ADMINISTRATIVE SERVICES AGREEMENT

by and between

RxBenefits, Inc.

and

County of Sonoma

EFFECTIVE AS OF: September 1, 2024

ADMINISTRATIVE SERVICES AGREEMENT

THIS ADMINISTRATIVE SERVICES AGREEMENT, dated effective as of 12:01 a.m. local time in Birmingham, Alabama on **September 1, 2024** ("Effective Date"), is made and entered into by and between **RxBenefits, Inc.**, an Alabama corporation ("Administrator"), and **County of Sonoma** ("Client"). Administrator and Client are sometimes referred to herein individually as a "Party" and collectively as the "Parties."

Recitals

A. Client has indicated a desire to enter into a contractual relationship with Administrator in order to procure the administration of prescription drug benefits for Client's Plan Participants (defined below) by Client's execution of this Agreement (defined below), including without limitation the Client application attached to this Agreement and incorporated herein by reference as Exhibit A ("Client Application");

B. Administrator desires to administer the prescription drug benefits specified in the Client's Plan described herein in a ministerial capacity, subject to all the terms and conditions thereof; and

C. Administrator has entered into an agreement with an independent, third-party pharmacy benefit manager, CaremarkPCS Health, L.L.C. (hereinafter referred to as "CVS/caremark", "Caremark", or "PBM"), for the purpose of being able to provide a network of pharmacies and related pharmacy benefit management programs and services for utilization by Client and its Plan Participants as administered through Administrator working in conjunction with Client, all as more fully provided for in this Agreement.

Agreement

NOW, THEREFORE, in consideration of the mutual covenants, duties and obligations made by the Parties herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties, intending to be legally bound, hereby agree as follows:

ARTICLE I – CERTAIN DEFINITIONS

A. The initially capitalized terms below in this Section A of Article I shall have the following meanings when used in this Agreement. In addition, there are other initially capitalized terms that are defined in other parts of this Agreement and such terms shall have the meanings ascribed to them in such other parts of this Agreement whenever they are used in this Agreement.

"340B Claim" means a Claim identified by the submission of "20" in any of the Submission Clarification Code fields and/or a Claim submitted by pharmacy owned by a covered entity, as defined in Section 340B(a)(4) of the Public Health Services Act, whose 340B status is coded as "38" or "39" in the NCPDP DataQ database.

"AWP" means the "average wholesale price" for a standard package size of a prescription drug from the most current pricing information provided to PBM by Medi-Span Prescription Pricing Guide (with supplements), or following notice to Client, any other nationally available reporting service of pharmaceutical prices as utilized by PBM as a pricing source for prescription drug pricing. The standard package size applicable to a mail service pharmacy shall mean the actual 11-digit NDC of the package size used to fulfill the quantity dispensed. The standard package size applicable to a Participating Pharmacy shall be the actual package size dispensed from a Participating Pharmacy as reported by such Participating Pharmacy to PBM.

"Agreement" means this Administrative Services Agreement between Administrator and Client, the Client Application and all other exhibits, supplements, amendments, addenda and/or schedules to this Administrative Services Agreement.

"Biosimilar" means a biological product that is highly similar to a biological product already approved by the FDA (i.e., Reference Product) and is licensed and approved by the FDA as a Biosimilar notwithstanding

minor differences in clinically inactive components but otherwise no meaningful differences between the biologic product and the reference products in terms of safety, purity and potency of the product.

"Brand Drug" shall mean drugs or devices for which the Medi-Span Multisource Code field contains "M" (co-branded product), or "N" (single source brand), or "O" (originator). In limited circumstances, CVS Caremark may preserve the generic status of a product and override the M, N, or O indicators and deem the drug to be a Generic Drug through review of additional information such as: (a) Multisource code;(b) FDA Application Data (NDA/ANDA); (c) Medispan Brand Name Code; (d) Medispan Labeler Code; (e) Medispan FDA Reference Listed (Orange Book) and (f) price.

"Claims" means those prescription drug claims processed through PBM's online claims adjudication system or otherwise transmitted or processed in accordance with the terms of this Agreement in connection with the Plan.

"Claims Cycle" means the frequency by which Claims are billed.

"Contract Year" means the full twelve (12) month period commencing on the Effective Date and each full consecutive twelve (12) month period thereafter that this Agreement remains in effect.

"Cost Share" means the amount which a Plan Participant is required to pay for a prescription, which may be a deductible, a percentage of the prescription price, a fixed amount and/or other charge or penalty.

"Covered Product" means a drug or device that is covered under the formulary adopted by the Plan pursuant to this Agreement, and which requires a prescription for dispensing and/or coverage as a Plan benefit.

"Drug Interchange" means any substitution initiated by PBM of a Covered Product for a clinically comparable Covered Product that is not a preferred Brand Drug. Drug Interchange shall not include any substitution initiated by PBM that is (a) due to a drug utilization review; (b) due to Plan Participant safety reasons; (c) due to market unavailability of the originally prescribed drug; (d) a substitution of a Generic Drug for a Brand Drug; or (e) due to the originally prescribed drug not being Covered Product.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations promulgated thereunder.

"FDA" means the United States Food and Drug Administration.

"Formulary" means PBM's formulary, adopted by Client, as created, maintained and amended by PBM from time to time. The Formulary consists of (a) a ranking of Covered Products into preferred and non-preferred tiers, (b) a listing of Non-Covered Products, where applicable, and (c) associated utilization review programs pursuant to PBM's standard clinical criteria, which may include, but not limited to, prior authorizations, step therapy and/or quantity limits for one or more Covered Products. These programs may be conducted prospectively or retrospectively. The Formulary has been approved by the PBM's P&T Committee.

"Generic Drug" means drugs or devices for which the Medi-Span Multisource Code field contains a "Y" (generic). In limited circumstances, CVS/caremark may preserve the generic status of a product and override the M, N, or O indicators and deem the drug to be a Generic Drug through review of additional information such as: (a) Multisource code; (b) FDA Application Data (NDA/ANDA); (c) Medispan Brand Name Code; (d) Medispan Labeler Code; (e) Medispan FDA Reference Listed (Orange Book) and (f) price.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder.

"Losses" means all claims, causes of action, judgments, penalties, fines, liabilities, demands, damages, losses, costs, fees or expenses of any kind, including, without limitation, reasonable attorneys' fees and associated expenses.

"Manufacturer Administrative Fees" means the administrative fees received by PBM from pharmaceutical companies for administrative services rendered by PBM in its capacity as a group purchasing organization for the Plan in contracting for Rebates and administering Rebate contracts.

"Maximum Allowable Cost" or "MAC" means the unit price that has been established by PBM for a drug with more than two sources, included on the MAC drug list applicable to Client, which list may be amended from time to time by PBM in maintaining its generic pricing program. PBM shall update MAC pricing at least once every seven (7) days and shall, in a timely manner, eliminate Covered Products from the MAC drug list or modify MAC pricing based on changes in product availability and pricing data utilized by PBM in establishing the MAC unit prices. Client acknowledges that the MAC list applicable to Client is not the same as the MAC list published by the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration, or "HCFA MAC"). A copy of such MAC drug list shall be provided upon Client's reasonable request.

"Non-Covered Products" means drugs or other related products that are not Covered Products. Non-Covered Products may also be referred to as "Excluded Products". All designations of products as Non-Covered Products shall be approved by PBM's P&T Committee.

"P&T Committee" means the PBM Pharmacy and Therapeutics Committee, which is an independent body of health care professionals and academicians recognized as national experts and leaders in their field of specialty who periodically review new drugs introduced to the market, re-evaluate selected therapeutic drug classes and drugs in the pharmaceutical drug pipeline, and evaluate any current, relevant drug safety issues.

"Participating Pharmacy" means a retail pharmacy that participates in a retail network established by PBM.

"PDL" means PBM's formulary and includes the "Performance Drug List" and the "Prescribing Guide", and is a ranking of Covered Products into preferred and non-preferred tiers, as created, maintained and amended by PBM from time to time, which (a) has been approved by PBM's pharmacy and therapeutics committee and (b) represents the formulary that PBM recommends that its clients adopt as the Plan formulary.

"PPACA" means the Patient Protection and Affordable Care Act, as amended from time to time, and the regulations promulgated thereunder.

"Plan" means the health benefit plan(s) sponsored by Client that the prescription drug benefit is/are a part.

"Plan Administrator" means the Plan sponsor or committee designated by the Plan sponsor with respect to the Plan, as contemplated by Section 3(16)(A) of ERISA.

"Plan Participant" means each individual who Client identifies in the eligibility file to be eligible for prescription drug benefits under its Plan.

"Prescriber" means a health care practitioner licensed or authorized by law to issue an order for a prescription drug.

"Prescribing Guide" means the Caremark Prescribing Guide, as modified and published from time to time, which has been approved by PBM's pharmacy and therapeutics committee.

"Protected Health Information" or "PHI" shall have the meaning given such term by HIPAA, but limited to that information created or received by PBM in its capacity as a subcontractor to Administrator or by Administrator in its capacity as a business associate to the Plan.

"Rebates" means the formulary rebates received by PBM from various pharmaceutical companies whether directly or indirectly in PBM's capacity as a group purchasing organization for the Plan that are based on the utilization of Covered Products by Plan Participants, including price/inflation protection.

"Representatives" of a Party means such Party's directors, officers, managers, employees, agents and other representatives.

"Specialty Drugs" means certain pharmaceuticals, biotech or biological drugs, as offered by PBM, that are used in the management of chronic or genetic disease, including but not limited to, injectable, infused, or oral medications, or products that otherwise require special handling.

"Term" shall mean the time period between the Effective Date and termination or expiration of this Agreement, including the Initial Term, as extended by any Renewal Term (as such terms are defined in Article VI.A).

"Usual and Customary" or "U&C" means the lowest price a Participating Pharmacy would charge to a particular customer if such customer were paying cash for filling an identical prescription on that particular day at that particular location, as submitted by the Participating Pharmacy. This price must include any applicable dispensing fee and/or level of effort and must include any applicable discounts offered to attract customers.

ARTICLE II – ADMINISTRATIVE SERVICES PROVIDED

A. Administrator shall administer the prescription drug benefits provided by the Plan, subject to all of the terms and conditions of this Agreement, as the same may be amended or supplemented from time to time.

B. Administrator shall provide such assistance as may reasonably be necessary to Client's personnel in enrollment of eligible employees and former employees and dependents eligible under the Plan. Administrator shall maintain up-to-date eligibility status records on all enrolled Plan Participants as submitted by Client for purposes of appropriate adjudication of Claims under the Plan.

C. Administrator shall issue prescription drug cards to each Plan Participant-employee who is enrolled in the Plan and who is declared eligible by Client, as evidence of such Plan Participant-employee's entitlement to prescription drug benefits under the Plan.

D. Upon reasonable request, Administrator shall provide Client with costs projections and analyses of Claims and such other statistical data as may reasonably be requested by Client in connection with Client's management, oversight and control of the Plan. Client acknowledges, understands, and agrees that due to the various factors that can affect live claims adjudication, including, but not limited to, changes in the plan participant population, utilization, drug mix, and other factors, and the fact that costs projections are based on historical and/or test claims only, Administrator does not guarantee the accuracy of any costs projections and shall not be liable or otherwise held responsible for any Losses arising out of or related to such costs projections or the provision thereof.

E. Administrator shall invoice Client for the Claims due to be paid and shall collect Claims due, plus monthly administration fees and any other fees payable by Client under Article IV hereof and/or the Client Application.

ARTICLE III – DUTIES OF CLIENT

A. Client shall be solely responsible for determining the eligibility of its employees and their dependents to participate and receive benefits under the Plan.

B. Administrator has established and shall maintain a website located at www.rxbenefits.com (the "Website") through which Client shall have the ability to access, revise and update the eligibility and enrollment information of Client's Plan Participants. Client agrees that it shall be solely responsible for effecting timely revisions and updates to the enrollment information through the Website (or, in the alternative, through a secure file transfer protocol (ftp) site or via secure electronic data file in a format acceptable to Administrator delivered to Administrator via electronic mail) and shall be responsible for the accuracy of the enrollment information and any and all revisions and updates to the enrollment information. Upon becoming aware of

any errors in the enrollment information, Client shall promptly correct the information as necessary through the Website or via other acceptable alternative means provided for above in this Article III.B. Administrator shall not be responsible for Claims payments made to Plan Participants or ineligible and former employees of Client who are no longer or, if applicable, should never have been Plan Participants, based on information that is or was inaccurate, was not updated or not updated on a timely basis, or otherwise revised as required by Client or this Agreement. Administrator agrees that revisions and updates to the enrollment or other applicable Plan Participant or Claim information made as described will be considered for purposes of this Agreement revised and updated within forty-eight (48) hours of receipt by Administrator of written notice from Client of such revision or update. For emergency revisions and updates that need to be effective on the same day, Client must call in or fax such revisions and updates to Administrator during Administrator's normal business hours and follow up with Administrator as appropriate to ensure such revisions and updates become effective on the same day. In addition, to the extent such emergency revisions are communicated by Client to Administrator orally (e.g., via telephone), Client agrees (and it shall be Client's sole responsibility) to provide Administrator with a written description in reasonable detail setting forth the emergency revisions and/or updates within forty-eight (48) hours after such emergency revisions/updates were orally communicated by Client to Administrator.

