or Internet) to the date it is shipped. Calculated as the number of "clean" mail order prescription claims processed within two (2) business days divided by the total number of mail order claims processed.	Contractor Book of Business	100% within 2 business days
Mail order turnaround time (non-clean Rx)	Measured in business days from the date the prescription is received by the Contractor (either via paper, phone, fax or Internet) to the date it is shipped. Calculated as the number of mail order prescription claims requiring intervention processed within five (5) business days divided by the total number of mail order claims processed.	Contractor Book of Business	100% within 5 business days
Account management meetings	Contractor agrees to meet with the County on a regular basis as follows: (a) Contractor will meet in person or by conference call with the County on a monthly basis as agreed upon to review ongoing account and service issues, (b) Contractor will meet with the County on a quarterly basis to review program performance including financial, clinical and plan design and (c) Contractor will meet with the County on an annual basis within 120 days after the end of each calendar year for an overall program review including Contractor's book of business comparisons, prescription drug program trends, Contractor initiatives and recommendations for the County program.	County Specific	100%
Account management staffing changes	Contractor agrees that Client will be consulted on account management staffing changes (national account executive, account manager, account coordinator, clinical account executive and financial analyst) and have the opportunity to interview potential replacements with final right of approval.	County Specific	100%

	If the account executive/manager is promoted, moves to a new role or leaves the organization, OptumRx will notify the Customer and work through the director of client management to seamlessly transition responsibility. If a new account team is requested by County, Contractor will make a reasonable attempt to appoint a new account team within thirty (30) days of request.		
Account management reporting	Contractor will prepare and provide the County its standard management/utilization reports (including reviews and appeals management reports) and other standard reports to be mutually agreed upon. Penalty for late delivery of any and all reports, including the report card, any pricing guarantee reports, rebate payments, clinical programs reports, etc. Specified reports (as mutually agreed upon in advance). Online reporting data will be available within ten (10) days after each month end. Billing data will be available within ten (10) days after the billing cycle.	County Specific	Reports delivered on time - 100%
Account management scorecard for pharmacy designated account representatives	Designated members of the County's benefits staff will complete a quarterly report card to evaluate overall satisfaction with account management. Contractor will guarantee overall satisfaction ratings of at least 4.0 on a 5-point scale (5 is best rating). For the purposes of this guarantee, satisfaction shall be defined as Satisfied or better on the following 5-point scale: Completely Satisfied, Very Satisfied, Satisfied, Dissatisfied, or Very Dissatisfied. Contractor will be responsible for data collection, analysis and all costs associated with the surveys.	County Specific	>= Meets Expectation
Account Management Responsiveness	Contractor guarantees that 100% of the County calls to the account service team will be responded to within twenty-four (24) hours of receipt and 100% of written inquiries responded to within twenty-four (24) hours of receipt.	County Specific	100% within 24 hours
Rebate Payment	Contractor will pay/credit applicable	County Specific	Payment and

Timeliness	"estimated" per brand Rx rebates to the County within ninety (90) calendar days of the close of each calendar quarter.		reporting within 90 calendar days of each calendar quarter
Rebate Payment Reconciliation	An annual reconciliation of the rebate pass-through percentage against contractually specified guaranteed minimums will be made within 180 calendar days of the end of the contract year. Any additional collections received from manufacturers after the annual reconciliation period will be remitted thereafter on a calendar quarter basis (every 90 calendar days).	County Specific	<=180 Days Measured and reported annually.
Clinician savings guarantee	Reconciliation of all newly implemented clinical program guarantees including but not limited to; DUR, coverage management and physician profiling	County Specific	100%
Report Accuracy	Penalty for inaccurate reporting of any and all reports, including the report card, any pricing guarantee reports, quarterly rebate payment reports, annual rebate reconciliation reports, any clinical programs reports, etc.	County Specific	Reports provided with 98% accuracy
Quality control documentation	Contractor will maintain a documented quality control and pre-implementation document and provide it to County for review and approval prior to implementation of any benefit or program change.	County Specific	100%
Plan administration accuracy	With written Client sign-off of the accuracy of Client's plan design(s) and/or requested changes and testing, Contractor guarantees that the Client plan design(s) will be implemented with 99% accuracy. Client will be responsible for reporting any failure to meet the above stated guarantee to Contractor on an annual basis. This is measured and reported on a calendar year and Client specific basis.	County Specific	99%
Corrective Action Plan	For any missed performance guarantee Contractor shall define the source problem and create a written Corrective Action Plan which shall be submitted to the County within a mutually agreed upon timeframe. Once agreed to by the County, the actions and timelines will be adhered to.	County Specific	100%
Accumulators Data	The standard accumulator extract	County Specific	99%

