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ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT

THIS ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT (this "Addendum"**),** entered into effective as of **January 1, 2023** (the "Addendum Effective Date"), is made by and between **RxBenefits, Inc**. **f/k/a Prescription Benefits, Inc.** ("Administrator"), and **City of Orange Beach** ("Client"). The parties, intending to be legally bound, hereby agree as follows:

1. Administrator and Client are parties to that certain Administrative Services Agreement dated January 1, 2021 (the "Agreement").

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

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

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

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EXHIBIT A

CLIENT APPLICATION

January 1, 2023

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

A. CLIENT INFORMATION

Client's Name: City of Orange Beach

Client's Mail Address: P.O. Box 458, Orange Beach, Alabama 36561, United States

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B. PLAN DESIGN; MEMBER COST SHARE

Member Cost Share:

Please see current Summary of Benefits.

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

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C. SERVICES; FORMULARY.

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

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

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

2.1 Transaction Fees

Administrative Services	Fees
Transaction Fees Payable for Administrative Services (per Article IV.B of the Agreement)	**$2.15 per Prescription Drug Claim** made by Members payable on a bi-monthly basis
Transaction Fees Payable for Administrator's Protect Program (individual prices listed in table below)	
• City of Orange Beach Clinical -All Plans-Remove SaveOn SP fee	**$1.25 per claim**

Manufacturer Copay Assistance Programs	Fees
• Out of Pocket Protection (Accumulation)	
• City of Orange Beach Clinical -All Plans-Remove SaveOn SP fee	Not Elected
• Out of Pocket Protection + Variable Copay Assistance Program	
• City of Orange Beach Clinical -All Plans-Remove SaveOn SP fee	Not Elected
• SaveOnSP	
• City of Orange Beach Clinical -All Plans-Remove SaveOn SP fee	Not Elected
• Out of Pocket Protection + SaveOnSP	
• City of Orange Beach Clinical -All Plans-Remove SaveOn SP fee	No Charge (Elected)
Reviews and Appeals Management	
• Low Clinical Value Exclusions (LCV)	**Elected**
○ City of Orange Beach Clinical -All Plans-Remove SaveOn SP fee	**$0.30 per claim**

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• High Dollar Claim Review (HDCR)	**Elected**
○ City of Orange Beach Clinical -All Plans-Remove SaveOn SP fee	**$0.95 per claim**
Initial Determinations (i.e. coverage reviews) and Level One Non-Urgent Appeals under the UM program. Examples: Prior Authorization, Step Therapy, Drug Quantity Management	Included in the existing utilization management PMPM charge **OR** Included in the existing PA charge of $55 per initial determination* **OR** **No Charge if Client elects HDCR**
Initial Determinations and Level One Non-Urgent Appeals for benefit reviews. Examples: copay review, plan excluded drug coverage review, administrative plan design review.	$55 per initial determination **OR** **No Charge if Client elects HDCR**
Final Internal Appeals – Level Two Appeals and/or Urgent Appeals for UM, formulary, and benefit reviews.	$10 per review* **OR** **No Charge if Client elects HDCR**
External Reviews by Independent Review Organizations - for non-grandfathered plans	$800 per review **OR** **No Charge if Client elects HDCR**
Miscellaneous	
Third Party Integration Fees	Charges passed through from provider or mutually agreed upon by Parties

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

* Initial determination – this is the first review of drug coverage based on the Plan's conditions of coverage. Initial determinations are also referred to as initial reviews, coverage reviews, prior authorization reviews, UM reviews, or benefit reviews.

- The Level 2 and Urgent Appeal Service is an optional service for Clients to enroll in and there is an incremental fee of $10 per initial determination.
- Level 2 and Urgent Appeals are not included in the UM package fees.
- The Level 2 and Urgent Appeal Service fee is not charged per appeal. It is charged for each initial review. This allows Client to better estimate their appeal costs since it is based on the number of initial determinations. The fees cover the legal and operational costs involved with handling final and binding appeal reviews, which includes, but is not limited to the following: staffing of clinical professionals and supportive personnel, notifications to patients and prescribers, and maintaining a process aligned with state and federal regulations.
- Charges for the Level 2 and Urgent Appeal Service are billed on the monthly admin invoice for completed initial determination for UM, formulary, and benefit reviews. No subsequent charges are incurred when cases are appealed.
- Appeals can be deemed urgent at Level 1 or Level 2. Urgent appeal decisions are final and binding. If a Level 1 Appeal is processed as urgent, there is no Level 2 appeal.