C. Administrator will provide unique alphanumeric passwords ("Passwords") to Client that will permit Client to access, revise, and update the enrollment information on the Website. Client will distribute the Passwords to the individuals named on the list of authorized users (the "Users") provided by Client to Administrator, as updated from time to time. Client is responsible for all uses of the Passwords, whether or not authorized by Client. Client is responsible for maintaining the confidentiality of the Passwords and ensuring that the Users also maintain such confidentiality. Client agrees to immediately notify Administrator of any unauthorized use of a Password of which Client becomes aware or has a reasonable basis to believe to have occurred. Client shall indemnify, defend and hold harmless Administrator and its Representatives from and against all Losses resulting from, arising out of or relating to any unauthorized use or access, except where such Losses result solely from the willful or intentional act or misconduct or negligence of Administrator. To amend the list of Users, Client must notify Administrator in writing of such amendment(s). Within one (1) business day after the business day on which Administrator receives such amendment(s) in writing from Client, Administrator will deactivate the Password(s) issued to any deleted User(s) and will activate and issue new Password(s) for any new User(s) identified by Client. Notwithstanding anything in this Agreement to the contrary, Administrator shall not (and Client acknowledges and understands that Administrator shall not) be liable or otherwise held responsible for fraudulent Claims submitted by any Plan Participant, other third party acting or purporting to act on any Plan Participant's behalf or any unauthorized party using any Plan Participant's prescription drug card, information or otherwise.

D. Client expressly understands, acknowledges and agrees that any and all information, data, documentation or software disclosed by Administrator and/or PBM in the course of conducting its business and performing administrative and related services for Plan Participants and/or Client are confidential and proprietary to, and a valuable trade secret of, Administrator and/or PBM and that any disclosure or unauthorized use – that is, any use other than to evaluate Administrator's performance under this Agreement – will cause irreparable harm and damage to Administrator and/or PBM. Client shall not, directly or indirectly, release or disclose or otherwise use or attempt to use any patient-specific prescription information, trade secrets, proprietary software and technical processing, financial, pricing or other confidential information of Administrator and/or PBM obtained by Client from Administrator and/or PBM (regardless of the reason such information was provided or obtained) to any other party or for the benefit of any other party without the prior written consent of Administrator and/or PBM.

E. Client expressly represents and warrants that (i) it has provided notice to its employees and their dependents regarding participation in the Plan and Client's disclosure or anticipated disclosure of employee or dependent confidential information to Administrator in connection with the Plan and applicable law, and (ii) it has obtained all required consents and/or other approvals or authorizations (either in writing or through opt-out procedures) from each Plan Participant regarding such disclosures to Administrator for purposes of this Agreement and the services provided to Client and Plan Participants hereunder, and relating to the use and disclosure of information by Administrator or other applicable parties, including without limitation Protected Health Information under HIPAA as permitted under this Agreement or as otherwise reasonably necessary

to effect and/or carry out the purposes and intent of this Agreement and the services to be performed and rendered by Administrator, PBM, Client or other applicable third parties with respect to this Agreement. Further, Client hereby authorizes PBM to contract with pharmaceutical companies for Rebates as a group purchasing organization for the Plan. PBM and/or Administrator may use, disclose, reproduce or adapt information obtained in connection with this Agreement, including Claims and eligibility information, which is not identifiable on a Plan Participant basis. PBM and/or Administrator shall maintain the confidentiality of this information to the extent required by applicable law and may not use the information in any way prohibited by applicable law.

F. Should Client identify erroneous, mistaken or incorrect Claims payments made by Administrator, refunds in the amount of any such erroneous Claims payments to Client shall be made by Administrator within thirty (30) days after the Claim has been reprocessed, following receipt by Administrator of written notice from Client identifying such errors and providing reasonable supporting documentation. Client acknowledges, covenants and agrees that such refunds made by Administrator as provided in this Article III.F shall be the sole and exclusive remedy of Client and any Plan Participant against Administrator, its Representatives or any third party (including PBM) resulting from any such erroneous, mistaken or incorrect Claims payments made by or to Administrator, and Client further covenants and agrees to hold harmless and indemnify Administrator and its Representatives for any Losses beyond such refunds claimed by any party from Administrator. The Parties acknowledge that Administrator may seek to recover any overpayments from the Plan Participants, the providers of service or any other party unjustly enriched as a result of such overpayments at any time after notice or awareness of any such error.

G. Without limiting the generality or scope of any other provision of this Agreement, Administrator shall not be held responsible or liable for any performance standard or obligation required of it hereunder if Client (or Client's designee(s)) or any Plan Participant fails to provide Administrator with accurate, timely and complete information as necessary and/or required to meet any such performance standard or obligation under this Agreement or otherwise.

ARTICLE IV – FINANCIAL ARRANGEMENT

A. Administrator will invoice Client for the Prescription Charges paid during the immediately prior Claims Cycle in accordance with the Claims Cycle billing applicable to Client's adjudication platform (collectively, "Charges").

B. Administrator will invoice Client for the Transaction Fees (defined below), regardless of the amount of Claims activity, if any. All invoices will be due and payable seven (7) days from receipt by Client and payment shall in no event be received by Administrator later than the due date stated in the invoice. Refer to Article V, below, for rules applicable to late payment of invoices. Client shall not (and acknowledges that it shall not) have any right to offset any disputed amounts or amounts due and/or payable or purported to be due and/or payable from Administrator and/or PBM from any payments of Client except as specifically approved in writing by Administrator.

C. Administrator's charges to Client for Claims will include the sum of the Prescription Charges (defined below) with respect to such Claims that Administrator has paid or is obligated to pay to PBM on behalf of Client. For purposes of this Agreement, the "Prescription Charges" with respect to a particular Claim shall be an amount equal to:

(a) the lesser of: (i) the sum of (x) the ingredient cost of the drug, plus (y) the pharmacy dispensing fee for such drug (each as set forth on the Client Application); or (ii) the pharmacy's U&C amount for such drug; **plus**

(b) state tax, where applicable; **minus**

(c) any co-pay and/or deductible amount which the Plan Participant is obligated to pay with respect to such Claim under the Client's Plan or other applicable benefits program.

In addition to and without limiting the foregoing, any sales, use or other tax or assessment, including without limitation any surcharge or similar fee imposed under applicable law on any health care provider, Client, Plan Participant, service, supply or product provided or to be provided under this Agreement, will be the responsibility of Client and will be added to any invoices to Client hereunder as applicable.

D. Administrator may charge Client administration fees (a) per Plan Participant or Plan Participant-employee per calendar month payable on a monthly basis, and/or (b) per Claim made by Plan Participants payable on a bi-weekly basis (collectively, the "Transaction Fees"). The Transaction Fees to be paid by Client to Administrator under this Agreement are as specified in the Client Application.

E. Client acknowledges that there are certain clinical programs and related prescription drug services (e.g., formulary management, generic substitution programs, prior authorizations, appeals) made available by PBM and other strategic partners of Administrator and administered by Administrator for the benefit of Client and its Plan Participants which Client may elect, in its discretion and subject to mutual agreement with Administrator, to include as part of the prescription drug benefits and services made available by Client to its Plan Participants under this Agreement (collectively, "Clinical Programs" and "Optional Services"). Client further acknowledges and agrees that (a) any such Clinical Programs and Optional Services it elects to include as part of its Plan may require the payment of additional charges as set forth in the Client Application (collectively, the "Program Fees") and (b) a portion of any such Program Fees paid by Client may be retained by Administrator.

F. Rebates actually received by Administrator from PBM during the Term for Claims attributable directly to the Plan Participants will be paid or remitted to Client or the Plan in accordance with and subject to the terms and conditions agreed upon by the Parties in the Client Application. Furthermore, Client acknowledges and understands that except for the Rebates payable to Client on Claims for Brand Drugs pursuant to Section C.1 (Minimum Guaranteed Pricing) of the Client Application: (i) PBM may retain all or a portion of any formulary rebate fees received from pharmaceutical companies or otherwise prior to making payment of Rebates, if any, to Administrator; and (ii) PBM will retain any discounts paid to it with respect to Specialty Drugs, and no such discounts (besides the contracted discount with Client) will be paid or remitted to Administrator or Client. The Parties further acknowledge and understand that Rebates will not be paid to the Parties with respect to any Claims reimbursed on a unit basis by Medicaid agencies or other federal or state health care programs.

G. Client acknowledges and is aware that Administrator, pursuant to its contractual agreement with PBM: (a) is paid by PBM an administrative services credit payment per mail and retail Claim administered by Administrator on behalf of each Plan Participant in the Plan (the "PBM Service Credit"); and (b) may also receive from PBM a one-time per Plan Participant implementation and marketing credit payment designed to reimburse Administrator for actual expenses and out-of-pocket costs incurred by Administrator to market and implement PBM products and services and transition Client (and its Plan Participants) to PBM's benefit offerings (the "Implementation Credit"). It shall be Administrator's responsibility to obtain and collect such PBM Service Credit and any Implementation Credit directly from PBM and Client shall have no responsibility (payment or otherwise) with respect to such credits payable by PBM. The PBM Service Credit and Implementation Credit are the sole and exclusive responsibility of PBM to credit and compensate to Administrator. The Parties acknowledge and agree that (1) Administrator shall be responsible for any and all transition and implementation costs it incurs (exclusive of any Implementation Credit received by it as described above) with respect to the marketing and transition of Client (and its Plan Participants) to benefit offerings administered by Administrator for Client, and (2) Client shall be responsible for any and all transition and implementation costs it incurs with respect to the transition and implementation of such benefit offerings. To the extent applicable to the Parties, it is the Parties' intention that, for purposes of the Federal Anti-Kickback Statute and any required government reporting, the PBM Service Credit and Implementation Credit shall constitute and shall be treated by Administrator and Client as a discount against the price of drugs within the meaning of 42 U.S.C. § 1320a-7b(b)(3)(A). By executing this Agreement, each of Administrator and Client hereby agrees that the PBM Service Credit and any Implementation Credit shall be so treated and reported, as and to the extent applicable to each such Party.

H. Client acknowledges that Administrator may, in its sole discretion, compensate brokers and/or third-party consultants from monies received or due to be received by Administrator.

I. Upon reasonable advance written request by Client through its authorized Representative, Administrator agrees, if required to do so by applicable law, to provide Client with any additional information or data within Administrator's possession or control, including without limitation specific payment or financial information, relating to this Agreement and the terms hereof, both in connection with the execution of this Agreement by the Parties as of the Effective Date and thereafter during the Term of this Agreement, whether or not in connection with any filing with respect to the Plan or otherwise required of Client or the Plan under applicable law, provided that such information will be made available by Administrator at mutually convenient and reasonable times, intervals and places and at no out-of-pocket cost or expense to Administrator. In the event any information requested by Client pursuant to this Article IV.I constitutes Confidential Information such disclosure will be made in accordance with the terms and conditions of Article VIII.I hereof. In the event any information requested by Client pursuant to this Article IV.I is subject to an obligation or covenant of confidentiality, Administrator agrees to exercise its commercially reasonable efforts (provided, however, that such efforts shall not require Administrator to incur any out-of-pocket cost or expense) to obtain permission or consent to disclose to Client any such information in Administrator's possession and/or control, subject to Client's execution of a confidentiality agreement with Administrator and any other applicable party in a form reasonably acceptable to Administrator and any such other applicable party.

ARTICLE V – LATE PAYMENT

A. If the Charges for Claims, the Transaction Fees or any Program Fees specified in this Agreement are not paid by Client and received by Administrator by the due date of the applicable invoice, then Client shall pay Administrator a service charge equal to five percent (5%) (or the maximum amount allowable under applicable law if such amount is less than 5%) of all then past due amounts. In addition to such service charge, any past due amounts (inclusive of service charges) will incur interest beginning on the due date and continuing thereafter until fully paid at a rate of ten percent (10%) per annum (or the maximum amount allowable under applicable law if such amount is less than 10%).

B. Furthermore, if payment of the Charges for Claims, the Transaction Fees or any Program Fees payable by Client are not received by the due date of the applicable invoice, Administrator may, at its option, cease or suspend the provision of administrative services provided by Administrator under this Agreement, and deactivate all prescription drug cards issued to the Plan Participants. Consult Article VI for Administrator's option and right to terminate this Agreement at any time if Client fails to make full and timely payment of such Charges and fees (including any applicable service charges and interest) to Administrator.

C. If at any time Administrator reasonably determines that Client may have difficulty meeting its financial commitments under this Agreement, Administrator may request from Client financial information, reasonable assurances, or both, satisfactory to Administrator as to Client's ability to timely and fully meet its commitments and responsibilities hereunder. Such assurances may include, without limitation, Administrator requiring Client to make a deposit in such amount reasonably sufficient in Administrator's judgment to secure Client's payment obligations. If Client provides Administrator with such a deposit, Administrator may apply the deposit to past due balances and shall return the remaining deposit, if any, after the termination of this Agreement and the payment of all amounts payable to Administrator hereunder. Any deposit made by Client hereunder shall not be deemed a Plan asset.