File Accuracy – Batch	format will be accurately populated based on data in the adjudication system. Data accuracy is dependent on plan setup, eligibility feeds, and the accuracy of the data provided in the file.		
Accumulators Data File Timeliness – Batch	The standard accumulator extract will be available by 12:00 PM CST on a date mutually agreed upon within a scheduled frequency.	County Specific	99%
Accumulators Data File Accuracy – Incoming Files – Batch	Incoming medical adjustments will be accurately loaded into the claims adjudication system. Load accuracy is dependent on eligibility, plan set-up and the accuracy of the data provided in the file.	County Specific	99%

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 County'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.

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ATTACHMENT E

Account Management Scorecard

Rating Methodology:
5 = Completely Satisfied
4 = Very Satisfied
3 = Satisfied
2 = Somewhat Satisfied
1 = Dissatisfied

Client/Company Name: County of Orange
Completed By (please print): _____
Client Signature_____
Date completed: _____
Telephone #:_____

County will complete the box with the score that most closely reflects the level of satisfaction with the local account management team with respect to the following service categories. Contractor will achieve an average rating, across all responses, on a five (5) points scale. A separate quarterly scorecard will be completed, signed and dated each quarter.

Measurable Need	**1st Q**	**2nd Q**	**3rd Q**	**4th Q**	**Composite Score**
Members of the Account Management Team will: 1. Manage issues to include providing County with timely notification of issues impacting program and/or participants, identifies root cause and overall impact of the issue, develops effective action plans to resolve open issues and follows through on plans to ensure issues are resolved.					
2. Respond in a timely and comprehensive manner to inquiries, issues and questions from the County, County members and prospective members, and third-party representatives (i.e. the County's medical TPA, Benefit Administrator, Consultant and/or Audit firm).					
3. Attend regularly scheduled quarterly meetings and provide follow-up details in a timely manner.					
4. Deliver accurate reports, billing statements, communications and ad hoc requests an on time.					
5. Effectively manage project and program changes; meet agreed upon deadlines and manage member impact.					

6. Be knowledgeable of company's products and provide County with program and clinical recommendations appropriate for member utilization.					
Account Management Composite Score (All Categories)	N/A	N/A	N/A	N/A	

Fill in for each quarterly period:
Date Sent to Client: __/ /__ __/ /__/ /_____ __/ /__
Date Returned by Client: __/ /__ __/ /__/ /_____ __/ /__

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:_____
Print Name Title

_____
Signature Date

By:_____
Print Name Title

_____
Signature Date

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

By:_____
Print Name Title

_____
Signature Date

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

2. 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)	Standard Package included in EGWP fee.
• CMS compliant document monthly print and mail (where applicable)	Customization requirements may incur additional fees for production and postage.

• Spanish translated EOB, per Eligible Participant's request	
• Client variable information (plan logo, hours of operation, customer service information)	
• 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 1.	Included in EGWP Fee
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 2.	Included in EGWP Fee
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. Customization requirements may incur additional fee.
• ID Cards	
• 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	
• Payment distribution to Eligible Participants and LTC's	

~~for adjustments that identified previous overpayment of the Eligible Participant cost share/Drug Refund Checks~~	~~Included in EGWP Fee~~
~~Other Eligible Participants or physician communications~~	~~Included in EGWP Fee~~
~~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.~~	~~Production and Postage at cost~~
~~Return Mail Charge~~	~~Included in EGWP Fee~~
	~~Included in EGWP Fee~~
	~~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~~
~~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~~	

Term of contract:	Pass-Through Pricing	01/01/2024 to 12/31/2024
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-19.25%	Brand Drug Dispensing Fee $0.80 PNPC	Generic Drug Discount AWP-84.00%	Generic Drug Dispensing Fee $0.80 PNPC
Broad Retail 90 Pharmacy Network			
Brand Drug Discount AWP-21.75%	Brand Drug Dispensing Fee $0.00 PNPC	Generic Drug Discount AWP-87.00%	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-87.00%	Generic Drug Dispensing Fee $0.00 PNPC
Specialty Pharmacy – Open Overall Aggregate Guarantee			
Discount AWP-19.30%		Dispensing Fee $0.00 PNPC	

Rebate Management – Silver Rebate Guaranteed Amount			
Retail Pharmacy $235.00 PNPB	Retail 90 Pharmacy $570.00 PNPB	Home Delivery $650.00 PNPB	Specialty $1,285.00 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.