PBM Services	**Fees**
Advanced Utilization Management (AUM Bundle)	
• City of Orange Beach Clinical -All Plans-Remove SaveOn SP fee	**$0.57** / PMPM or Passed through from PBM
Member-submitted paper claims processing fee Commercial Medicaid or Medicare subrogation claims fee	$3.00 per claim $3.00 per claim
Advanced Opioid Management Program	$0.32 / PMPM (If Elected)
ACA Statin "Trend Management" Program	$0.03 / PMPM (If Elected)
Combined Benefit Management	

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PBM Services	Fees
Services to manage combined medical-pharmacy benefits that are not a consumer-directed health (CDH) plan. Services include ongoing management of the data exchange platform with the medical vendor/TPA, production monitoring and quality control, and designated operations team. Combined benefit types may include deductible, out of pocket, spending account, and lifetime maximum.	$0.10 PMPM per combined accumulator up to maximum of $0.20 PMPM for existing connection with medical carrier or TPA. Fees to establish connection with new medical carrier or TPA are quoted upon request.
Network Pharmacy Service Audits (Options (except Basic) are paid annually by total of paid claims submitted per Client)	
Audit Option One: Enhanced Plus Network Pharmacy Audit. Next day paid claim review with lower dollar (i.e., $50 claim) thresholds. Standard 4% field audit of network with >250 ESI claims. Client-specific field audit of network, special reporting, unique audit modules, specific Client claim audits, regional auditing, extensive compliance checks. Includes next day desk paid claim auditing and standard audit summary reports. 100% of recoveries returned to Client.	$0.04 Per Claim Program Max Annual Billing $300,000.00
Audit Option Two: Basic Network Pharmacy Audit: 30-60 day historical review of paid claims (no next day review) and high thresholds, so lower dollar claims not reviewed. 100% of recoveries returned to Client. Very limited ability for Client requested audits if mutually agreed.	No Charge

Comprehensive Consumer Driven Health (CDH) Solution	
<u>Technical</u> Bi-directional data exchange; dedicated operations; 24-hour a day, seven-days a week monitoring and quality control; performance reporting; and analytics <u>Decision Support</u> Dedicated CDH member services, Prescription Benefit Review Statements, Retail Pricing Transparency <u>Member Adherence</u> ScreenRx Preventive Medications <u>Member Education</u> Proactive, personalized member communications open enrollment tools and member communications library, robust online features, and preventive care proactive, personalized member communications	$0.48 PMPM *these charges would be in addition to any pricing adjustments if greater than ten percent of Client's total utilization for all Plans is attributable to a CDHC. These services and fee are required for all CDH enrollees.
ScreenRx for PPO Plans	$0.25 PMPM (If Elected)
Medicare Part D – Retiree Drug Subsidy (RDS)	
RDS enhanced service (ESI sends reports to CMS on behalf of Client) (i) Notice of Creditable Coverage	$1.12 PMPM for Medicare-qualified Members with a minimum annual fee of $7,500 $1.35/letter + postage
RDS standard service (ESI sends reports to Client) A. Notice of Creditable Coverage	$0.62 PMPM for Medicare-qualified Members with a minimum annual fee of $5,000 $1.35/letter + postage

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Communication with physicians and/or members (e.g., program descriptions, notifications, formulary compliance, non-Medicare EOBs, etc.	$1.35/letter + postage
Medicare EOB	$1.75/letter + postage
Custom non-standard materials	Priced upon request
Electronic Pharmacy Benefit Eligibility Verification	
Eligibility confirmation of pharmacy benefit coverage shared with prescribers and other healthcare professionals through their Electronic Medical Records (EMR) or other digital channels. Pass-through charge to Client at PBM's preferred rate with data switch such as Surescripts.	
Miscellaneous	
RxDC Reporting (Submission of P2, D3-D8, and Narrative Response file via HIOS, and any other files deemed necessary)	Charges passed through from PBM
Coordination of Benefits - Custom reimbursement formula - Setup and ongoing maintenance - Product support	$0.01 PMPM, If Elected
Medicare Part B Solution - Integrated Retail & Mail Program - Retail Only Program - Program Introductory Letter	 - $0.42 PMPM - $0.20 PMPM - $1.35/letter + postage

PBM Services – No Additional Fee	
Customer service for Members	Electronic claims processing
Electronic/on-line eligibility submission	Plan setup
Standard coordination of benefits (COB) (reject for primary carrier)	Software training for access to on-line system(s)
FSA eligibility feeds	
A. Network Pharmacy Services	
Pharmacy help desk	Pharmacy reimbursement
Pharmacy network management	Network development (upon request)
B. Home Delivery Services	
Benefit education	Prescription delivery – standard
Reporting Services	
Web-based client reporting	Annual Strategic Account Plan report
Ad-hoc desktop parametric reports	Billing reports
Claims detail extract file electronic (NCPDP format)	Inquiry access to claims processing system
Load 12 months claims history for clinical reports and reporting	
Website Services	
Express-Scripts.com for Members — access to benefit, drug, health and wellness information; prescription ordering capability; and customer service	Mobile App for Members — Includes My Rx Choices, My Medicine Cabinet, Pharmacy Care Alerts, Refills and Renewals, and virtual prescription ID card.
Implementation Package and Member Communications	
• New Member packets (includes two standard resin ID cards or virtual cards, depending on PBM's procedures) • Member replacement cards printed via web (for hard-copy cards, charges are passed through from the PBM)	

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• Member-requested replacement packets or Client requested re-carding	$1.50 + postage per packet or card
Clinical	
Concurrent Drug Utilization Review (DUR) Overrides a. Client-requested overrides b. Lost/stolen overrides c. Vacation supplies	No Charge