D. Administrator's failure to charge or collect a service charge and/or interest from Client shall not waive or otherwise limit in any respect any future right of Administrator under this Agreement to charge or collect a service charge and/or interest from Client.

ARTICLE VI – TERM AND TERMINATION

A. The initial term of this Agreement shall commence on the Effective Date and shall continue in effect, unless sooner terminated as provided herein, for a period of three (3) years after the Effective Date (the "Initial Term"). Unless either Party gives the other Party written notice of its intention to terminate (given in the manner prescribed in Article VIII.B below) effective as of the last day of the Initial Term or any Renewal

Term at least ninety (90) days in advance of the expiration of then applicable Initial Term or Renewal Term (as the case may be), the Term of this Agreement shall automatically renew and extend for additional one (1) year renewal terms (each, a "Renewal Term") without any additional act on the part of either Party (unless sooner terminated as provided herein and subject to the consequences of any such termination). Administrator may terminate this Agreement at any time if its contractual arrangement with PBM terminates by giving at least ninety (90) days' prior written notice of the termination of this Agreement to Client.

During the second quarter of the second Contract Year of the Initial Term, Client may solicit proposals from third parties (hereinafter "Competitive Bids") for the provision of administrative services currently provided by Administrator pursuant to this Agreement (hereinafter, the "Market Check"). Before the end of the second quarter of the second Contract Year of the Initial Term, Client shall share with Administrator the financial terms of any Competitive Bid received during the Market Check, including the guaranteed "Net Savings" – that is, gross cost less member cost share less Rebates – of any Competitive Bid calculated using Client's claims data from the previous twelve (12) months. Administrator will have the opportunity to respond to any Competitive Bid with its own proposal within thirty (30) days of disclosure of such Competitive Bid. If the Net Savings of Administrator's proposal are not within five percent (5%) of the Net Savings of the Competitive Bid, Client shall have the right to terminate this Agreement effective as of the last day of the second Contract Year of the Initial Term after giving Administrator at least ninety (90) days' written notice of such termination in the manner prescribed in Article VIII.B below. If the Net Savings of Administrator's proposal are within five percent (5%) of the Net Savings of the Competitive Bid, Client shall have no such right to terminate this Agreement, which shall continue in effect pursuant to this Article VI.A.

B. Administrator or Client may terminate this Agreement upon written notice to the other Party if, as a result of any change in law, the rights or obligations of the requesting Party would be materially and adversely affected. Any such termination shall be effective on the day immediately preceding the effective date of such change in law, subject to the provisions of the following sentence. Notwithstanding the foregoing sentence, the Parties hereby agree to use prompt, good faith efforts to renegotiate the terms of this Agreement. If the Parties successfully conclude such negotiations prior to the effective date of the change in law, this Agreement shall not terminate and shall be amended to reflect the negotiated terms mutually agreed upon by the Parties. In the event the Parties are unable to successfully conclude and reach mutual agreement through such good faith negotiations, this Agreement shall terminate as provided above and herein.

C. On and after the date of termination of this Agreement, Administrator shall be obligated to complete such administrative services provided for in this Agreement as have been commenced prior to the date of termination. Therefore, Claims incurred or reported after the date of termination are the sole responsibility of Client and are not the responsibility of Administrator. Furthermore, termination of this Agreement shall not relieve Client of its obligation to pay Administrator for any outstanding Claims, charges, fees (including without limitation any applicable service charges), interest and reasonable collection costs and attorneys' fees incurred by Administrator associated with such collections. Upon termination of this Agreement, Administrator shall not have any obligation to transition Claims files and/or histories (or other information prior to such information being scrubbed of PBM's or Administrator's confidential, proprietary or trade secret information) to the extent that they contain PBM and/or Administrator cost, pricing and/or other proprietary, financial information, to Client's new prescription benefit manager or any other third party. With respect to any files requested by Client or its new prescription benefit manager, any associated charges shall be the responsibility of Client.

D. Administrator may, in its sole and absolute discretion, suspend performance or terminate this Agreement at any time without giving any advance notice, written or otherwise, to Client (or to any other party) and without penalty or liability for any Losses if (1) Client fails to make timely payment of the Charges for Claims, the Transaction Fees or any Program Fees owed to Administrator in accordance with the terms and conditions of this Agreement or, if requested, does not provide a deposit to Administrator as provided in Article V.C above, (2) Client makes an assignment for the benefit of creditors, (3) Client is the subject of a voluntary or involuntary petition for bankruptcy or is adjudicated insolvent or bankrupt, or (4) a receiver or trustee is appointed for any portion of Client's property.

E. Termination of this Agreement shall not terminate either Party's rights and obligations under Article III.C, Article III.D, Article IV (Financial Arrangement), Article V (Late Payment), Article VI.C, Article VII (Indemnification), Article VIII.B (Notices), Article VIII.C (Applicable Law; Venue; Consent to Jurisdiction), Article VIII.D (Entire Agreement; Construction), Article VIII.F (Relationship of the Parties), Article VIII.I (Confidential and Proprietary Information), Article IX (ERISA, COBRA & HIPAA Duties) and the Client Application (as amended, if applicable), and all such rights and obligations shall expressly survive any such termination.

ARTICLE VII – INDEMNIFICATION

A. Except as otherwise provided in this Agreement, Client and Administrator agree to hold harmless and to indemnify each other and each other's Representatives from and against any Losses arising out of or related to the indemnifying Party's breach or violation of this Agreement.

B. Client acknowledges that: (1) Administrator and its Representatives do not bear any liability for Losses under the Plan; (2) Administrator and its Representatives do not insure nor underwrite the liability of Client under the Plan; and (3) Administrator's execution of this Agreement shall not be deemed as the assumption by Administrator or its Representatives of any responsibilities, obligations or duties other than those required of Administrator pursuant to the express terms and conditions of this Agreement.

C. Client further agrees to hold harmless and to indemnify Administrator and its Representatives from and against all Losses arising out of or in connection with (1) Client's default in the performance of any duty, requirement or obligation of Client under this Agreement, the Plan or otherwise owed to Client's employees and their dependents (whether or not in relation to this Agreement or the Plan), (2) the acts or omissions of any Representative of Client (whether or not in relation to this Agreement or the Plan) or (3) any representations, warranties, covenants or statements, whether written, oral or otherwise, made by Client to its Representatives and/or their dependents.

D. Each Party's liability to the other Party and its Representatives hereunder shall not exceed the actual proximate Losses caused by or arising from the indemnifying Party's breach or violation of, or failure to perform, any term or provision of this Agreement. In no event shall either Party or any of its Representatives be liable for any indirect, special, incidental, consequential, exemplary or punitive damages (in each case, to the fullest extent that such damages may be waived by contract under applicable law), or any damages for lost profits relating to a relationship with a third party, however caused or arising, whether or not they have been informed of the possibility of their occurrence.

ARTICLE VIII – GENERAL PROVISIONS

A. **Changes in Agreement**. This Agreement may be amended at any time, without prior notice to any Plan Participant, by mutual written agreement executed by Administrator (through its duly authorized Representative) and Client (through its duly authorized Representative). No employee, agent or other Representative of Administrator is authorized to amend or vary the terms and conditions of this Agreement or to make any agreement or promise not specifically contained herein or to waive any provision hereof other than by the means prescribed above in this Article VIII.A.

B. **Notices**. Any notices to be given hereunder shall be deemed sufficiently given when in writing and (1) actually delivered to the Party to be notified or (2) placed in an envelope directed to the Party to be notified at the following addresses and deposited in the United States mail by certified or registered mail, postage prepaid:

If to Administrator at: RxBenefits, Inc.
Attn: Legal
3700 Colonnade Parkway, Suite 600
Birmingham, AL 35243

If to Client at: County of Sonoma
Attn: Cheryl Thibault, Employee Benefits Manager
575 Administration Drive, Suite 117C
Santa Rosa, California 95403
United States

Such addresses may be changed by either Party by written notice as to the new notice address given to the other Party as provided in this Article VIII.B. Client shall act as agent of its employees (and such employees' dependents, as and whenever applicable) to receive all notices to them hereunder and to notify the employees and their participating dependents affected thereby. It also shall be the responsibility of Client to notify all employees (and their dependents) of the expiration or termination of this Agreement by a Party pursuant to Article VI or otherwise. In the case of changes in, or termination of, the Agreement, notice to or by Client shall be deemed to constitute notice to all employees of Client and their dependents, and no further notice need be given by Administrator to any employee or dependent in order to effectuate any change in, or termination of, this Agreement or the benefits or coverage provided for herein or made available hereby.

C. **Applicable Law; Venue; Consent to Jurisdiction**. This Agreement shall be governed by, and construed and interpreted in accordance with, the internal laws of the State of California without regard to conflicts of law principles. The Parties agree that the exclusive venue for any action, suit, claim, counterclaim, cross-claim or otherwise with respect to this Agreement and/or the subject matter hereof shall be in the federal and state courts sitting in Sonoma County, California (the "California Courts"), and each Party knowingly and voluntarily hereby submits and consents to the jurisdiction of said courts over such Party and hereby expressly waives and releases any and all defenses, claims or other rights or remedies it may have or may assert or allege to establish that jurisdiction or venue in the California Courts is in error, improper or otherwise invalid in any respect. As such, each Party agrees that any such California Courts shall have *in personam* jurisdiction over it and consents to service of process in any manner authorized by California law. Each Party further covenants not to sue the other Party (or such other Party's Representatives) in any court or jurisdiction other than the California Courts.

D. **Entire Agreement; Construction**.

1. This Agreement constitutes the entire agreement and understanding of the Parties and supersedes any prior oral or written communication between the Parties with respect to the subject matter hereof. All Recitals to this Agreement set forth above and all exhibits and addenda hereto are hereby incorporated into and made a part of this Agreement.

2. In the event any provision of this Agreement shall be determined invalid or unenforceable, such invalidity or unenforceability shall not invalidate or render unenforceable the entire Agreement, but rather this Agreement shall be construed as if not containing the particular invalid or unenforceable provision or provisions and the rights and obligations of the Parties shall be construed and enforced accordingly; provided, that if the invalidation or unenforceability of such provision(s) shall, in the reasonable, good faith opinion of either Party, have a material adverse effect on such Party's rights or obligations under this Agreement, then the Agreement may be terminated by such Party upon thirty (30) days advance written notice by such Party to the other Party.

3. The Parties hereto agree that no provisions of this Agreement or any related document shall be construed for or against or interpreted to the advantage or disadvantage of any Party hereto by any court or otherwise by reason of any Party's having or being deemed to have structured or drafted such provision, each Party hereby expressly acknowledging its participation and/or its right and

ability to participate, in the structuring and drafting hereof. The Parties further acknowledge that: (i) this Agreement is the product of good faith, arm's length negotiations between them; (ii) such Parties possess substantially equal bargaining power; and (iii) each Party has had the opportunity to obtain the advice of legal counsel regarding the negotiation and execution of this Agreement and its terms.

4. This Agreement is not a third party beneficiary contract, nor shall this Agreement create (or be construed or deemed to create) any rights or remedies, whether legal, equitable or otherwise, on behalf of Plan Participants or any other third parties as against Administrator.

5. This Agreement is not a contract of insurance and Administrator is not an insurer or underwriter of Client's liability under, or with respect to, the Plan. Except as otherwise provided in this Agreement, Client has and will retain the ultimate responsibility for payment of Claims and other expenses under the Plan.

6. The article and section headings contained in this Agreement are solely for the purpose of reference, are not part of the agreement of the Parties and shall not in any way affect the meaning or interpretation of this Agreement.

E. **Authority; Counterparts**. Each signatory to this Agreement represents and warrants that he/she has full corporate or company authority to sign this Agreement on behalf of his/her respective Party and to legally bind and obligate such Party by so signing. Additionally, upon such signature by such authorized signatory(ies) of Client in each signature block of this Agreement (and the Client Application made a part hereof), Client represents, warrants, covenants and agrees that it has the necessary power and authority, corporate, company or otherwise (and that all necessary action has been taken for Client), to enter into this Agreement and to consummate the transactions provided for herein. This Agreement may be executed simultaneously in any number of counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. Electronic signatures shall be deemed to be original signatures for all purposes.

F. **Relationship of the Parties**.

1. Administrator and Client are, and shall at all times be, solely independent contractors. Neither Party nor its Representatives is, nor shall such Party or its Representatives be construed to be, by any Party to this Agreement or by any third party, an employee, joint venturer, partner, principal, agent, master, servant, fiduciary or other Representative of the other Party. Neither Party is authorized to assume or create any obligations, duties or liabilities, express or implied, on behalf of or in the name of the other Party, except as otherwise expressly provided to the contrary in this Agreement. Furthermore, Client acknowledges, agrees and understands that Administrator, on the one hand, and PBM and any other contracting parties of Administrator, on the other hand, are unaffiliated entities and independent parties who are solely independent contractors of one another.