- Under the Pass-Trough 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 deducible phase, must not be responsible for more than 50 percent of the ingredient cost (e.g. a 50% or more co-insurance plan).
- This amendment must be signed at least 90 days before the effective date of the EGWP Services pricing in this Attachment F1.

- The effective date of the EGWP services pricing in this attachment F1 will be January 1, 2024, with prior notice of award 120 days before the effective date of this amendment.
- The EGWP services pricing in this attachment F1 is for a one-year contract term, subject to the terms and conditions in this amendment.
- The pricing guarantees included in Optum Rx's offer to not account for the financial impact of manufacturer action in response to recent regulatory changes (i.e. the Inflation Reduction Act's AMP Cap provision); accordingly, Optum Rx may invoke certain contractual rights in response to the financial impacts caused by these changes.

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
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
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 $50 per Prior Authorization

• Prior Authorization (includes clinical Prior Authorization and B vs. D coverage determinations)	Included in EGWP Fee
• 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	
Print Fulfillment (as applicable)	
• ID Cards	Standard Package included in EGWP Fee. 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	
• Summary of Benefits & Opt Out letter	Standard Package included in EGWP Fee.
• Geo-Coded Pharmacy Directories	Customization requirements may incur additional fees
• Formulary Drug List	Included in EGWP Fee
• Payment distribution to Eligible Participants and LTC's for adjustments that identified previous overpayment of the Eligible Participant cost share/Drug Refund Checks	Included in EGWP Fee Included in EGWP Fee Included in EGWP Fee
• 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	
• Loading of the required 306 months of pharmacy data	$0.50 per record
• Website with standard design: Access for Eligible Participants and Physicians	Included in EGWP Fee Included in EGWP Fee
• Custom Website Development	
• PBP And Plan Changes	$250 per Hour
• 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	Included in EGWP Fee
• GeoAccess report (in excess of one annually provided in Core Services)	$5,000 per Report Included in EGWP Fee
• DMR Coverage letter (paper claim)	
This is not an inclusive list. OptumRx may charge for any products or services not specifically represented herein	

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Attachment G
Transparency CAA Section 204 Reporting Services Direct ASO Clients

This Transparency Reporting Services Amendment (the "Amendment") is by and between OptumRx, Inc., and its affiliates ("**OptumRx**") and The County of Orange ("**Client**" or "**County**"), effective as of December 27, 2022 (the "Amendment Effective Date") and shall be added to and incorporated into the Prescription Drug Benefit Administration Agreement between OptumRx and Client, as amended, together with any Exhibits attached thereto (the "Agreement").

In order to support these transparency and disclosure requirements of Section 204 of Title II of Division BB of the Consolidated Appropriations Act of 2021 ("**Section 204 of the CAA**") which requires insurance companies and employer-based health plans to submit certain data about prescription drugs and health care spending to the Center for Medicare and Medicaid Services ("CMS") as the designated data collector on behalf of certain federal departments in the form of Prescription Drug Data Collection Report ("**RxDC Report**"), OptumRx will provide Client with the transparency reporting services as described herein.

1. **DEFINITIONS.** All capitalized terms used in this Amendment not otherwise defined herein have the meanings established for purposes of Section 204 of the CAA and its implementing regulations, as amended and supplemented.

2. **TRANSPARENCY REPORTING SERVICES**. Effective December 27, 2022, OptumRx will cooperate with Client in support of Client's obligations as necessary to comply with applicable health plan and health insurance issuers disclosure requirements for prescription drugs set forth in Section 204 of the CAA as published on November 23, 2021. For the fees set forth in this Amendment, OptumRx will make available to Client and Client may elect from a range of certain transparency reporting services set forth herein ("***Transparency Reporting Services***"). Transparency Reporting Services will conform to applicable industry standards and Applicable Law.

3. **REQUIRED DATA FROM CLIENT.** Client agrees to provide OptumRx with Client Information and such other data at the "carrier/account/group" level with aggregation instructions as necessary to facilitate Transparency Reporting Services provided pursuant to Section 204 of the CAA and its implementing regulations, as amended and supplemented, including but not limited to the data elements set forth herein and applicable Prescription Drug Data Collection (RxDC) Reporting Instructions made available by CMS. Client acknowledges that OptumRx will not be responsible for accuracy and completeness of the data elements and crosswalk to be provided by Client or any liability arising from Client's failure to provide OptumRx with updated and correct information. Client is responsible for timely notifying OptumRx of any changes in the event any information changes during or after OptumRx receives the initial data. Performance of Transparency Reporting Services is conditioned upon Client's timely and accurate submission of information any updates to information to OptumRx.