2.2 Administrator Clinical Programs

- If elected, the ***Low Clinical Value ("LCV")*** exclusion option prevents unnecessary spending by removing LCV medications from the formulary without impact to client rebates while providing equal or more effective medicines at a lower cost. LCV medications are drugs that treat common conditions that do not provide any additional or superior therapeutic value when compared to currently existing therapies already in the marketplace. These medications are excluded in addition to any products that would normally be excluded by the PBM Formulary. This exclusion occurs without affecting Rebate minimum guarantees or contracted discount rates. Administrator reserves the right to amend, from time to time, the list of low clinical value medications. The list of low clinical value medications may be updated quarterly. Client may request a current list of LCV medications.
- If elected, Administrator's ***High Dollar Claim Review program ("HDCR")***, will provide Client with umbrella protection against high-cost Prescription Drug Claims for approved formulary drugs. Prescription Drug Claims over the threshold dollar amount are flagged prior to payment and reviewed for clinical appropriateness. This additional level of clinical oversight protects against unnecessary spending, saving clients money and providing improved visibility into claim reviews, decision processes, and cost savings. If HDCR is elected, Administrator's **Complex Clinical Intervention ("CCI")** program is included. CCI addresses complex case management issues for Plan Participants on a trajectory to generate more than $250,000.00 in annual pharmacy plan spend. Clinical pharmacists reach out to Prescribers to request and review medical documentation and tackle issues such as redundant therapies, dosing errors, potential drug-on-drug interactions, and medication misuse.
- The following may apply TO HDCR:
  - Administrator manages the clinical review process for high dollar claims, providing oversight of the process. Administrator communicates trends and savings results to clients through detailed reporting and analytics.
  - Review turnaround time is dependent on prescriber activity and whether additional information is required. If additional information is required, the reviewer will attempt to contact physician at least once daily for three days; direct contact with the prescriber will discontinue after the third day. The majority of reviews are completed with a disposition within 24 to 72 hours.
  - Following a clinical review, one of four actions will occur: (i) the medication is ***approved***, (ii) the medication claim is ***denied***, (iii) the prescriber may decide to ***withdraw*** and prescribe a different medication, or (iv) the reviewer can ***dismiss*** the claim due to lack of communication from the prescriber; or
  - If denied, an appeal process is available.

- The appeal process:
  - If an initial review is denied, the Member may appeal the decision to have a different pharmacist reviewer evaluate the prior authorization.

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- If the denial is upheld upon first appeal, a second appeal may be made, which is completed in consultation with a peer physician reviewer from an Independent Review Organization.
- If the denial is again upheld upon second appeal, a final appeal for a Federal External Review completed by an Independent Review Organization may be made.
- If the denial is upheld by the final review, the appeal process has been exhausted and the decision is final and binding.

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

2.3 Protect Program Guarantee

- **General**: The Administrator clinical programs elected by Client shall be collectively referred to as the "Protect Solutions" for purposes of this Exhibit A. The fees associated with the Protect Solutions which are invoiced to the client shall be referred to herein as the "Protect Fees".
- **Protect ROI Guarantee**: Administrator guarantees that Client will generate savings from the Protect Solutions ("Protect Savings") that are equal to or greater than the Protect Fees paid by Client during the given Contract Year (the "Protect ROI Guarantee"). To the extent that the Protect Fees exceed the Protect Savings in a given Contract Year, Administrator will pay Client an amount equal to the difference between the Protect Fees and the Protect Savings (the "Protect Guarantee Payment".
- **Conditions**:
  - **Eligibility**. To be eligible for the Protect ROI Guarantee, Client must be on one of Administrator's four Protect Program packages:
    - Advanced;
    - Intermediate;
    - Basic; or
    - Custom UM.

    In all instances, Administrator's LCV and HDCR programs must be elected.
- **Protect Savings Validation**: Protect Savings are calculated using a proprietary methodology developed by Administrator that analyzes rejected Claims and the paid alternatives to calculate definitive actual-dollar savings realized as a result of the Protect Solutions. Protect Savings generated by the PA and appeals process are based on the AWP contracted discount for the specific drug

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involved in a Claim. Protect Savings generated by the HDCR process are based on the net cost after actual discount. Administrator may use information from PBM in its calculation of Protect Savings (e.g., AWP, gross cost, plan cost, member cost, rejected Claims data). Generic product identifier (GPI) and national drug code (NDC) data will be retrieved from Medi-Span.

- Within one hundred and twenty (120) days after the end of each Contract year, Administrator shall report to Client performance for the Protect ROI Guarantee. If Protect Savings exceeds Protect Fees during a Contract Year, no payment shall be made by Administrator to Client. If Protect Fees exceed Protect Savings, amounts due resulting from an Administrator failure to meet the Protect ROI Guarantee, shall be calculated and paid to Client within thirty (30) days following Administrator's reconciliation report.

- The Protect Guarantee Payment, if any, shall be issued as a credit to Client's account. Client must have the Protect Solutions in place for the entirety of the Agreement Term to be eligible for the Protect ROI Guarantee. If this Agreement is terminated prior to the end of a given Contract Year or if the Agreement is terminated in breach of the terms of the Agreement (e.g., insufficient notice of non-renewal is given), then Administrator is not required to meet the Protect ROI Guarantee set forth above. No Protect Guarantee Payment will be paid (a) until this Agreement (including any applicable Client Application) is executed by Client, or (b) if the Administrative Services Agreement has been terminated as of the date that such Protect Guarantee Payment is to be paid to Client.