2. Client acknowledges that: (i) Client shall be responsible, in its sole discretion, for the selection of any consultants or experts to provide advice to Client as to liabilities under the Plan or duties or obligations of the Plan or Client under applicable law or otherwise; and (ii) Client is not contracting hereunder with Administrator for the provision of any such advice by Administrator. To the contrary, the Parties expressly acknowledge that Administrator will not provide such advice to Client, and that neither Party has any obligation or responsibility to advise the other Party about such other Party's compliance or noncompliance with any law, regulation, statute, rule or otherwise (including without limitation under ERISA, the Internal Revenue Code, the Public Health Services Act and/or any regulation thereunder).

G. **Compliance with Laws; Force Majeure**.

1. Each Party hereby certifies and shall perform its duties and obligations under this Agreement in a manner that complies with all laws applicable to such Party and its performance hereunder, including without limitation the federal anti-kickback statute set forth at 42 U.S.C. § 1320a-7b(b)

("Anti-Kickback Statute") or the federal "Stark Law" set forth at 42 U.S.C. § 1395nn ("Stark Law") as and to the extent applicable to each such Party. Each Party is responsible for obtaining its own legal advice concerning its compliance with applicable laws. If Administrator's performance of its duties and obligations under this Agreement is made materially more burdensome or expensive due to a change in federal, state or local laws or regulations or the interpretation or enforcement thereof, the Parties shall, at the option of Administrator, negotiate promptly and in good faith an appropriate adjustment to the fees, costs, expenses and/or charges paid to Administrator hereunder or other amendment to this Agreement reasonably necessary in light of the change in law or regulation or the interpretation or enforcement thereof. If the Parties cannot agree on such adjusted amounts or amended terms, then either Party may terminate this Agreement upon thirty (30) days' prior written notice to the other Party.

2. Neither PBM nor Administrator shall be obligated at any time to provide the prescription drug benefit and related services identified in this Agreement to Client or the Plan Participants if Client or, if applicable, Plan Participants, are located in a state requiring a prescription benefit manager to be a fiduciary to Client or Plan Participants, in any capacity, contrary to or inconsistent with the terms and conditions specifically identified in this Agreement. In the event any state law or regulation requires PBM or Administrator to be a fiduciary to Client or a Plan Participant contrary to or inconsistent with the terms and conditions identified in this Agreement, Administrator may elect not to provide such prescription drug benefit and related services identified in this Agreement to the impacted Plan Participants upon thirty (30) days' prior written notice to Client.

3. Each Party, upon giving prompt written notice thereof to the other Party, shall not be liable for delay or failure to perform hereunder (except with regard to payment of invoices), if such delay or failure is due to a cause or causes beyond the reasonable control of such Party (a "Force Majeure Event"). For purposes of this Agreement, a Force Majeure Event may include, but shall not be limited to, acts of God, fire, explosion, earthquake, war, terrorism, malicious mischief, accident, transportation tie-up, riot or civil insurrection, embargo, strike or labor disturbance, slowdown or labor stoppage of any kind or act of any government, foreign or domestic. Each Party shall have the option, but not the obligation, to terminate this Agreement in its entirety if the other Party fails to perform any material obligation of this Agreement because of the occurrence of a Force Majeure Event and either (i) the other Party does not cure such breach within thirty (30) days after the occurrence of the Force Majeure Event, or (ii) such failure is not reasonably subject to cure within such period. The non-breaching Party must provide written notice of termination to the breaching Party.

H. **Access to Information; Audit Rights; Government Agency Submitted Claims**.

1. Administrator and Client will allow each other reasonable access at reasonable times to administrative information relating to this Agreement and the Parties' respective duties, obligations and benefits described herein, upon the giving of reasonable advance notice by the requesting Party (subject to any limitations with respect to information that is not in the possession or control of Administrator or is otherwise subject to a covenant of confidentiality in favor of a third party). The requesting Party agrees to execute a confidentiality agreement in form and content satisfactory to the disclosing Party as a condition precedent to being permitted such access to such information.

2. Client, or a mutually acceptable third party retained by Client, may conduct, with at least sixty (60) days prior written notice and at Client's sole cost and expense, an annual Claims audit of Administrator's data that directly relates to Claims billings for the prior Agreement year. The scope and manner of such a Claims audit (including applicable guidelines and timelines) shall be as reasonably determined by Administrator and communicated to Client sufficiently in advance of any such audit. Client agrees that it will execute (and shall cause any mutually acceptable third party taking part in any such audit to execute) a confidentiality agreement in form and content reasonably acceptable to Administrator prior to conducting any such audit. In the event of an audit by a mutually acceptable third party, Administrator and Client shall be provided with a copy of any proposed audit report or other written materials documenting such audit, and Administrator will have a reasonable opportunity to comment on any such report or written materials documenting such

audit before such are finalized. Upon finalization of audit results and agreement between Client and Administrator on any identified adjustments or discrepancies, if any, the period under review will be considered closed by the Parties and such agreed upon adjustment payments, if any, shall be paid by the appropriate Party within thirty (30) days of execution by the Parties of an appropriate release document covering the audit period. Client acknowledges that it shall not be entitled to audit documents that Administrator is barred from disclosing by applicable law or pursuant to an obligation of confidentiality to a third party. Client further acknowledges that there shall be a blackout period for audits from November 1 – February 1 each year.

3. Government Agency Submitted Claims. Client acknowledges that government agencies, or their agents may seek eligibility or similar data from PBM regarding Plan Participants. Additionally, government agencies, or their agents, may submit to PBM claims for reimbursement for prescription drug benefits provided by such government agencies, or their agents, to Plan Participants ("Government Claims"). Client authorizes PBM to provide such data as requested by government agencies or their agents and further authorizes PBM to process such Government Claims, in accordance with applicable law. Client acknowledges that PBM and Administrator may advance payment for Government Claims on behalf of Client. Client will reimburse PBM or Administrator, in accordance with Client's payment obligations under this Agreement, for all amounts advanced by PBM or Administrator for payment of Government Claims. Client acknowledges that Government Claims submitted by or on behalf of a state Medicaid agency shall be paid if submitted within three (3) years from the original date of fill unless a longer period is required by applicable law. In addition, Government Claims submitted by or on behalf of a state Medicaid agency may not be denied on the basis of the format of the Government Claim or failure to present proper documentation at the point of sale. Client shall also reimburse PBM or Administrator for any adjustments or reconciliations to previously processed Government Claims that may be payable to government agencies in accordance with applicable laws and regulations. The administrative fee for processing Government Claims will be invoiced at the paper submitted Claim rate stated in the Client Application or as otherwise agreed in writing by Client and Administrator. PBM reserves the right to (i) terminate these services upon ninety (90) days prior written notice to Client; or (ii) delegate these services to a third-party claims processor. In no event will PBM process Government Claims beyond the Term of this Agreement.

I. **Confidential and Proprietary Information.**

1. The term "Confidential Information" includes, but is not limited to, this Agreement or any information of either Client or Administrator (including without limitation its designees) disclosed or made available before the Effective Date, now or in the future (whether oral, written, electronic, visual or fixed in any tangible medium of expression) relating to either Party's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers, contractors, costs and pricing data, trade secrets, know-how, processes, plans, designs and other information of or relating to either Party's business. Confidential Information does not include Protected Health Information, the use and disclosure of which is governed by Article IX.C (including Exhibit B) of this Agreement. Without limiting the foregoing in any way, Client acknowledges and agrees, for itself and its Representatives, that the following financial fields constitute Confidential Information of Administrator for purposes of this Agreement and shall not be disclosed by Client to any third parties without the express, prior written consent of Administrator: (a) total AWP; (b) ingredient cost; (c) dispensing fees; (d) drug cost; (e) patient amount paid; (f) total amount paid; (g) sales tax; (h) U&C charges; (i) specialty indicator; and (j) brand/generic indicator.

2. Administrator and Client shall not disclose or make use of any Confidential Information except as permitted under this Agreement without the prior written consent of the non-disclosing Party, which consent may be conditioned upon the execution of a confidentiality agreement. Each Party may disclose Confidential Information of the other Party only to its authorized Representatives who have a need to know the Confidential Information in order to accomplish the purpose of this Agreement and who (i) have been informed of the confidential and proprietary nature of the Confidential

Information; and (ii) with respect to Representatives, have agreed in writing not to disclose it to others and to treat it in accordance with the requirements of this Section. Administrator or Client, as applicable, shall be responsible to the other Party for any breach of this Agreement by its respective Representatives. Representatives, for the purpose of this Article VIII(I), include entities that directly or indirectly (i) control; (ii) are controlled by; or (iii) are under common control with a Party, including any subsidiary or successor.

3. The foregoing shall not apply to such Confidential Information to the extent: (i) the information is or becomes generally available or known to the public through no fault of the receiving Party or any of its Representatives; (ii) the information was already known by or available to the receiving Party prior to the disclosure by the other Party on a non-confidential basis; (iii) the information is subsequently disclosed to the receiving Party by a third party who is not under any obligation of confidentiality to the disclosing Party; (iv) the information has already been or is hereafter independently acquired or developed by the receiving Party without violating any confidentiality agreement or other similar obligation; or (v) the information is required to be disclosed pursuant to a court order. Except in accordance with the requirements of this Article VIII.I.3, neither Party nor its Representatives may disclose, or permit to be disclosed, Confidential Information of the other Party as an expert witness in any proceeding, or in response to a request for information by oral questions, interrogatories, document requests, subpoena, civil investigative demand, formal or informal investigation by any government agency, judicial process or otherwise. If either Party, or any of its respective Representatives, is requested to disclose the Confidential Information of the other Party for any of the reasons described in the preceding sentence such Party shall give prompt prior written notice to the other Party to allow the other Party to seek an appropriate protective order or modification of any requested disclosure. The receiving Party agrees to reasonably cooperate with the disclosing Party in any action by the disclosing Party to obtain a protective order or other appropriate remedy. If the receiving Party is ultimately legally compelled to disclose such Confidential Information, the receiving Party shall disclose only the minimum required pursuant to and in order to comply with the court order or other legal compulsion.

4. Without limiting any other rights and remedies available under this Agreement or otherwise, any unauthorized disclosure or use of Confidential Information would cause Administrator or Client, as applicable, immediate and irreparable injury or loss that may not be adequately compensated with money damages. Accordingly, if either Party fails to comply with this Article VIII.I, the other Party will be entitled to seek to obtain specific performance including immediate issuance of a temporary restraining order or preliminary injunction enforcing this Agreement, and to judgment for Losses caused by the breach, and to seek to obtain any other remedies provided by law or in equity.

5. The confidentiality provisions of this Agreement supersede any and all prior oral or written communication(s) or agreement(s) of the Parties with respect to the confidential information of either Party, including, but not limited to, any mutual nondisclosure agreement between or among the Parties and/or Client's broker or consultant.

6. Public Records Acts; Sunshine Laws. Except as provided herein, the terms of this Section shall apply to any Client that is a public or quasi-public or similar entity subject to state laws governing disclosure of public records. Client agrees that the confidential and proprietary information of PBM and Administrator which is in writing and marked as confidential and proprietary, shall be afforded protection from disclosure except to the extent such disclosure is necessary under applicable law.

7. Gag Clause Compliance. Nothing in this Agreement may be construed or enforced by a Party as a gag clause that prohibits the exchange of information required under 26 U.S.C. § 9824(a); 29 U.S.C. § 1185m(a)(1); or 42 U.S.C. § 300gg-119(a)(1).

J. **Government Programs**. To the extent required by applicable law or contractual commitment, Client agrees to fully and accurately disclose and report to Medicare, Medicaid or other government health care programs any discount, rebate or other credit received by Client under this Agreement, whether reflected in the fees for the products and services or otherwise provided hereunder, as discounts against the price of the drugs under

all applicable state or federal programs that provide reimbursement to Client for products or services provided by CVS/caremark. It is the intention of the Parties, for purposes of the Federal Anti-kickback Statute, that any discount, rebate or other credit shall constitute and be treated as a discount against the price of drugs within the meaning of 42 U.S.C. § I 320a-7b(b)(3)(A).

K. **Assignment.** Neither Party may assign this Agreement without the prior written consent of the other Party, provided such consent will not be unreasonably withheld. However, Administrator may assign this Agreement or delegate the duties to be performed by or on behalf of Administrator under this Agreement without the consent of Client as part of a change in ownership or the sale of all, or substantially all, of the assets of Administrator or similar sale or disposition of Administrator that would, upon consummation, be deemed to constitute an assignment of this Agreement under applicable law.

L. **Exclusivity**. PBM and Administrator shall be the exclusive providers of each of the services described in this Agreement for the Plan receiving services as set forth in this Agreement, provided that PBM will be a provider of specialty products and services if Client elects an "open specialty" relationship with the PBM. Client acknowledges and agrees that it will not, directly or indirectly, engage any prescription benefit manager or other third party, to provide concurrently to Client or the Plan any service that is similar to any of the services provided by Administrator or PBM, including without limitation, retail pharmacy network contracting, pharmacy claims processing, mail pharmacy services, formulary and rebate administration services, and specialty pharmacy services to the extent an exclusive option has been selected. Client acknowledges and agrees that a breach of this Section shall be deemed a material breach of this Agreement and shall entitle PBM and Administrator to modify pricing terms of this Agreement.