4. **DATA AGGREGATION.** In support of Client's obligations to report aggregated data in accordance with Section 204 of the CAA, OptumRx will create and submit aggregated prescription drug elements and pertinent prescription drug pricing (e.g., D3 – D8) and assist with preparation of narrative responses, subject to Client's election of Services. Client agrees to provide OptumRx with sufficient information in a crosswalk to comply with aggregation restrictions required for prescription drug data. In the event Client or Client's reporting entity aggregates medical data for the D2 data element, OptumRx will prepare or report prescription drug data at an aggregate level; if medical data is not aggregated, prescription drug data will not be aggregated.

5. **REPORTING OF PRESCRIPTION DRUG DATA.** OptumRx will report the data elements applicable to prescription drug data as required by Section 204 of the CAA and as elected by Client as part of Transparency Reporting Services such as the Top 50 Most Frequent Brand Drugs, Top 50 Most Costly Drugs, and Top 50 Drugs by Spending Increase. Vendor will confirm submission of the RxDC Report to Client within ten (10) business days of completion.

6. **RECORDS RETENTION FOR TRANSPARENCY REPORTING SERVICES.** Vendor will retain reports directly related to the performance of the Transparency Services for a period of one (1) year following

the date of their creation or for a longer time period, if required by Applicable Law or regulatory agency guidance.

7. **COMPENSATION FOR AND ELECTION OF TRANSPARENCY REPORTING SERVICES**. By checking the appropriate box below, Client selects Transparency Reporting Services, as follows:

Client Election	Transparency Reporting Services (OptumRx)	Client Responsibility	Fees per year
[X]	Premium 1 Services		$1,000
	• Inclusion of plan level information for the D files submitted	• Completed CAG to State & Market Segment Crosswalk	
	• Compiling an aggregated file set for D3-D8 for submission by Optum	• Completion and Submission of Plan & Data Files 1 & 2	

7.1 OptumRx reserves the right to modify or amend the financial provisions of the Transparency Reporting Services Amendment upon sixty (60) days prior written notice (if possible) to Client if changes in the scope of services to be performed, including but not limited to any government imposed change in Laws or interpretation thereof that affect or are related to the Transparency Reporting Services, or if an industry wide change makes performance by OptumRx of its duties hereunder materially more burdensome or expensive, or if there is a material difference or change in the actual program performance from the underlying assumptions used to develop the pricing and rates set forth herein.

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Attachment H
Price Edge For Non-Covered Drugs Addendum

County and Optum Rx agree that Optum Rx, by and through its affiliates, shall provide Price Edge for Non-Covered drugs to and for the benefit of Members in Wellwise Choice, Sharewell Choice and Sharewell Retiree as set forth below.

NOW THEREFORE, the Parties agree as follows:

1. DESCRIPTION OF SERVICES

1.1 Price Edge for Non-Covered Drugs for Members. Optum Rx, through its affiliates, shall provide services through which Members may utilize their existing prescription drug identification cards to access negotiated pricing (where applicable) for certain prescription claims for Generic Drugs which are not covered by County's Plan Specifications and are dispensed at Network Pharmacies ("Price Edge for Non-Covered Drugs"). The list of drugs included in the Price Edge for Non-Covered Drugs program will be developed and maintained by Optum Rx.

1.2 Optum Rx agrees to provide access to Price Edge for Non-Covered Drugs at no charge to Members or County. Members will be responsible for paying the full (discounted, if applicable) price of the drug, including any dispensing fees or other applicable fees at the point of sale. Claims processed through Price Edge for Non-Covered Drugs are excluded from any reporting obligations and any discount or rebate, reconciliation, or other pricing commitments set forth in the Agreement.

2. TERM AND TERMINATION

2.1 Termination for Convenience. Either Party may terminate the services provided under Price Edge for Non-Covered Drugs for convenience on written notice provided to the other Party no later than thirty (30) days prior to the effective date of such termination. This termination for convenience right applies solely to Price Edge for Non-Covered Drugs and does not affect any other services offered under the Agreement.

2.2. Effect of Termination. If Price Edge for Non-Covered Drugs is terminated as a result of breach by either Party, each Party shall retain any and all rights and remedies under the Agreement, and applicable law. Upon termination of Price Edge for Non-Covered Drugs, County shall be responsible for notifying the affected Members.