- If Client has not paid any outstanding invoice(s) when payment of the Protect Guarantee Payment, if any, is to be made, such outstanding amounts (including any applicable interest, service charge, or other outstanding amount) may be deducted from the Protect Guarantee Payment.

- In the event Administrator fails to meet the Protect ROI Guarantee, the Protect Guarantee Payment described above will be the sole and exclusive remedy available to Client for such failure.

2.4 **PBM Clinical Programs**

- If elected, PBM's ***Manufacturer Assistance Program for Specialty Medications ("MAP")***, consists of 1 or 2 components when available, dependent on the specific Plan Design: (1) Accumulator Protection using Manufacturer Copay assistance dollars to help lower Member out-of-pocket costs and Client costs where funds are not applied to member deductible and member out-of-pocket maximum totals; and (2) Accumulator Protection Plus Variable Cost-Share, where plan changes can maximize available assistance funds to offset Plan costs and cover the Member Cost Share but does not apply to their deductible and out-of-pocket maximum, yielding high savings potential, or Therapeutic Interchange Programs where the specialty pharmacy will move Members to preferred agents in order to allow the usage of copay assistance funds from manufacturers. Requires exclusive specialty pharmacy relationship.

- If elected, the **SaveOnSP program** is a benefit design change implemented by PBM in conjunction with a third-party vendor, SaveOnSP. Within the SaveOnSP program, certain specialty medications are classified as non-essential health benefits. In addition, the targeted drugs are assigned higher copays. In all cases, SaveonSP helps the Member coordinate manufacturer-sponsored copay assistance. SaveOnSP targets drugs in six of the top ten specialty categories. SaveOnSP is also available as "SaveOnSP Advantage" for high deductible health plans.
- If elected, PBM's **Advanced Opioid Management[SM] program** reaches out to physicians, pharmacists and patients at key touchpoints to minimize early exposure to opioids and to prevent patients from progressing to overuse and abuse. Patients will be required to start therapy with no more than a 7-day supply of short-acting medications (with certain exceptions). Member Education will start at the first fill. Prescribers will be notified at the point of care when specific signs of misuse and abuse are observed.

3. **Pricing Terms.** The financial terms herein are conditioned on an exclusive arrangement and all other specified conditions set forth in this Exhibit A. Client will pay to Administrator the amounts set forth below, net of applicable Copayments. The application of Brand Drug and Generic Drug pricing below may be

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subject to certain "dispensed as written" (DAW) protocols and Client defined Plan Design and coverage policies for adjudication and Member Copayment purposes. Sales or excise tax or other governmental surcharge, if any, will be the responsibility of Client.

Members will always pay based on the logic below:

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

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

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

3.1 Pricing.

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

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

Notwithstanding anything herein to the contrary: (i) a Prescription Drug Claim that processes at the Brand Drug rates (Participating Pharmacy Reimbursement Rates) and (Mail Pharmacy Reimbursement Rates), as indicated on the ingredient cost field of the Prescription Drug Claim's data record, shall be reconciled as part of the Brand Drug guarantee below; and (ii) a Prescription Drug Claim that processes at the Generic Drug rates (Participating Pharmacy Reimbursement Rates) and (Mail Pharmacy Reimbursement Rates) above, as indicated on the ingredient cost field of the Prescription Drug Claim's data record, shall be reconciled as part of the Generic Drug guarantee below. The Prescription Drug Claims that may be excluded from the reconciliation of the pricing guarantees are as identified in the "Prescription Drug Claims Excluded" paragraphs below in addition to Prescription Drug Claims dispensed in Puerto Rico, Guam, Northern Mariana Islands, Virgin Islands, Hawaii, Massachusetts, Alaska, West Virginia, and rural pharmacies. Furthermore, prices may vary in certain states for reasons such as most favored nations laws, other state or local legal requirements, geographic location, or other factors beyond the control of Administrator. In those situations, some Claims may be exempt from reconciliation of the financial guarantees set forth herein. All Claims may be aggregated for purposes of such rates. Claims dispensed in states subject to NADAC or another pricing benchmark required by law for pharmacy reimbursement may be excluded from dispensing fee guarantees only. Additionally, under any retail pricing arrangement(s) subject to NADAC pricing, Administrator will retrospectively invoice Client for the difference between Client's contracted dispensing fee and any state mandated pharmacy dispensing fee resulting from claims incurred in any state that mandates the use of NADAC or another pricing benchmarks in pharmacy reimbursement.

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PARTICIPATING PHARMACY	
BRAND	
• **PPO**	AWP – 20%
GENERIC	
• **PPO**	AWP – 85.75%
RETAIL MAINTENANCE NETWORK (84-90 DAYS' SUPPLY)	
BRAND	
• **PPO**	AWP – 23.5%
GENERIC	
• **PPO**	AWP – 85.75%
MAIL SERVICE PHARMACY	
BRAND	
• **PPO**	AWP – 25%
GENERIC	
• **PPO**	AWP – 88.75%

Prescription Drug Claims Excluded: Specialty Products (other than specialty guarantee), 340B Claims, Subrogation Claims, long term care pharmacy claims, Member Submitted Claims, compounds, OTC products (excluding insulin, diabetic strips, and test strips), vaccines, U&C, and Exclusive or Limited Distribution Products, claims with ancillary charges, products filled through in-house pharmacies and COB claims.