ARTICLE IX – ERISA, COBRA AND HIPAA DUTIES

A. If Client's offering of the prescription drug program provided for in this Agreement constitutes part of a "welfare plan" within the meaning of Section 3(1) of ERISA, it is understood and agreed that the duties of Client and Administrator are as follows:

1. Plan and Summary Description: It shall be the duty of Client (and not the duty of Administrator) to furnish any Plan or summary plan description to participants and beneficiaries as required by ERISA and any regulations under it. It shall be the duty of Administrator to provide Client, upon request, with a summary of benefits available under the Plan for use in conjunction with the summary plan description.

2. Annual and Summary Annual Reports: It shall be the duty of Client to furnish any annual reports to participants and/or governmental agencies as required by ERISA, the Internal Revenue Code and any regulations thereunder. It shall be the duty of Administrator to send to Client, upon Client's reasonable request, such information which Administrator has within its possession as will permit Client to make the annual reports. It shall be the duty of Client to provide the Plan Participants with summary annual reports as required by ERISA and any regulations under it.

3. Plan Administrator: It is expressly understood and agreed by the Parties that any and all duties assigned by ERISA and any regulations thereunder to the Plan Administrator including, but not limited to, those duties specified in the Plan shall be deemed for purposes of this Agreement as duties of Client and not those of Administrator. It is also expressly understood and agreed by the Parties that any notices required by the amendments to ERISA by COBRA (P.L. 99-272, as amended) to be given by the Plan Administrator to participants and beneficiaries shall be the obligation of Client under this Agreement and not the obligation of Administrator. Further, Administrator will not accept payment directly from any former employee (or dependent of such employee) who is eligible for continuation coverage under the Plan. It shall be the responsibility of Client (and not Administrator), or such other third party administrator handling the health plan of which the prescription drug program is a part, to collect the premiums due from the employee (or dependent of the employee) for continuation coverage and to satisfy any and all other COBRA duties and responsibilities.

B. Client expressly acknowledges and agrees that: (1) Administrator is not (nor shall it be deemed to be at any time) a "fiduciary" under ERISA, the Internal Revenue Code and any regulations thereunder, applicable state

law, common law or otherwise for any purposes whatsoever pursuant to this Agreement or otherwise; and (2) Client (and not Administrator) possesses and expressly retains at all times during this Agreement and thereafter the sole and absolute authority to design, amend, terminate, modify, in whole or in part, all or any portion of the Plan, including without limitation the sole and absolute authority to control and administer the Plan and any assets of the Plan. Client (and not Administrator) will also have complete discretionary, binding and final authority to construe the terms of the Plan, to interpret ambiguous Plan language, to make factual determinations regarding the payment of Claims or provision of benefits, to review denied Claims and to resolve complaints by Plan Participants.

C. Client shall be responsible for any and all duties and responsibilities applicable to Client under HIPAA and similar state law that may apply to the prescription drug program offered under this Agreement at any time, including but not limited to those provisions applicable to Client relating to portability, non-discrimination, privacy and security. The Parties agree to sign a HIPAA Business Associate Agreement in the form attached hereto as Exhibit B.

D. Claims, as well as eligibility information, which is de-identified in accordance with HIPAA and other applicable law, and which is not identifiable on a Plan Participant basis, may be used, disclosed, reproduced, adapted or sold by PBM and/or Administrator. Such de-identified data may be provided to nationally recognized data integration firms to support appropriate administration of PBM's drug management programs as this benchmarking data enables PBM to compare against other drug population sets and seek to improve programs and services for clients or otherwise.

IN WITNESS WHEREOF, Administrator and Client have caused this Administrative Services Agreement to be executed and delivered by their respective authorized Representatives as of the Effective Date.

Client: County of Sonoma

By: _____

Printed Name: _____

Its: _____

Administrator: RxBenefits, Inc.

By: _____

Printed Name: Lauren Simmons

Its: Vice President of Compliance & Legal Affairs

EXHIBIT A

ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT

THIS ADDENDUM TO ADMINISTRATIVE SERVICES AGREEMENT (this "Addendum"), entered into effective as of **September 1, 2024** (the "Addendum Effective Date"), is made by and between **RxBenefits, Inc**. **f/k/a Prescription Benefits, Inc.** ("Administrator"), and **County of Sonoma** ("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 September 1, 2024 (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.

CLIENT APPLICATION

[IMPORTANT – PLEASE READ CAREFULLY: Client should review 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: County of Sonoma

Client's Mail Address: 575 Administration Drive, Suite 117C, Santa Rosa, California 95403, United States

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B. PLAN DESIGN; PLAN PARTICIPANT COST SHARE

Plan Participant 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 Plan Participants of any Plan design changes prior to the effective date of any such changes as required by applicable law.

C. FINANCIAL TERMS; ADDITIONAL SERVICES AND PROGRAMS

PRICING TERMS

September 1, 2024

1. RETAIL, MAIL, SPECIALTY & REBATES [1], [2], [3], [4], [5] (Minimum Guaranteed Pricing):

RETAIL-30 NETWORK		
BRAND		
• Year 1	AWP – 19.1%	+ $0.20 dispensing fee
• Year 2	AWP – 19.1%	+ $0.20 dispensing fee
• Year 3	AWP – 19.1%	+ $0.20 dispensing fee
GENERIC		
• Year 1	AWP – 89.1%	+ $0.20 dispensing fee
• Year 2	AWP – 89.2%	+ $0.20 dispensing fee
• Year 3	AWP – 89.3%	+ $0.20 dispensing fee
RETAIL 90 NETWORK		
BRAND		
• Year 1	AWP – 19.35%	+ $0.00 dispensing fee
• Year 2	AWP – 19.35%	+ $0.00 dispensing fee
• Year 3	AWP – 19.35%	+ $0.00 dispensing fee
GENERIC		
• Year 1	AWP – 89.1%	+ $0.00 dispensing fee
• Year 2	AWP – 89.2%	+ $0.00 dispensing fee
• Year 3	AWP – 89.3%	+ $0.00 dispensing fee
MAIL/MAINTENANCE CHOICE		
BRAND		
• Year 1	AWP – 19.6%	+ $0.00 dispensing fee
• Year 2	AWP – 19.6%	+ $0.00 dispensing fee
• Year 3	AWP – 19.6%	+ $0.00 dispensing fee
GENERIC		

[1] The Year 1 pricing above will be implemented as of the Addendum Effective Date.

[2] Shipping fees and/or postage will be increased if PBM's third party carrier increases its charges to PBM for shipping fees and/or postage costs.

[3] New to market Specialty drugs filled at CVS Specialty will be priced at AWP -16% or MAC, if applicable; New to market Limited Distribution drugs filled at CVS Specialty will be priced at AWP -16%; a copy of the CVS specialty list will be provided upon request.

[4] See Section 4.1 of this Exhibit for Rebate conditions.

[5] 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).

• Year 1	AWP – 93.15%	+ $0.00 dispensing fee
• Year 2	AWP – 93.25%	+ $0.00 dispensing fee
• Year 3	AWP – 93.35%	+ $0.00 dispensing fee
SPECIALTY DRUGS (filled at mail; as provided in the CVS specialty list)		
Exclusive		
• Year 1	AWP –23.75%	+ $0.00 dispensing fee
• Year 2	AWP –23.75%	+ $0.00 dispensing fee
• Year 3	AWP –23.75%	+ $0.00 dispensing fee
REBATES		
RETAIL		
• Year 1	$331.00 per Brand claim	
• Year 2	$347.00 per Brand claim	
• Year 3	$364.00 per Brand claim	
RETAIL 90		
• Year 1	$801.00 per Brand claim	
• Year 2	$839.00 per Brand claim	
• Year 3	$880.00 per Brand claim	
MAIL		
• Year 1	$813.00 per Brand claim	
• Year 2	$853.00 per Brand claim	
• Year 3	$895.00 per Brand claim	
SPECIALTY		
• Year 1	$3,940.00 per Brand claim	
• Year 2	$4,137.00 per Brand claim	
• Year 3	$4,343.00 per Brand claim	
TRANSACTION FEES		
Transaction Fee Per Claim	$0.65	
PROTECT PROGRAM FEES		
Transaction Fee Per Claim	N/A	

The pricing set forth in the table in Section 1 above is subject to and/or contingent upon the following:

(a) The Year 2 and Year 3 pricing and rebates shown in the table above represent floors that will be available to Client during the second and third years of this Agreement respectively, subject to applicable terms and conditions. Client will be required to execute additional Exhibits A (Client Applications) each year reflecting the applicable pricing and such associated terms and conditions.

(b) 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 above in the pricing table. All Claims may be aggregated for purposes of such rates.

(c) When traditional pricing is prohibited, or state law mandates a pharmacy dispensing fee, any charges, expenses, or fees associated with applicable Claims or otherwise assessed by PBM will be passed through to Client by Administrator.

(d) PBM shall be the exclusive specialty provider (in the event Client has elected an exclusive specialty network) and the exclusive mail service provider. Claims for specialty products will not be processed through the retail network, except for those specialty drugs that CVS Caremark Specialty mail pharmacies are unable to dispense. 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.

(e) Rebate guarantees are based upon fully-funded plan designs, that allows for at least 90 days' supply at mail, and claim utilization and Plan design(s) are as represented by Client. Rebate guarantees for mail and retail are measured and reconciled in the aggregate.

(f) Rates for drugs may vary from the above if filled by a pharmacy other than Caremark SpecialtyRx. Certain drugs will be priced separately from, and not be subject to the contracted rate for prescription Claims due to, among other things, specialized manufacturer processes, limited availability or extraordinary shipping requirements. If Client elects Exclusive Specialty, Caremark Specialty Rx will be Client's and the Plan's exclusive in-network provider of specialty medications. All other providers supplying specialty medications will be considered out-of-network providers and may be excluded from any pricing guarantee.

(g) Unless Client is participating in a transparent pricing election, Participating Pharmacy rates may vary and the amount paid by PBM to the Participating Pharmacy may not be equal to the amount billed to Client, and PBM shall retain the difference.

(h) The Participating Pharmacy may collect from the Plan Participant the lowest of the applicable Cost Share, the discounted cost, or the Participating Pharmacy's U&C price.

(i) Guarantees for pricing components are measured and reconciled in the aggregate on a Contract Year basis. Any dollar savings generated in excess of one pricing component may be used to offset a short fall for any other component.

(j) Administrator may exclude the following from any pricing guarantee (i.e., mail, retail and specialty discount, dispensing fee, etc.):

- Specialty Drugs (with the exception of the specialty guarantee);
- Non-Specialty Drug claims with a high-dollar undiscounted AWP value;
- Over the counter (OTC) claims and/or products;
- Limited distribution drugs, exclusive distribution drugs and/or products that enter the market with exclusive and/or supply limitations or restrictions that limit marketplace competition;
- U&C Claims;
- Paper or member submitted Claims;
- 340B Claims and/or products filled through in-house or Client-owned pharmacies;
- Long term care (LTC) pharmacy claims and/or claims that may be subject to ancillary charges;
- Coordination of Benefit (COB) or secondary payor, and/or Subrogation Claims;
- Claims paid at government required amounts;
- Compound drug Claims;
- COVID treatment Claims;
- Vaccines (including COVID), vaccine administration Claims and/or, if covered by the Plan design, in those cases where the purchase price includes both the ingredient cost and the cost to administer the vaccine.

(k) The following exclusions shall apply to the rebate guarantees:

a. 340B Claims;
b. Compound drug Claims;
c. Paper or Member submitted Claims;
d. Coordination of Benefits (COB) or secondary payor, and/or Subrogation Claims;

e. Vaccines (including COVID), vaccine administration Claims and/or, if covered by the Plan design, in those cases where the purchase price includes both the ingredient cost and the cost to administer the vaccine;
f. COVID treatment Claims;
g. Over the Counter (OTC) products, except insulin and diabetic test strips;
h. Claims approved by formulary exception;
i. Limited distribution and exclusive distribution drugs;
j. Any other Claim identified as having received 340B program pricing and, therefore, ineligible for a Rebate.

(l) If Client elects the Retail-90 Network, the CVS/caremark Retail-90 Network provides the flexible option of a nationwide network of retail pharmacies that can fill up to a 90 days' supply of medications. CVS/caremark Retail-90 Network pricing is applicable for non-specialty Claims equal to or greater than an 84 days' supply filled by a participating CVS/caremark Retail-90 Network pharmacy. Claims up to Administrator's qualified retail days' supply plan design limits can be filled at any Participating Pharmacy. Claims greater than Client's qualified retail plan design limits shall only be filled by a CVS/caremark Retail-90 Network pharmacy. Implementation of Maintenance Choice and/or a mandatory plan design may limit the implementation of this offering.