3. GENERAL TERMS

3.1 Non-payment. If a Member fails to meet any payment obligations at the point of sale, then such Member will be unable to utilize the services provided under Price Edge for Non-Covered Drugs.

3.2. Regulatory Notification. County shall promptly notify Optum Rx of all inquiries from federal or state governmental departments, attorneys, Members, or other persons alleging a complaint with Price Edge for Non-Covered Drugs and provide any applicable documentation of such.

3.3. Compliance with Law. Each Party is responsible for ensuring its compliance with any laws applicable to the provision of services under Price Edge for Non-Covered Drugs, including any necessary licenses and permits.

3.4. Notification. County shall be solely responsible for communicating in writing, via a mutually agreed-upon notice, to Members with respect to services offered under Price Edge for Non-Covered Drugs

3.5 Fees. Although Optum Rx agrees not to charge an administrative fee to County for these Price Edge for Non-Covered Drugs claims, Optum Rx, its affiliates, subcontract service providers, brokers, consultants, and administrators, may receive and retain fees, proceeds, and/or other revenues in connection with Price Edge for Non-Covered Drugs.

3.6. Incentives. Only Optum Rx, its affiliates, or their contracted service providers, and not County, shall retain exclusive rights to all program data and marketing incentives, rebates or discounts from manufacturers, and any fees which may be payable in connection with or derived from Price Edge for Non-Covered Drugs or its Claims, if any. Any third-party fees shall be paid per net paid claim solely where Optum Rx has collected fees from Network Pharmacies with respect to processed claims.

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EXHIBIT 1

BUSINESS ASSOCIATE CONTRACT

A. GENERAL PROVISIONS AND RECITALS

1. The Parties agree that the terms used, but not otherwise defined below in Paragraph B, shall have the same meaning given to such terms under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and their implementing regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations") as they may exist now or be hereafter amended.

3. The Parties agree that a business associate relationship under HIPAA, the HITECH Act, and the HIPAA regulations between the Contractor and County arises to the extent that Contractor performs, or delegates to subcontractors to perform, functions or activities on behalf of County pursuant to, and as set forth in, the Contract that are described in the definition of "Business Associate" in 45 CFR § 160.103.

4. The County wishes to disclose to Contractor certain information pursuant to the terms of the Contract, some of which may constitute Protected Health Information ("PHI"), as defined below in Subparagraph B.10, to be used or disclosed in the course of providing services and activities pursuant to, and as set forth, in the Contract.

5. The Parties intend to protect the privacy and provide for the security of PHI that may be created, received, maintained, transmitted, used, or disclosed pursuant to the Contract in compliance with the applicable standards, implementation specifications, and requirements of HIPAA, the HITECH Act, and the HIPAA regulations as they may exist now or be hereafter amended.

6. The Parties understand and acknowledge that HIPAA, the HITECH Act, and the HIPAA regulations do not pre-empt any state statutes, rules, or regulations that are not otherwise pre-empted by other Federal law(s) and impose more stringent requirements with respect to privacy of PHI.

7. The Parties understand that the HIPAA Privacy and Security rules, as defined below in Subparagraphs B.9 and B.14, apply to the Contractor in the same manner as they apply to a covered entity (County). Contractor agrees therefore to be in compliance at all times with the terms of this Business Associate Contract and the applicable standards, implementation specifications, and requirements of the Privacy and the Security rules, as they may exist now or may hereafter be amended, with respect to PHI and electronic PHI created, received, maintained, transmitted, used, or disclosed pursuant to the Contract.

B. DEFINITIONS

1. "Administrative Safeguards" are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic PHI and to manage the conduct of Contractor's workforce in relation to the protection of that information.

2. "Breach" means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the PHI.
   a. Breach excludes:
      i. Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of Contractor or County, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.
      ii. Any inadvertent disclosure by a person who is authorized to access PHI at Contractor to another person authorized to access PHI at the Contractor, or organized health care arrangement in which County participates, and the information received as a result of such disclosure is not further used or disclosed

in a manner not permitted under the HIPAA Privacy Rule.

iii. A disclosure of PHI where Contractor or County has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

b. Except as provided in paragraph (a) of this definition, an acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule is presumed to be a breach unless Contractor demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

i. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

ii. The unauthorized person who used the PHI or to whom the disclosure was made;

iii. Whether the PHI was actually acquired or viewed; and

iv. The extent to which the risk to the PHI has been mitigated.

3. "Data Aggregation" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 164.501.

4. "Designated Record Set" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 164.501.

5. "Disclosure" shall have the meaning given to such term under the HIPAA regulations in 45 CFR § 160.103.