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

[total dispensing fee of applicable Prescription Drug Claims for the annual period divided by total of applicable Prescription Drug Claims for the annual period]

PARTICIPATING PHARMACY	
BRAND	
• **PPO**	$0.35 dispensing fee
GENERIC	
• **PPO**	$0.35 dispensing fee
RETAIL MAINTENANCE NETWORK (84-90 DAYS' SUPPLY)	
BRAND	
• **PPO**	$0.35 dispensing fee
GENERIC	
• **PPO**	$0.35 dispensing fee
ESI MAIL PHARMACY	
BRAND	
• **PPO**	$0.00 dispensing fee
GENERIC	
• **PPO**	$0.00 dispensing fee

Prescription Drug Claims Excluded: Specialty Products (other than specialty guarantee), 340B Claims, Subrogation Claims, long term care pharmacy claims, Member Submitted Claims, compounds, OTC products

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(excluding insulin, diabetic strips, and test strips), vaccines, U&C, Exclusive or Limited Distribution Products,, claims with ancillary charges, products filled through in-house pharmacies and COB claims. Claims dispensed at West Virginia pharmacies may be excluded from dispensing fee guarantees or claims subject to NADAC or another pricing benchmark required by law for pharmacy reimbursement will be excluded from fee guarantees.

If applicable, Prescription Drug Claims filled through in-house pharmacies that are no bill, no remit or that have not entered into an ESI pharmacy network agreement are excluded from the discount and dispensing fee guarantees.

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

Guarantees will be measured and reconciled on an annual basis within 180 days of the end of each Contract Year. The guarantees are annual guarantees - if this Agreement is terminated prior to the completion of the then current contract year or if the applicable Term or Renewal Term being reconciled is less than twelve (12) months in length (hereinafter, a "Partial Contract Year"), then the guarantees will not apply for such Partial Contract Year. Furthermore, in the event Client terminates the Agreement outside the terms and conditions in the Agreement, Client forfeits the right to receive any shortfall payments for financial guarantees. To the extent Client changes its benefit design or Formulary during the Term of the Agreement, the guarantee will be equitably adjusted if there is a material impact on the discount achieved. Subject to the remaining terms of this Agreement, Administrator will pay the difference of Client's cost for any shortfall between the actual result and the guaranteed result. Shortfall payments for financial guarantees, if any, will not be paid until this Agreement, including any applicable Client Application, and any amendment(s) or addenda to this Agreement or Client Application, is signed. Guarantees for pricing components are measured and reconciled in the aggregate across all pricing components. Any dollar savings generated in excess of one component may be used to offset a shortfall for any other component.

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

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

3.2 Specialty Products

(a) Exclusive Specialty. If Client elects Exclusive Specialty, then ESI Specialty Pharmacy is the exclusive provider of Specialty Products for the reimbursement rates shown on the Exclusive ESI Specialty Pharmacy Specialty Product List. Any Specialty Product dispensed at a Participating Pharmacy (for example, Limited Distribution Products not then available through ESI Specialty Pharmacy or overrides) will be reimbursed at the standard Participating Pharmacy Specialty Product

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rates shown below. Upon ESI Specialty Pharmacy acquisition of Exclusive or Limited Distribution Products, Members will obtain prescriptions through ESI Specialty Pharmacy.

(b) Precision Specialty. In situations where regulations prevent implementation of Exclusive Specialty arrangements, Plans may implement a Precision Specialty arrangement where the ESI Specialty Pharmacy or a Specialty Precision Network participating retail pharmacy are the exclusive pharmacies that may fill Specialty Products for Members (other than Exclusive or Limited Distribution Products not available at the ESI Specialty Pharmacy or a Specialty Precision Network participating retail pharmacy).

(c) Dispensing Fee for Specialty Products.

	Dispensing Fee*
Exclusive ESI Specialty Pharmacy	$0.00
Participating Pharmacy Specialty Products	$0.35

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

(d) **SPECIALTY NET EFFECTIVE DISCOUNT GUARANTEE** Administrator guarantees the overall annual net effective discount for the products listed on the Specialty Products List (excluding Limited Distribution Products) pursuant to the table below. Within one hundred and eighty (180) days following the end of each Contract Year, Administrator will calculate the actual net effective discount for the products listed on the Specialty Products List to determine if the guarantee has been met. Client will retain any amount that the actual net effective discount exceeds the guaranteed net effective discount. The calculation for the actual net effective discount will be as follows: ((Total Ingredient Cost for the products listed on the Specialty Products List) divided by (Total AWP for the products listed on the Specialty Products List)) minus 1. This guarantee is contingent on Client's participation in the National Preferred Formulary or Basic Formulary and an exclusive, precision, or open specialty arrangement, as applicable. For Exclusive Specialty guarantees to be reconciled annually and any shortfalls paid, Client must be enrolled in the Exclusive Specialty program for the entire Contract Year.