(m) If Client elects the CVS-90 Network, the CVS-90 Network option is available exclusively at CVS/pharmacy retail locations and the associated pricing is applicable for non-specialty Claims equal to or greater than 84 days' supply. Claims greater than Participating Group's qualified retail days' supply plan design limit shall only be filled by a CVS/pharmacy retail location. Implementation of the CVS-90 network may be limited by applicable law.

(n) If Client elects the CVS/caremark Advanced Choice Network, the CVS/caremark Advanced Choice Network is a national managed network that was solicited to balance savings while eliminating network access redundancy and it includes most major chains and independent pharmacies. Implementation of this network requires evaluation of each Client's Claims distribution and plan design to determine eligibility. Implementation of the CVS/caremark Advanced Choice Network requires a minimum 60 days' advance notice and may be limited by applicable law.

(o) If Client elects to implement Caremark's Maintenance Choice program, then following requirements apply. The Maintenance Choice program is only available to clients that have an executed Maintenance Choice letter agreement which outlines programs and pricing options. Administrator has previously executed the Maintenance Choice letter agreement on behalf of its clients, and upon Client's direction, Administrator will include Client in the Maintenance Choice letter agreement. Client acknowledges and agrees that by participating in the Maintenance Choice program, Client may not participate in the Caremark Retail-90 Network program.

(p) If Client elects to implement PBM's generic step therapy plans (hereinafter referred to as the "GSTP Program"), then the following requirements apply. Client acknowledges and agrees that, as a condition of electing to participate in the GSTP Program, Client shall adopt PBM's GSTP Program, as amended from time to time by PBM, as part of its Plan design. Client, by electing the GSTP Program, directs PBM to implement the coverage limitations, generic substitutions, step-therapies or prior authorizations for the therapeutic classes as identified in the PDD. If Client implements the GSTP Program and fails to adopt the GSTP Program conditions or otherwise qualify for the GSTP Program, then PBM reserves the right to modify the financial terms of this Exhibit, including any financial guarantees. Client shall be responsible for amending any applicable Plan documents, as Client deems appropriate, to reflect the GSTP Program as part of its benefit.

(q) If elected, the Advanced Control Formulary ("Advanced Control Formulary") consists of specialty and non-specialty drugs that are excluded from the Formulary. The Advanced Control Formulary also has its own list of preferred drugs. By selecting the Advanced Control Formulary, Client agrees to adopt all therapy classes unless Client does not cover an entire therapy class. If an entire class is not covered by Client, it must be noted on the CPM form but it must still be listed on the Advanced Control Formulary drug lists. Requires that Plan maintain a Plan Participant Cost Share higher for non-preferred/non-

formulary drugs than for preferred/formulary drugs (both specialty and non-specialty drugs; i.e. at least a three tier plan).

(r) The pricing set forth in the pricing table is contingent upon Client's alignment with the standard PBM PDL/formulary strategy, which determines product placement for tiered cost sharing and identifies therapeutic classes with formulary excluded products; this does not apply to the non-aligned formulary.

(s) For compound drugs, PBM applies the NCPDP D.0 standard. For each compound drug, the submitting pharmacy shall provide the following: (a) compound indicator; (b) eleven-digit NDC, quantity, and submitted ingredient cost for each component in the recipe; (c) Total quantity and total U&C price; and (d) level of effort value. PBM shall determine the appropriate ingredient cost, or NDC, for each component using the lower of (1) the AWP discount; (2) MAC; or (3) the submitted ingredient cost. PBM shall apply a level of effort charge to the compound drug in addition to the appropriate dispensing fee.

(t) Caremark Cost Saver™ Program - Overview. Effective January 1, 2024, for those clients that do not opt-out of the Program (as defined below), CVS Caremark may compare the price available under the CVS Caremark contracted network with the price available through a non-CVS Caremark contracted network if available for that pharmacy with its Caremark Cost Saver™ Program (the "Program"). When the Plan Participant presents a prescription for an eligible Covered Product at a Participating Pharmacy that participates in the Program, CVS Caremark may compare the price available under the CVS Caremark contracted network with the price available through a non-CVS Caremark contracted network. If the price for the Covered Product is lower through a non-CVS Caremark contracted network (including an administrative fee paid to the third party that contracts the network), the Claim will be processed through that network (a "Program Claim"). If the price for the Covered Product is lower through the CVS Caremark contracted network, the Claim will process through the CVS Caremark contracted network. The Plan Participant and/or Client will never pay a higher cost for a Program Claim than they would if the Program was not in place. The selection of the lowest cost option shall occur automatically and no enrollment or additional action is required by the Plan Participant(s) beyond presenting their pharmacy benefit identification card. CVS Caremark shall perform all standard utilization review services with respect to Program Claims that it performs for other Claims pursuant to this Agreement. There is no cost for Clients' Plan(s) to participate in the Program and this Program is automatically implemented unless you opt out. Opt out will require ninety (90) days written notice to RxB.

(u) Caremark Cost Saver™ Program – Terms. The scope of the Program applies to Covered retail commonly dispensed, non-specialty, non-rebate eligible generic medications only. The Program does not apply to Brand or Specialty medications and is not available on any mail order. Client acknowledges and agrees that CVS Caremark is not guaranteeing savings for Plan Participants or Client through the Program. If Client participates in CVS Caremark's Maintenance Choice® Program, notwithstanding anything to the contrary elsewhere in the Agreement, Maintenance Choice Prescriptions that process as Program Claims will process at a price that is lower than the price at the CVS Caremark mail service pharmacy. Program Claims constitute discount card program claims and may not be subject to all pharmacy reimbursement price procedures and terms that apply to a CVS Caremark contracted pharmacy network. Generic drug prescription through retail may be less than the same generic drug, dosage form, and dose through mail on the same day of adjudication. Program Claims constitute Claims, as defined in the Agreement, and are included in the reconciliation of all financial guarantees under the Agreement in the same manner and to the same extent as other Claims. For purposes of Claim reporting and reconciliation of financial guarantees, the Program shall allocate a portion of the total Program Claim cost as a dispensing fee, consistent with the maximum dispensing fee guarantees set forth in Exhibit A of this Agreement. The Plan is responsible for complying with all laws and regulations applicable to the Plan, for making any appropriate notifications to Plan Participants concerning the Program and for making any appropriate changes to Plan documents to reflect Client's participation in the Program, if necessary. CVS Caremark reserves the right to modify the Program. CVS Caremark and Administrator reserve the right to terminate Client's participation in the Program without cause and upon sixty (60) days' prior written notice to the Client. Client acknowledges and agrees that additional terms and conditions will apply to the Program which are available upon request.

(v) If this Agreement is terminated prior to the end of a given Contract Year or outside the terms and conditions of the Agreement, or if the applicable Contract Year being reconciled is less than twelve (12) months in length, or if Client does not provide Administrator with notice of its intent to terminate at least ninety (90) days in advance of the expiration of the applicable Contract Year, then Administrator is not required to meet the financial guarantees set forth above. Shortfall payments for financial guarantees, if any, will not be paid until this Agreement, including any applicable Client Application, and any amendment(s) or addendum to this Agreement or Client Application, is signed.

(w) All specialty claims where manufacturer copay assistance dollars are paid shall be included in all financial guarantees.

(x) When remitting and reconciling minimum Rebate guarantees, PBM may add "Rebate Credit" value to the total Rebates remitted to Administrator for each respective Rebate component. As such, Client's quarterly rebate guarantee payments may be reduced by Rebate Credits for the remainder of the term of the Agreement. "Rebate Credits" shall consist of (i) the differential between the Wholesale Acquisition Cost (WAC) of a lower net cost Brand Covered Product, including but not limited to a Biosimilar ("Low Cost Brand"), Claim processed and the WAC of the reference Brand Drug, subject to the below cap; and/or (ii) the value of price reductions for rebateable products that have experienced a WAC decrease, measured as the differential between the Baseline WAC of the product and the WAC of the product when the Claim is processed, subject to the below cap. The "Baseline WAC" will be the WAC of the product prior to a reduction in WAC or, as applicable, for Low Cost Brands, the Baseline WAC will be the WAC of the reference Brand Drug at the time of Claim processing.

- In no way will the Rebate Credit exceed the Baseline Rebate less the earned Rebates on either the Low Cost Brand or the rebateable product that has experienced a WAC decrease. "Baseline Rebate" is calculated as follows: in the year the price reduction occurred, Baseline Rebate will be the Rebate available for coverage of the product prior to the WAC reduction or, as applicable, for Low Cost Brands the Baseline Rebate will be the Rebate available for coverage of the reference Brand Drug on the date of claim processing. For a product experiencing a WAC reduction, in subsequent years the Baseline Rebate will increase over the prior year Baseline Rebate at the WAC inflation rate of the GPI subclass (GPI-6) of the applicable product.

(y) The pricing in this Addendum does not reflect any anticipated impacts from the Inflation Reduction Act (IRA) or the American Rescue Plan Act or change in formulary status of any preferred biologic drug such as Humira (adalimumab) and Stelara (ustekinumab), through removal of preferred status or addition of preferred biosimilars. For example, rebate guarantees have not been adjusted to incorporate lower list prices for insulin products or other drugs. As such, Client's quarterly rebate guarantee payments may be reduced for the remainder of the term of the Agreement.

2. CLINICAL SERVICES AND PROGRAMS. As consideration for the clinical services and programs selected by Client as described in this Agreement, Client shall pay to Administrator the fees set forth below:

2.1 Core Clinical Services and Programs:

Core Clinical Services and Programs		**Cost**
Formulary Management (as described in Section 5.3 of this Exhibit A)		No Charge
Safety Programs		
	POS Safety Review	No Charge
	Retrospective Safety Review	No Charge
Savings Programs		
	Comprehensive Generics Solutions	No Charge
	POS Utilization Management	No Charge

	POS Preferred Product Messaging	No Charge
	Physician Profiling Report	No Charge
Health Programs		
	Adherence to Drug Therapy	No Charge
	Gaps in Care Pharmacy	No Charge
	Face-to-Face Physician Consultation	No Charge
Audit Programs		
	Pharmacy Audit Programs	20% of recovered amounts

2.2 Enhanced Clinical Programs and Services:

Enhanced Clinical Programs and Services		**Guaranteed Return on Investment ("ROI")**
Safety Programs		
Prescription Safety Management/Integrated Fraud, Waste & Abuse	Charges passed through by PBM (If Elected)	N/A
Savings Programs		
Prior Authorization	$30.00 per prior authorization (including formulary exception requests) In instances where a state regulation requires denial oversight by a physician, the charges for prior authorization requests are as follows: 1. Internal CVS Caremark Physician: $45 per request 2. External Physician: $55 per request **OR** No Charge *if client elects HDCR** **If Client has elected the Advanced Control Formulary, the $30.00 fee for formulary exception requests will apply even if Client has elected HDCR.*	N/A
Appeals	1st Level Appeals: $100.00 per review 2nd Level Appeals: $500.00 per review Urgent 1st Level Appeals with an IRO: $600.00 per review **OR** No Charge *if client elects HDCR**	N/A

	External Review	$500 per IRO external review requested **OR** No Charge *if client elects HDCR**	N/A
	Specialty Guideline Management (Specialty)	$30.00 per review (Open Specialty) No additional charge (Exclusive Specialty)	N/A
	Drug Savings Review	$0.30 per Retail Claim	N/A
	SpecialtyRx Cost Control	$1.35 PMPM (If Elected)	N/A
	Medicare Part D – Retiree Drug Subsidy (RDS)		
	Core Administrative Service Package	$0.20 PMPM for Covered Retirees with a minimum annual fee of $1,000.00	
	<u>Optional Additional Services:</u> Letter of Creditable or Non-creditable Coverage Supplemental Customized Reporting Eligibility Submission and Reconciliation Submission of RDS Drug Cost Files/Drug Cost Report Upload and Reconciliation	 $1.25 per mailing Mailing one (1) letter of creditable coverage to each beneficiary once per year, or as required by CMS (includes postage) $100.00 per hour Any customization to alter CMS-ready standard reporting $0.20 PMPM for Covered Retirees Submission and processing of retiree response files returned from CMS related to the direct submission to CMS of the initial and ongoing retiree files to CMS $0.30 PMPM for Covered Retirees Upload and processing of response records returned from CMS related to the submission of the CMS aggregate drug costs	

Enhanced Clinical Programs and Services Managing Good Trend	Fee
I. Pharmacy Advisor Counseling at CVS/pharmacy Condition specific messaging plus: • Face-to-face interventions and messaging at CVS/pharmacy • Inbound pharmacist phone support for Plan Participants who utilize mail and other Participating Pharmacies	$0.25 PMPM (If Elected)
II. Pharmacy Advisor Counseling All Channels Condition specific messaging plus: • Face-to-face interventions and messaging at CVS/pharmacy • Outbound and inbound pharmacist phone support for Plan Participants who utilize mail and other Participating Pharmacies	$0.60 PMPM (If Elected)
III. Condition Alerts (Health Advisor/Medical Cost Avoidance)	Complete: $0.45 PMPM (If Elected)
Client may terminate the Pharmacy Advisor program by providing PBM at least 60-days prior written notice.	