6. "Health Care Operations" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 164.501.

7. "Individual" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

8. "Physical Safeguards" are physical measures, policies, and procedures to protect CONTRACTOR's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

9. "The HIPAA Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

10. "Protected Health Information" or "PHI" shall have the meaning given to such term under the HIPAA regulations in 45 CFR § 160.103.

11. "Required by Law" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 164.103.

12. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

13. "Security Incident" means attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. "Security incident" does not include trivial incidents that occur on a daily basis, such as scans, "pings", or unsuccessful attempts to penetrate computer networks or servers maintained by Contractor.

14. "The HIPAA Security Rule" shall mean the Security Standards for the Protection of electronic PHI at 45 CFR Part 160, Part 162, and Part 164, Subparts A and C.

15. "Subcontractor" shall have the meaning given to such term under the HIPAA regulations in 45 CFR § 160.103.

16. "Technical safeguards" means the technology and the policy and procedures for its use that protect electronic PHI and control access to it.

17. "Unsecured PHI" or "PHI that is unsecured" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services in the guidance issued on the HHS Web site.

18. "Use" shall have the meaning given to such term under the HIPAA regulations in 45 CFR § 160.103.

C. OBLIGATIONS AND ACTIVITIES OF CONTRACTOR AS BUSINESS ASSOCIATE:

1. Contractor agrees not to use or further disclose PHI County discloses to Contractor other than as permitted or required by this Business Associate Contract or as required by law.

2. Contractor agrees to use appropriate safeguards, as provided for in this Business Associate Contract and the Contract, to prevent use or disclosure of PHI County discloses to Contractor or Contractor creates, receives, maintains, or transmits on behalf of County other than as provided for by this Business Associate Contract.

3. Contractor agrees to comply with the HIPAA Security Rule at Subpart C of 45 CFR Part 164 with respect to electronic PHI County discloses to Contractor or Contractor creates, receives, maintains, or transmits on behalf of County.

4. Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a Use or Disclosure of PHI by Contractor in violation of the requirements of this Business Associate Contract.

5. Contractor agrees to report to County immediately any Use or Disclosure of PHI not provided for by this Business Associate Contract of which Contractor becomes aware. Contractor must report Breaches of Unsecured PHI in accordance with Paragraph E below and as required by 45 CFR § 164.410.

6. Contractor agrees to ensure that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of Contractor agree to the same restrictions and conditions that apply through this Business Associate Contract to Contractor with respect to such information.

7. Contractor agrees to provide access, within fifteen (15) calendar days of receipt of a written request by County, to PHI in a Designated Record Set, to County or, as directed by County, to an Individual in order to meet the requirements under 45 CFR § 164.524.

8. Contractor agrees to make any amendment(s) to PHI in a Designated Record Set that County directs or agrees to pursuant to 45 CFR § 164.526 at the request of County or an Individual, within thirty (30) calendar days of receipt of said request by County. Contractor agrees to notify County in writing no later than ten (10) calendar days after said amendment is completed.

9. Contractor agrees to make internal practices, books, and records, including policies and procedures, relating to the use and disclosure of PHI received from, or created or received by Contractor on behalf of, County available to County and the Secretary in a time and manner as determined by County or as designated by the Secretary for purposes of the Secretary determining County's compliance with the HIPAA Privacy Rule.

10. Contractor agrees to document any Disclosures of PHI County discloses to Contractor or Contractor creates, receives, maintains, or transmits on behalf of County, and to make information related to such Disclosures available as would be required for County to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR § 164.528.

11. Contractor agrees to provide County or an Individual, as directed by County, in a time and manner to be determined by County, that information collected in accordance with the Contract, in order to permit County to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR § 164.528.

12. Contractor agrees to satisfy all applicable provisions of HIPAA standards for electronic transactions and code sets, also known as the Electronic Data Interchange (EDI) Standards, at 45 CFR Part 162, as well as all operating rules that apply to standard transactions, submission of certifications to HHS (to the extent HHS permits) concerning standard transactions, and all other electronic data interchange requirements included in the Patient Protection and Affordable Care Act of 2010. Contractor further agrees to ensure that any agent, including a subcontractor that conducts standard transactions on its behalf will comply with the EDI Standards.

13. Contractor agrees that it will determine the minimum necessary type and amount of PHI required to perform its services and will comply with 45 CFR §§ 164.502(b) and 514(d).