Average Annual Ingredient Cost Guarantee: Exclusive or Precision Specialty Arrangements	AWP- 22.5%

(e) Exclusions. For Exclusive Specialty arrangements, the specialty guarantee shall only apply to Plans for which the ESI Specialty Pharmacy is the exclusive pharmacy that may fill Specialty Products for Members, other than Exclusive or Limited Distribution Products not available at the ESI Specialty Pharmacy. In addition to the general exclusions identified above, all non-Specialty Products, and all Exclusive or Limited Distribution Products are excluded from the specialty guarantee. Prescription Drug Claims filled through in-house pharmacies that are no bill, no remit or that have not entered into an ESI pharmacy network agreement are excluded from the specialty guarantee.

(f) Exclusive or Limited Distribution Products. Administrator guarantees that the overall annual net effective discount for Exclusive or Limited Distribution Products will be at least AWP (-) minus 15.00% for Client. This does not apply to gene therapy.

(g) Ancillary Supplies, Equipment, and Services. For Specialty Products needing an additional charge to cover costs of all ASES required to administer the Specialty Products, Administrator, ESI or ESI Specialty Pharmacy will bill at the following standard per diem and nursing fee rates set forth below, maintained and updated by ESI from time to time. If ESI elects to bill Client's medical plan for ASES, Administrator will work with ESI to coordinate the invoicing and payment of ASES through Client's medical plan. If Client's medical plan will not cover the cost of ASES billed through ESI

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or ESI Specialty Pharmacy, Client shall be responsible for the costs of all ASES. If a Specialty Product dispensed or ASES provided by ESI Specialty Pharmacy is billed to Administrator or a Client directly by ESI Specialty Pharmacy instead of being processed through ESI, Client will timely pay Administrator, and Administrator will timely pay ESI Specialty Pharmacy for such claim pursuant to the rates below. ESI Specialty Pharmacy shall have 360 days from the date of service to submit such electronic or paper claim.

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

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

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

(a) General terms applicable to Vaccine Claims

1. "Vaccine Claim" means a claim for a Covered Drug which is a vaccine.
2. "Vaccine Vendor Transaction Fee" means the data interchange fee that ESI is charged by its third party vendor to convert Vaccine Claims submitted electronically by physicians to NCPDP 5.1 format in order for PBM to process the claim.
3. Vaccine Claims shall adjudicate at the lower of U&C or the amounts shown in the table below. In the case of Vaccine Claims, the U&C shall be the retail price charged by a Participating Pharmacy for the particular vaccine, including administration and dispensing fees, in a cash transaction on the date the vaccine is dispensed as reported to PBM by the Participating Pharmacy.
4. The Vaccine Administration Fee for Vaccine Claims for Members enrolled in Client's Medicaid programs, if any, will be capped at the maximum reimbursable amount under the state Medicaid program in which the Member is enrolled.
5. All Vaccine Claims will be subject to any Transaction Fees set forth in the Agreement.

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

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

	Participating Pharmacy INFLUENZA	Participating Pharmacy ALL OTHER VACCINES	Member Submitted Vaccine Claims (excluding foreign claims)
Vaccine Administration Fee	Pass-Through (capped at $15 per vaccine claim)	Pass-Through (capped at $20 per vaccine claim and $40 per covid vaccine claim)	Submitted amount
Ingredient Cost	Participating Pharmacy Ingredient Cost as set forth in the Agreement	Participating Pharmacy Ingredient Cost as set forth in the Agreement	Submitted amount
Dispensing Fee	Participating Pharmacy Dispensing Fee as set forth in the Agreement	Participating Pharmacy Dispensing Fee as set forth in the Agreement	Submitted amount
Administrative Fee/Vaccine Claim	Administrative Fee per Prescription Drug Claim as set forth in the Agreement		Administrative Fee per Prescription Drug Claim (plus manual claim administrative fee) as set forth in the Agreement
Vaccine Program Fee	$2.50 per vaccine claim		N/A

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

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

D. <u>REBATES</u>

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

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REBATES PER BRAND DRUG	FORMULARY: ESI NATIONAL PREFERRED
PARTICIPATING PHARMACIES (1-83 DAYS' SUPPLY)	
• **PPO**	$265.00 per Brand Drug claim
RETAIL MAINTENANCE NETWORK (84-90 DAYS' SUPPLY	
• **PPO**	$700.00 per Brand Drug claim
MAIL SERVICE PHARMACY	
• **PPO**	$700.00 per Brand Drug claim
SPECIALTY PRODUCTS	
• **PPO**	$2,600.00 per Brand Drug claim

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

2. **Exclusions For Non-Specialty Rebates:** Specialty Products, Member Submitted Claims, Subrogation Claims, biosimilar products (excluding Semglee), Exclusive and Limited Distribution Products, vaccines, OTC products (excluding insulin, diabetic strips, and test strips), claims older than 180 days, products filled through in house or 340b Claims, COB claims, and claims pursuant to a 100% Member Copayment plan are not eligible for the guaranteed Rebate amounts set forth in Section D.1 above.

   Exclusions For Specialty Rebates: Member Submitted Claims, Subrogation Claims, biosimilar products (excluding Semglee), Exclusive and Limited Distribution Products, vaccines, OTC products (excluding insulin, diabetic strips, and test strips), claims older than 180 days, products filled through in house or 340b Claims, COB claims, and claims pursuant to a 100% Member Copayment plan are not eligible for the guaranteed Rebate amounts set forth in Section D.1 above.