RxDC Reporting (Submission of P2, D3-D8, and Narrative Response file via HIOS, and any other files deemed necessary)	Charges passed through from PBM
Paper Submitted Claim (per processed Claim)	$1.50
Card Re-issuance (including ExtraCare Card Re-issuance)	Charges passed through from PBM
Manual Eligibility Submission	$1.00/Manual Entry
Client Specific Programming	$150.00/Hour
Third Party Integration Fees	Charges passed through from provider or mutually agreed upon by Parties
Member Communications / Mailings from PBM	Passed Through from the PBM
Point Solutions Management, e.g., Progyny (Terms and Conditions available upon Request)	Charges passed through from PBM (If Elected)

NOTES:

- For those programs that have a shared savings component over the targeted savings, Client will receive the full savings amount. Any overachievement of guaranteed savings related to any clinical program will be applied to any underachievement of guaranteed savings.
- PBM and Administrator reserve the right to adjust any ROI in Section 2.2 above if the total number of Plan Participants changes by 20% or more or if Client implements certain Plan design or other program changes as designated by PBM (including, but not limited to, Maintenance Choice, the GSTP and prior authorization).

2.3 Additional and Certain Optional Programs.

2.3.1 Debit Card Program. Client hereby authorizes and directs Administrator and/or its designee to disclose data, upon the request of Client, to a third party vendor for the purposes of administering debit card program payments under a flexible spending account or other consumer directed health plan subject to and expressly conditioned upon such third party's execution of Administrator's form confidentiality agreement. Administrator or its designee may provide such data, as requested by the third party for this purpose, until such time as Client advises Administrator otherwise in writing.

2.3.2 Maintenance Choice Program.

Voluntary Maintenance Choice. The voluntary Maintenance Choice® program combines CVS/caremark's mail and CVS/pharmacy's retail capabilities to provide members improved choice in how they access and receive maintenance medications (e.g., 84-90-day supplies). This voluntary Program allows Plan Participants to: (i) receive prescriptions from all participating retail pharmacies for 30-day maintenance medications; and (ii) receive 90-day prescriptions of Maintenance Choice prescriptions from CVS/pharmacy retail locations and CVS/caremark mail service. All 30-day maintenance medications dispensed by participating retail pharmacies will be charged in accordance with the retail rates set forth in the Agreement. If Client participates in the voluntary Maintenance Choice program, Client may not participate in the CVS/caremark Retail-90 Network program. Implementation of Maintenance Choice may be limited by applicable law and/or implementation of narrow network options. Maintenance Choice Prescriptions will be treated the same as prescriptions filled at PBM's mail service pharmacies for purposes of any mail pricing guarantees and generic dispensing rate guarantees set forth in the Agreement. Maintenance Choice prescriptions will be disregarded and therefore excluded for purposes of calculating all mail service pharmacy non-financial performance guarantees set forth in the Agreement.

Adoption of this program requires that the Plan implement a Plan design that (i) requires the Cost Share for a Maintenance Choice Prescription to be the same or similar as the Cost Share for the same days' supply at mail to provide an incentive for Plan Participants to move to a 90-day supply, (ii) allows PBM to communicate with Plan Participants regarding the benefits of moving to a 90-day supply consistent with the Plan design; and (iii) limits the ability of Plan Participants to receive 90-day supplies to CVS/Pharmacy retail locations and CVS/caremark mail service only.

Maintenance Choice All Access. CVS/caremark's Maintenance Choice® All Access program combines CVS/caremark's mail and CVS Pharmacy's retail capabilities to provide Plan Participants improved choice in how they access and receive maintenance medications (e.g., 84-90-day supplies) under mandatory plan designs. Maintenance Choice All Access provides Plan Participants with the added benefit of prescription delivery from a local CVS Retail pharmacy at a reduced rate for Plan Participants. Client will receive a program credit from PBM which will be applied to reduce the delivery fee charged. It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, the program credit shall constitute and shall be treated by Clients as discounts against the price of drugs within the meaning of 42 U.S.C.§1320a-7b(b)(3)(A).

Maintenance Choice All Access Opt-Out. If Client chooses the Maintenance Choice® All Access Opt-Out Program, the Plan Participants may "opt out" of the Maintenance Choice All Access Program by calling CVS's Customer Care Center. Upon opting out, Plan Participants can continue to fill their 30-day maintenance medication prescriptions at a retail pharmacy of their choice. The prescriptions that are dispensed pursuant to the opt-out request: (i) are excluded from the Maintenance Choice pricing; and (ii) are subject to the retail network pricing set forth above.

2.3.3 Prior Authorization and Appeals. As consideration for the services selected by Client and administered by Administrator in accordance with this Agreement, Client will pay to Administrator the fees set forth below:

(a) Prior Authorization: $30 per prior authorization
(b) Appeals: $100 per 1st level review and $500 per 2nd level appeal

(c) Appeals shall be conducted in accordance with the following terms and conditions:

(1) Prior to PBM processing appeals for Client, Client shall represent in writing whether the Plan **is** or **is not** governed by ERISA.

(2) If the Plan **is not** governed by ERISA:

(A) Client represents and warrants to PBM that the Appeals Program, as defined in sub-section 4 of this Section 2.3.3(c), satisfies any and all laws applicable to the Plan with respect to appeals from denials of Claims for prescription drug benefits. Client shall promptly notify PBM in writing in the event a change in law causes the Appeals Program to be in non-compliance with applicable laws. Upon such notice, PBM shall have the option of revising its Appeals Program to be in compliance with such change in law or terminating the Appeals Program.

(B) PBM may from time to time modify the Appeals Program. In the event of any such modification, PBM shall provide (or cause Administrator to provide) Client with written notice of such modification at least thirty (30) days prior to implementation of such modification. If Client determines that any such modification would cause the Appeals Program to be in non-compliance with applicable laws, Client shall so notify PBM prior to the end of the thirty (30) day period. PBM shall then have the option of further modifying its Appeals Program to be in compliance with applicable laws or terminating the Appeals Program. If Client does not so notify PBM, then PBM shall implement the modification and shall continue to rely on the representation and warranty set forth in sub-paragraph (A) immediately above.

(3) Client (or Administrator on Client's behalf and request) shall provide PBM with a current and accurate copy of the Plan Document, as defined herein. The "Plan Document" shall be the written document (as required by ERISA, if the Plan is governed by ERISA), which sets forth the Plan design and all other information concerning Client's prescription drug benefit plan including, but not limited to, eligibility for such benefits, the benefits to be provided, limitations on such benefits and the Plan's claims and review procedures. Client (either directly or through Administrator), at Client's expense, will provide PBM with sufficient advance notice of any proposed amendments to the Plan Document.

(4) PBM will provide Client with the appeals program described in Sections 4(A) and 4(B) below ("Appeals Program").

(A) Review of Benefit Coverage. PBM shall conduct appeals relating to eligibility and coverage of prescription drug benefit determinations. Such reviews will be based on the Plan Document provisions and criteria approved by the Plan, with respect to coverage of prescription drug benefits only, and shall not include a review of medical necessity as may be defined under the terms of the Plan Document. With respect to such review of benefit coverage, PBM shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of PBM shall be final, subject to External Review under sub-section 5 of this Section 2.3.3(c), if applicable to Client, or available judicial review. PBM may, in its sole discretion, consider the opinions of additional medical and/or legal experts with respect to interpretation of the Plan Document. Under the Appeals Program, PBM agrees to be a fiduciary solely for the purpose of adjudicating appeals relating to the coverage of prescription drug benefits. PBM will review appeals in accordance with the rules and procedures established by PBM to govern appeals from the denials of Claims, as may be amended from time to time.

(B) Review of Medical Necessity. PBM has contracted with an independent vendor or vendors for the processing of appeals resulting from a denial of authorization of prescription benefits where the Plan beneficiary is entitled to obtain a review of the denial by an independent physician specialist. PBM has entered or will enter into an agreement with the independent vendor(s), which provides for an appeals process consistent with the Appeals Program. With respect to such reviews, the independent vendor shall act as a fiduciary and shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of the

independent vendor shall be final, subject to judicial review only for abuse of discretion.

(5) *External Review*. This sub-section of this Section 2.3.3(c) shall apply only if Client has elected to receive "Independent (External) Appeals Review" in the PDD ("External Review"). PBM has contracted with independent review organizations ("IROs") to provide External Review of benefit determination that are subject to External Review under PPACA. The decision of the independent review organization shall be final and binding on the Plan and Plan Participant, subject only to any judicial review. Either party may terminate at any time the External Review services provided under this Exhibit by providing the other parties with sixty (60) days' prior written notice. The External Review services described in this sub-section 5 will be available to Client on and after the Effective Date of this Agreement.

(6) As consideration for the services provided hereunder, Client shall pay to Administrator (and then Administrator shall pay to PBM) the fees set forth in this Agreement (including this Exhibit A). Payment shall be due in accordance with Article IV of the Agreement.

2.4 Per Diems.

(a) Per Diems for drugs administered:
- (i) Remodulin, Veletri, Flolan, Epoprostenol Sodium & Treprostinil Sodium for Injection: $60 per day.
- (ii) Ventavis: Client acknowledges and agrees an I-Neb is necessary for the administration of Ventavis. For each I-Neb provided to Plan Participant, upon the initiation of therapy or in the event a replacement I-Neb is necessary, Client shall be billed $1,811.
- (iii) Unless otherwise stated above: $75 per dose for drugs administered.

(b) Nursing Charges: $225.00 per visit up to 2 hours, $110.00 for each hour thereafter. Alternatively, PBM can refer any medically necessary nursing services to Client's contracted nursing agency, in which case nursing services will be billed separately by those agencies.

(c) In further consideration of the fees and charges to be paid under this Agreement, PBM will bill any applicable per diems to the Plan Participant's medical benefit. In the event it is not possible to bill such per diems to the Plan Participant's medical benefit or it is determined there is no coverage for such drugs, PBM shall bill Client (through Administrator) for any per diem associated with Specialty Drugs.

(d) Routine ancillary supplies (e.g., syringes, alcohol swabs, cotton balls) are included in the specialty drug prices set forth in PBM's Specialty Fee Schedule, unless otherwise indicated on PBM's Specialty Fee Schedule as being charged separately as part of an equipment fee or per diem.

2.5 Vaccines. PBM makes available a vaccine program pursuant to which PBM shall arrange for the provision of certain vaccination services through participating retail pharmacies. Client will work with Administrator to enroll in the vaccine program if desired. If elected by Client, PBM shall provide vaccine administration services in accordance with such elections. Vaccines administered by Participating Pharmacies shall be adjudicated using the same AWP discount and dispensing fee as would a standard 30-day supply Brand Drug Claim, plus an administration fee of $20.00. In the event of a change in the administration fee set forth in the preceding sentence, PBM shall provide Client written notification of such change at least thirty (30) days prior to the effective date of the change and Client shall have fifteen (15) days from receipt of such notification to make any changes in its vaccine program elections, including terminating its participation in the vaccine program, which changes, if any, shall be made by written notification to PBM. If Client does not elect to change its vaccine program elections, the charges in PBM's notification to Client shall apply to any vaccinations administered to Members on and after the effective date set forth in PBM's notification. Caremark Retail-90, CVS-90, Maintenance Choice and other 90-day network pricing terms, if any, do not

apply to vaccines. Client may, upon at least thirty (30) days' prior written notice to PBM, terminate participation in the vaccine program at any time. Vaccinations provided pursuant to the Program will be excluded from the calculation of any and all financial and performance guarantees. A Terms and Conditions document for the vaccine program is available upon request.

2.6 Generic Drug Substitution Program.

(a) Generic substitution may be conducted through PBM's mail service pharmacies and Participating Pharmacies under a program which substitutes Brand Drugs with Generic Drugs, where available and clinically appropriate, unless (i) the Prescriber requires the prescription to be dispensed as written and does not authorize generic substitution; or (ii) the Plan Participant has notified the dispensing pharmacy to dispense the Brand Drug only.

(b) PBM will provide generic messaging to Participating Pharmacies, which is intended to promote point-of-sale generic substitution of multi-source Brand Drugs. Client acknowledges that a pharmacist may override such messaging if the Prescriber or the Plan Participant has notified the dispensing Participating Pharmacy to dispense the Brand Drug only.

2.7 Drug Utilization Review Services ("DUR Services").

(a) PBM will provide its automated concurrent DUR Services including, but not limited to: (i) drug to drug interactions; (ii) therapeutic duplications; (iii) over-utilization; (iv) insufficient or excessive drug usage; and (v) early or late refills.

(b) Providers are individually responsible for acting or not acting upon information generated and transmitted through the DUR Services, and for performing services in each jurisdiction consistent with the scope of their licenses. The DUR Services are necessarily limited by the amount, type and accuracy of Plan Participant information made available to PBM.

2.8 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.

2.9 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 the 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 the PBM to Client.

3. CLINICAL PROGRAMS.

PBM shall provide the clinical programs identified in this Exhibit A as such are elected by Client.