14. Contractor agrees to restrict the use or disclosure of PHI as may be agreed to in accordance with 45 CFR § 164.522, to document those restrictions, and to provide to County such documentation upon request and in a prompt and reasonable manner consistent with the HIPAA regulations.

15. Contractor agrees to accommodate alternative means or alternative locations for communicating PHI and to document those alternative means or alternative locations at the request of County or an Individual, pursuant to 45 CFR § 164.522(b), in a prompt and reasonable manner consistent with the HIPAA regulations.

16. Contractor agrees to be the primary party responsible for receiving and resolving requests from an Individual exercising his or her individual rights described in subsections (7), (8), (10), and (15) of this Paragraph C.

17. Contractor agrees that to the extent Contractor carries out County's obligation under the HIPAA Privacy and/or Security rules Contractor will comply with the requirements of 45 CFR Part 164 that apply to County in the performance of such obligation.

18. Contractor shall work with County upon notification by Contractor to County of a Breach to properly determine if any Breach exclusions exist as defined in Subparagraph B.2.a above.

19. Contractor shall not receive direct or indirect remuneration for any exchange of PHI otherwise authorized under the Privacy and/or Security Rules without an Individual's authorization.

D. SECURITY RULE

1. Contractor shall comply with the requirements of 45 CFR § 164.306 and establish and maintain appropriate Administrative, Physical and Technical Safeguards in accordance with 45 CFR § 164.308, § 164.310, § 164.312, and § 164.316 with respect to electronic PHI County discloses to Contractor or Contractor creates, receives, maintains, or transmits on behalf of County. Contractor shall follow generally accepted system security principles and the requirements of the HIPAA Security Rule pertaining to the security of electronic PHI.
2. Contractor agrees to ensure that access to electronic PHI related to County is limited to those workforce members who require such access because of their role or function.

3. Contractor agrees to implement safeguards to prevent its workforce members who are not authorized to access such electronic PHI from obtaining access and to otherwise ensure compliance by its workforce with the HIPAA Security Rule.

4. Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit electronic PHI on behalf of Contractor agree through a contract with Contractor to the same restrictions and requirements contained in this Paragraph D of this Business Associate Contract.

4. Contractor shall report to County immediately any Security Incident of which it becomes aware. Contractor shall report Breaches of Unsecured PHI in accordance with Paragraph E below and as required by 45 CFR § 164.410.

E. BREACH DISCOVERY AND NOTIFICATION

1. Following the discovery of a Breach of Unsecured PHI, Contractor shall notify County of such Breach, however

   both Parties agree to a delay in the notification if so advised by a law enforcement official pursuant to 45 CFR § 164.412.
   a. A Breach shall be treated as discovered by Contractor as of the first day on which such Breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor.
   b. Contractor shall be deemed to have knowledge of a Breach, if the Breach is known, or by exercising reasonable diligence would have known, to any person who is an employee, officer, or other agent of Contractor, as determined by federal common law of agency.

2. Contractor shall provide the notification of the Breach immediately to the County Privacy Officer. Contractor's notification may be oral, but shall be followed by written notification within 24 hours of the oral notification.

Rafael Linares, Chief Information Security Officer OCIT – Enterprise Privacy & Cybersecurity 1501 E. St. Andrews Place Santa Ana, CA 92705 (714) 567-7611 Rafael.Linares@ocit.ocgov.com	Linda Le, County Privacy Officer, CHPC, CHC, CHP OCIT – Enterprise Privacy and Cybersecurity 1501 E. St. Andrews Place Santa Ana, CA 92705 (714) 834-4082 Linda.le@ocit.ocgov.com privacyofficer@ocgov.com

3. Contractor's notification shall include, to the extent possible:
   a. The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Contractor to have been, accessed, acquired, used, or disclosed during the Breach;
   b. Any other information that County is required to include in the notification to Individual under 45 CFR §164.404 (c) at the time Contractor is required to notify County or promptly thereafter as this information becomes available, even after the regulatory sixty (60) day period set forth in 45 CFR § 164.410 (b) has elapsed, including:
      (1) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
      (2) A description of the types of Unsecured PHI that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
      (3) Any steps Individuals should take to protect themselves from potential harm resulting from the Breach;
      (4) A brief description of what Contractor is doing to investigate the Breach, to mitigate harm to Individuals, and to protect against any future Breaches; and
      (5) Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

4. County may require Contractor to provide notice to the Individual and any governmental entities requiring notification at the sole discretion of the County. Such notification will contain the elements required in 45 CFR § 164.410 or applicable state law. Contractor agrees that the County will be given reasonable advance opportunity to review the proposed notice or other related communications to any individual or third party regarding the breach; the County may propose revised or additional content to the materials which will be given reasonable consideration by Contractor (or its agent).
5. In the event that Contractor is responsible for a Breach of Unsecured PHI in violation of the HIPAA Privacy Rule, Contractor shall have the burden of demonstrating that Contractor made all notifications to County consistent with this Paragraph E and as required by the Breach notification regulations, or, in the alternative, that the acquisition, access, use, or disclosure of PHI did not constitute a Breach.