3. **Rebate Payment Terms.** Subject to the conditions set forth herein, Administrator will receive from ESI the quarterly Rebate payments within approximately one hundred twenty (120) days following the end of a calendar quarter for Rebates received during the prior calendar quarter. Upon receipt, Administrator will credit Client's account. For Prescription Drug Claims dispensed through in-house pharmacies, if applicable, Rebate payments shall only be paid if ESI is billing pharmaceutical manufacturers on behalf of the in-house pharmacies.

4. **Conditions**

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

4.2 PBM reserves the right to adjust the Rebate guarantees if Rebate revenue is materially decreased because Brand Drugs move off-patent to generic status or due to a change in applicable law.

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

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

4.5 Rebate Acknowledgment; No Representation; Rebate Limitations. Client acknowledges that Administrator is not making any representation, warranty or guarantee of any kind or nature, either express, implied or otherwise, regarding the amount of Rebates to be paid or remitted to Client pursuant to this Agreement, except as specifically set forth in writing herein. In addition, Client waives, releases and forever discharges PBM and Administrator from any Losses arising from a pharmaceutical company's (a) failure to pay Rebates; (b) breach of an agreement related to Rebates; or (c) negligence or misconduct affecting Rebates. Client acknowledges that whether and to what extent pharmaceutical companies are willing to provide Rebates to Client may depend upon a variety of factors, including the content of the PDL, the Plan Design, Client meeting criteria for Rebates, and the extent of participation in PBM's formulary management programs, as well as PBM/Administrator receiving sufficient information regarding each Claim for submission to pharmaceutical companies for Rebates. Client acknowledges and agrees that PBM may, but shall not be required to, initiate any collection action to collect any Rebates from a pharmaceutical company. In the event PBM does initiate collection action against a pharmaceutical company to collect Rebates, PBM may offset any reasonable costs, including reasonable attorneys' fees and expenses, arising from any such action. Notwithstanding any provision of this Agreement to the contrary, Administrator shall only be responsible for payment of Rebates to Client pursuant to the terms of this Agreement if such Rebates are actually received by Administrator during the Term of

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this Agreement. In no event shall Administrator be obligated to pay Rebates to Client until Administrator receives payment for the same Rebates from PBM. In the event Client terminates the Agreement outside the terms and conditions in the Agreement, Client forfeits the right to receive any Rebates received by Administrator on Client's behalf after the date of such termination or notice of termination. Client acknowledges that Administrator shall not be obligated to pay Client any Rebates described herein until this Agreement, including any applicable Client Application, and any amendment(s) or addenda to this Agreement or Client Application, is signed by Client. PBM and Administrator reserve the right to apply Client's allocated Rebate amount to unpaid Fees.

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

6. Notwithstanding anything in the Agreement to the contrary, in the event PBM does not receive a manufacturer payment for a particular Brand Drug claim due to its identification by a pharmaceutical manufacturer as being a 340B eligible claim (even where such claim may not meet the definition of a "340B Claim"), ESI may reduce a subsequent Rebate quarterly payment (or reconciliation payment, if applicable) to account for any previously-paid Rebate amounts attributable to such claim up to one year after the Claims date of service.

E. MISCELLANEOUS

1. Member Cost Share. Administrator may, but shall not be obligated to, dispense or cause to be dispensed a prescription even if the prescription is not accompanied by the applicable Member Cost Share described above in this Exhibit A. Administrator will refund any amount submitted by a Member in excess of the Member's applicable Member Cost Share. In the event a Member submits an insufficient Member Cost Share and the Member fails to remit the balance of the Member Cost Share amount to Administrator (or its designee) within thirty (30) days of Administrator's (or its designee's) request, then Administrator shall have the right to invoice Client for, and Client shall have an obligation to pay Administrator (or its designee), the amount of the uncollected Member Cost Share(s). Client shall, in turn, have the right to recover uncollected Member Cost Shares from its Members at Client's determination. Shipping of prescriptions submitted without the appropriate Member Cost Share may be delayed.

2. Additional Optional Services: Charges for additional optional services not otherwise identified and priced in this Exhibit A (Client Application) shall be quoted upon request and/or as applicable. The Parties acknowledge that the arrangement between Administrator and PBM is a pass-through arrangement. To the extent Client requests or PBM administers services of PBM that are not outlined in this Agreement, Administrator will pass through any such charges from PBM to Client.

3. Translation Services. To the extent Client requests translation services from Administrator or PBM (for translating member materials, brochures, etc.) and there is a charge from Administrator's or PBM's translation services provider, such charge will be passed through to Client.

4. RESERVATION OF RIGHTS. Administrator expressly reserves (and Client hereby confirms, acknowledges and agrees to such reservation) the right to modify or amend financial provisions in this Agreement (including without limitation this Client Application/Exhibit A) in the event of:

   4.1 A change in the scope of services to be performed by Administrator or PBM or the assumptions upon which the financial provisions included in this Agreement are based (including PBM's pricing provided to Administrator) and/or: (1) any new – or change in existing – state or federal law or regulation, or the interpretation thereof, and/or; (2) any government imposed or industry wide change that would impede Administrator's ability to provide the pricing described in this Agreement, including without limitation any prohibition or restriction on the right of Administrator or any third party's ability to receive rebates from PBM and/or pharmaceutical manufacturers.

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4.2 Implementation or addition of a high deductible health plan/consumer-driven health plan option.

4.3 Implementation or addition of a 100% Member paid plan.

4.4 A change in the coverage of Medicare eligible Plan Participants, irrespective of the resulting change in total number of Members.

4.5 A change to the methodology by which AWP is calculated or reported.

4.6 A change in PBM's PDL or the PBM Prescribing Guide or Administrator's alignment with such PDL or PBM Prescribing Guide. In any event, Administrator will use its commercially reasonable efforts to provide Client with 30 days' notice prior to addition or removal of a drug from the PDL or PBM's Prescribing Guide. In the event safety concerns or regulatory action require PBM to remove a drug sooner, Administrator shall notify Client of the removal of a drug from the PDL or the Prescribing Guide within three (3) business days.

4.7 Termination of Administrator's contractual arrangement with PBM.

F. DEFINITIONS

Effective as of the Addendum Effective Date, the following definitions are either deleted and replaced with the following or added to the Agreement, as applicable:

1. "Brand Drug" means a prescription drug identified as such in ESI's master drug file using indicators from First Databank (or other source nationally recognized in the prescription drug industry used by ESI for all clients) on the basis of a standard Brand/Generic Algorithm utilized by ESI for all of its clients, a copy of which may be made available for review by Administrator, Client, or its Auditor upon request. Notwithstanding the foregoing, certain prescription drug medications that are licensed and then currently marketed as brand name drugs, where there exists at least one (1) competing prescription medication that is a generic equivalent and interchangeable with the marketed brand name drug, may process as "Generic Drugs" for Prescription Drug Claim adjudication and Member Copayment purposes.

2. "Non-Drug Claims" means a product or supply that does not have a drug component and can be identified utilizing Express Scripts proprietary list of non-drug NDCs.

G. EXECUTION BY CLIENT

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

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

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IN WITNESS WHEREOF, Client has caused this Exhibit A (Client Application) to be executed as of the Addendum Effective Date. In the event this Client Application is amended by the Parties after the Addendum Effective Date, the Parties may substitute such amended Client Application for the former Client Application, provided the Parties set forth the date from and after which such amended Client Application shall be effective. Any such amended Client Application must be signed by Client's authorized representative and acknowledged, agreed to, accepted and dated by Administrator's authorized representative.

CLIENT:

City of Orange Beach

By: ____________________________

Printed Name: Ford Handley

Its: ____________________________

Acknowledged, agreed to and accepted by:

ADMINISTRATOR:

RxBenefits, Inc.

By: ____________________________

Printed Name: Lauren Simmons

Its: Vice President of Compliance & Legal Affairs

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Certificate Of Completion

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Status: Sent
Subject: FOR CLIENT SIGNATURE: Addendum to ASA between City of Orange Beach and RxBenefits
Source Envelope:
Document Pages: 20
Signatures: 0
Certificate Pages: 5
Initials: 0
AutoNav: Enabled
EnvelopeId Stamping: Enabled
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Envelope Originator:
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Birmingham, AL 35243
docusign@rxbenefits.com
IP Address: 35.185.192.36

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Status	Holder	Location
Status: Original 3/15/2023 10:24:08 AM	Holder: Docusign docusign@rxbenefits.com	Location: DocuSign

Signer Events	Signature	Timestamp
Ford Handley fhandley@orangebeachal.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 4/13/2023 6:17:24 AM ID: 6ff6670d-a20b-4823-9e2e-a1fb91aa0b7f		Sent: 4/13/2023 5:26:28 AM Viewed: 4/13/2023 6:17:24 AM
Lauren Simmons lsimmons@rxbenefits.com Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign		

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
abice@rxbenefits.com abice@rxbenefits.com Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 9/28/2021 12:15:44 PM ID: fb3c748f-f9b9-4071-bc55-10c28fb96b53	COPIED	Sent: 3/15/2023 10:24:10 AM Viewed: 3/15/2023 10:39:00 AM
dleipert@rxbenefits.com dleipert@rxbenefits.com Paralegal Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 3/15/2023 10:24:10 AM Viewed: 3/15/2023 11:09:00 AM

Carbon Copy Events	Status	Timestamp
hslaughter@rxbenefits.com hslaughter@rxbenefits.com Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 3/15/2023 10:24:10 AM
Tiffany Powers tpowers@cobbsallen.com Senior Client Executive Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 4/12/2023 5:01:28 AM ID: a153e517-de48-4545-a1f7-77cfb004efa2	COPIED	Sent: 4/13/2023 5:26:29 AM Viewed: 4/13/2023 5:29:24 AM

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	3/15/2023 10:24:10 AM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

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Operating Systems:	Windows2000Â¬ or WindowsXPÂ¬
Browsers (for SENDERS):	Internet Explorer 6.0Â¬ or above
Browsers (for SIGNERS):	Internet Explorer 6.0Â¬, Mozilla FireFox 1.0, NetScape 7.2 (or above)
Email:	Access to a valid email account
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	Ã² Allow per session cookies Ã² Users accessing the internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection

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