6. Contractor shall maintain documentation of all required notifications of a Breach or its risk assessment under 45 CFR § 164.402 to demonstrate that a Breach did not occur.

7. Contractor shall provide to County all specific and pertinent information about the Breach, including the information listed in Section E.3.b.(1)-(5) above, if not yet provided as soon as practicable, but in no event later than fifteen (15) calendar days after Contractor's initial report of the Breach to County pursuant to Subparagraph E.2 above.

8. Contractor shall continue to provide all additional pertinent information about the Breach to County as it may become available, in reporting increments of five (5) business days after the last report to County. Contractor shall also respond in good faith to any reasonable requests for further information, or follow-up information after report to County, when such request is made by County.

9. Contractor shall bear all expense or other costs associated with the Breach and shall reimburse County for all expenses County incurs in addressing the Breach and consequences thereof, including costs of investigation, notification, remediation, documentation or other costs associated with addressing the Breach.

F. PERMITTED USES AND DISCLOSURES BY CONTRACTOR

1. Contractor may use or further disclose PHI County discloses to Contractor as necessary to perform functions, activities, or services for, or on behalf of, County as specified in the Contract, provided that such use or Disclosure would not violate the HIPAA Privacy Rule if done by COUNTY except for the specific Uses and Disclosures set forth below.
   a. Contractor may use PHI County discloses to Contractor, if necessary, for the proper management and administration of Contractor.
   b. Contractor may disclose PHI County discloses to Contractor for the proper management and administration of Contractor or to carry out the legal responsibilities of Contractor, if:
      i. The Disclosure is required by law; or
      ii. Contractor obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person and the person immediately notifies Contractor of any instance of which it is aware in which the confidentiality of the information has been breached.
   c. Contractor may use or further disclose PHI County discloses to Contractor to provide Data Aggregation services relating to the Health Care Operations of Contractor.

2. Contractor may use PHI County discloses to Contractor, if necessary, to carry out legal responsibilities of Contractor.

3. Contractor may use and disclose PHI County discloses to Contractor consistent with the minimum necessary policies and procedures of County.

4. Contractor may use or disclose PHI County discloses to Contractor as required by law.

5. Contractor shall share PHI as reasonably requested by the County to carry out its responsibilities as plan administrator of the Plan(s), including, without limitation, for purposes of auditing the performance of Contractor.

G. OBLIGATIONS OF COUNTY

1. County shall notify Contractor of any limitation(s) in County's notice of privacy practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Contractor's Use or Disclosure of PHI.

2. County shall notify Contractor of any changes in, or revocation of, the permission by an Individual to use or

disclose his or her PHI, to the extent that such changes may affect Contractor's Use or Disclosure of PHI.

3. County shall notify Contractor of any restriction to the Use or Disclosure of PHI that County has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Contractor's Use or Disclosure of PHI.

4. County shall not request Contractor to use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy Rule if done by County.

H. BUSINESS ASSOCIATE TERMINATION

1. Upon County's knowledge of a material breach or violation by Contractor of the requirements of this Business Associate Contract, County shall:
   a. Provide an opportunity for Contractor to cure the material breach or end the violation within thirty (30) business days; or
   b. Immediately terminate the Contract, if Contractor is unwilling or unable to cure the material breach or end the violation within (30) days, provided termination of the Contract is feasible.

2. Upon termination of the Contract, Contractor shall either destroy or return to County all PHI Contractor received from County or Contractor created, maintained, or received on behalf of County in conformity with the HIPAA Privacy Rule.
   a. This provision shall apply to all PHI that is in the possession of Subcontractors or agents of Contractor.
   b. Contractor shall retain no copies of the PHI.
   c. In the event that Contractor determines that returning or destroying the PHI is not feasible, Contractor shall provide to County notification of the conditions that make return or destruction infeasible. Upon determination by County that return or destruction of PHI is infeasible, Contractor shall extend the protections of this Business Associate Contract to such PHI and limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for as long as Contractor maintains such PHI.

3. The obligations of this Business Associate Contract shall survive the termination of the Contract.

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