3.1 Administrator Clinical Programs.

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

- If elected, Administrator's **High Dollar Claim Review, Prior Authorization and Appeals program ("HDCR")**, will provide Client with umbrella protection against high-cost prescription claims for approved formulary drugs. Prescription claims over the threshold dollar amount are flagged prior to payment and reviewed for clinical appropriateness. This additional level of clinical oversight protects against unnecessary spending, saving Client 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. Administrator's **Therapeutic Interchange for High-Cost Specialty Medications ("HTI")** identifies and promotes lower cost, clinically effective alternatives for anti-inflammatory and dermatological drugs.
    - 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 the Prescriber 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;
        - If denied, the appeal process is available.
    - If HDCR is elected, Administrator will also manage all other prior authorizations and appeals.
        - 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;
        - If denied, the appeal process is available.
    - The appeal process:
        - If an initial review is denied, the Plan Participant may appeal the decision to have a different pharmacist reviewer evaluate the prior authorization.
        - If the denial is upheld upon first appeal, a second appeal may be made, which is completed in consultation with a peer physician reviewer from an Independent Review Organization.
        - If the denial is again upheld upon second appeal, a final appeal for a Federal External Review completed by an Independent Review Organization may be made.
        - If the denial is upheld by the final review, the appeal process has been exhausted and the decision is final and binding.

- **Foundational Utilization Management ("UM")**. UM is a bundling of evidence-based clinical programs commonly used to provide appropriate clinical oversight of prescription drug claims. UM ensures the correct clinical evaluation processes are in place. Appropriate quantity limit ("QL") promotes FDA-approved dispensing guidelines by ensuring appropriate quantities are 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 UM program promoted by Administrator. NOTE: Client must have elected HDCR component to elect this 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.

3.2 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").

    - For Clients with one thousand (1,000) Plan Participants or more, the Protect ROI Guarantee shall be 2:1. This means that following Client's Contract Year, if necessary, Administrator's Protect Guarantee Payment will consist of reimbursing Client for Protect Fees in an amount such that the ratio of Client's Protect Savings to Client's net Protect Fees is 2:1. Notwithstanding the foregoing, in no event will Administrator reimburse Client in an amount greater than the Protect Fees paid by Client during the applicable Contract Year. For purposes of calculating Plan Participant count, Administrator shall, on a monthly basis, calculate how many Plan Participants are active during the given month. At the end of the Contract Year, Administrator shall take the sum total of each month and divide it by the number of months in the Contract Year. If the average Plan Participant count over the course of the Contract Year is 1,000 Plan Participants or greater, the Protect ROI Guarantee shall be 2:1. At no point during the Contract Year can the monthly Plan Participant count fall below 900 Plan Participants; in the event that it does, the Protect ROI Guarantee for the Contract Year shall revert to 1:1 (as described in the immediately preceding paragraph).

- **Conditions.**

    - Client's entire population must be enrolled in the Protect Solutions for Client to be eligible for the Protect ROI Guarantee. If any portion of Client's population is not enrolled in the Protect Solutions for the entire applicable Contract Year, the Protect ROI Guarantee will not be applicable to Client. Administrator reserves the right not to honor the Protect ROI Guarantee if Client makes overrides from the Protect Program Claims reviews/appeals.

- **Eligibility**. To be eligible for the Protect ROI Guarantee, Administrator's LCV and HDCR programs (including PA, HTI, and CCI) must be elected and Administrator (or a vendor designated by Administrator) must be the PA reviewer for all PA requests.

- **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 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 applicable Contract Year – and such Contract Year must be at least twelve (12) months in length – to be eligible for the Protect ROI Guarantee. If this Agreement is terminated prior to the end of a given Contract Year, or if Client does not provide Administrator with notice of its intent to terminate the Agreement at least ninety (90) days in advance of the expiration of the applicable Contract Year, or if the Agreement is terminated in breach of the terms of the Agreement, 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.

3.3 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 members' cost-share but does not apply to their deductible and out-of-pocket maximum, yielding high savings potential, or Therapeutic Interchange Programs where the

specialty pharmacy will move members to preferred agents in order to allow the usage of copay assistance funds from manufacturers. Requires exclusive specialty pharmacy relationship. These Manufacturer Assistance Programs for Specialty Medications can occur under Component 1 and/or 2 with CVS.

- If elected, Client may implement PBM's PrudentRx program to enroll its Plan Participants in the PrudentRx Manufacturer Copay Assistance Program. Additional terms and conditions will apply and will be detailed in a separate written agreement.
- If elected, PBM's **SpecialtyRx Cost Control ("SRCC")** program can help Client control costs related to the Plan's Specialty Drug spend. Implementation of SRCC requires that Client elect various other programs offered by Administrator and PBM. A Terms and Conditions document for SRCC is available upon request.
- Client may elect for PBM to perform services or programs (collectively referred to herein as "Additional Health-Related Services") that include Prescriber education programs, health research, compliance and persistency, and health education or management programs for Plan Participants. If elected by Client, PBM shall provide such Additional Health-Related Services in accordance with applicable law, including HIPAA. Client acknowledges and agrees that: (i) although the Additional Health-Related Services may be of benefit to Client and the Plan Participants, PBM will not charge Client or the Plan Participants for the performance of such Additional Health-Related Services; (ii) the performance of such Additional Health-Related Services may utilize PHI; (iii) the performance and scope of such Additional Health-Related Services shall be determined by PBM, and PBM shall have no obligation to perform Additional Health-Related Services; and (iv) PBM may contract with, and pursue and retain for its own account compensation or fees received from, pharmaceutical companies for the funding and provision of such Additional Health-Related Services. Client may discontinue one (1) or more Additional Health-Related Services upon sixty (60) days' prior written notice to PBM.

4. ADMINISTRATIVE CREDITS. This Section 4 of Exhibit A sets forth various Rebates and credits to be paid by PBM to Administrator (collectively "Administrative Credits"), as identified in Section 4 of this Exhibit A. It is the intention of the Parties that, for purposes of the Federal Anti-Kickback Statute, these Administrative Credits shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. § 1320a-7b(b)(3)(A).

4.1 Drug Rebates. Administrator shall remit to Client the Rebates as set forth in the table in Section 1 of this Exhibit A ("Client Rebates") to the extent such Rebates are actually received by Administrator during the Term. No Rebate shall be credited for any generic Claim, whether such Claim is filled with a Generic Drug or by a Brand Drug dispensed in lieu of a Generic Drug at the Generic Drug reimbursement rate. Subject to the foregoing: (1) Administrator will receive from PBM the quarterly Rebate payment within approximately one hundred twenty (120) days following the end of a quarter for Rebates received during such quarter; and (2) upon receipt, Administrator will credit Client's account. PBM or Administrator may adjust the Client Rebates payments in an equitable manner if: (i) a generic version of a branded product is unexpectedly introduced in the market; or (ii) a branded product is recalled or withdrawn from the market.

4.2 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's design features, 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 a 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. Administrator shall only be responsible for the payment of Rebates to Client pursuant to the terms of this Agreement to the extent such Rebates are actually received by Administrator during the Term of this Agreement. In no event shall Administrator be obligated to pay Rebates to Client until Administrator receives payment for the same Rebates from PBM. In the event Client terminates the Agreement outside the terms and conditions in the Agreement, or if Client terminates this Agreement before the end of the applicable Contract Year, or if Client does not provide Administrator with notice of its intent to terminate at least ninety (90) days in advance of the end of the applicable Contract Year, Client forfeits the right to receive any Rebates received by Administrator on Client's behalf after the date of such termination. Client acknowledges that Administrator shall not be obligated to pay Client any Rebates described herein until the Agreement, including any applicable Client Application, and any amendment(s) or addendum to this Agreement or Client Application, is signed by Client. PBM and Administrator will have the right to apply Client's allocated Rebate amount to unpaid Fees.

5. MISCELLANEOUS.

5.1 Plan Participant 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 Plan Participant Cost Share described above in this Exhibit A. Administrator will refund any amount submitted by a Plan Participant in excess of the Plan Participant's applicable Plan Participant Cost Share. In the event a Plan Participant submits an insufficient Plan Participant Cost Share and the Plan Participant fails to remit the balance of the Plan Participant 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 Plan Participant Cost Share(s). Client shall, in turn, have the right to recover uncollected Plan Participant Cost Shares from its Plan Participants at Client's determination. Shipping of prescriptions submitted without the appropriate Plan Participant Cost Share may be delayed.

5.2 Drug Classification and Pricing; AWP. With respect to drug classification and pricing, the Parties acknowledge and understand that (i) PBM will use indicators of Medi-Span Master Drug Database (Medi-Span), and their associated files, as updated regularly by Medi-Span, or another nationally available reporting service of pharmaceutical drug information in determining the classification of drugs (e.g., legend vs. over-the-counter, brand vs. generic, multi-source vs. single-source) for purposes of this Agreement; (ii) PBM is entitled to rely on Medi-Span or any other nationally available reporting service of pharmaceutical prices selected by PBM to determine AWP for purposes of establishing pricing provided under this Agreement; and (iii) PBM does not establish AWP. Client further acknowledges that (w) Administrator does not establish drug classifications; (x) Administrator does not establish AWP; (y) neither PBM nor Administrator shall have any liability to Client or the Plan Participants arising from the use of Medi-Span or any other nationally available reporting service; and (z) if the reporting source for determining AWP, relating to Administrator and Client should not continue to support AWP, Administrator and Client will cooperate with PBM to negotiate pricing hereunder to maintain the parties' respective economic position under this Agreement and otherwise as of the Addendum Effective Date.

5.3 Formulary Management.

5.3.1 The Parties acknowledge that Client shall adopt as part of Client's Plan design and as its formulary, the PDL and Prescribing Guide. Changes made by PBM to the PDL or the Prescribing Guide may be based upon, among other things, new products, customer safety, clinical appropriateness, efficacy, cost effectiveness, changes in availability of products, new clinical information and other considerations, changes in the pharmaceutical industry, introduction of generics, new legislation and regulations.

5.3.2 PBM may implement Drug Interchange program(s) which has/have been approved by PBM's pharmacy and therapeutics committee for selected prescriptions under which PBM's mail service

pharmacy shall contact Prescribers, as appropriate, to obtain approval for the Drug Interchange. In accordance with PBM's standard policies, PBM shall credit Administrator or Plan Participant, as appropriate, for any mail prescription returned to PBM upon rejection by the Plan Participant of the Drug Interchange. Client acknowledges that the adoption of therapeutic interventions may result in an increase of Rebates payable by pharmaceutical manufacturers pursuant to their agreements with PBM.

5.3.3 Client acknowledges the Prescriber shall have final authority over the drug prescribed to a Plan Participant, regardless of benefit coverage.

5.3.4 PBM may implement Drug Interchange programs, as approved by its pharmacy and therapeutics committee, for Participating Pharmacies to promote the use of the PDL or Prescribing Guide by encouraging Participating Pharmacies to: (i) identify appropriate opportunities for converting a prescription from a non-PDL or Prescribing Guide drug to a clinically comparable drug on the PDL or Prescribing Guide; and (ii) contact the Plan Participant and the Prescriber to request that the prescription be changed to a clinically comparable drug on the PDL or Prescribing Guide. Participating Pharmacies may be compensated by PBM for the services they provide in connection with Drug Interchange programs.

5.4 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:

5.4.1 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.

5.4.2 Implementation or addition of a high deductible health plan/consumer-driven health plan option;

5.4.3 Implementation or addition of a 100% Plan Participant paid plan;

5.4.4 A change in the coverage of Medicare eligible Plan Participants, irrespective of the resulting change in total number of Plan Participants;

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

5.4.6 A change in PBM's PDL or the Prescribing Guide or Administrator's alignment with such PDL or Prescribing Guide. In any event, Administrator will use commercially reasonable efforts to provide Client with thirty (30) days' notice prior to addition or removal of a drug from the PDL or the 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.

5.4.7 Termination of Administrator's contractual arrangement with PBM.

5.5 Provision of Information. Client acknowledges that Administrator shall not be held responsible for any obligation if Client, or Client's designee (including, without limitation, any Plan Participant), fails to provide Administrator with accurate, timely and complete information as needed to meet such obligation.

D. DEFINITIONS

Effective as of the Addendum Effective Date, the terms "Covered Drug" and "Covered Product" shall be used interchangeably throughout the definitions found in Article I of the Agreement.

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

IN WITNESS WHEREOF, Client has caused this 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 agreed to and accepted by Administrator's authorized representative.

CLIENT:

County of Sonoma

By: _____

Printed Name: _____

Its: _____

Acknowledged, agreed to and accepted by:

ADMINISTRATOR:

RxBenefits, Inc.

By: _____

Printed Name: Lauren Simmons

Its: Vice President of Compliance & Legal Affairs

EXHIBIT B
BUSINESS ASSOCIATE AGREEMENT

THIS BUSINESS ASSOCIATE AGREEMENT (this "Agreement"), by and between **County of Sonoma's Health Plan** (the "Plan") and **County of Sonoma** (the "Company") (the Plan and the Company are collectively referred to herein as the "Company"), and **RxBenefits, Inc.**, on behalf of itself and its subsidiaries (the "Business Associate"), is effective as of **September 1, 2024**.

RECITALS

WHEREAS, due to the services (the "Services") performed by the Business Associate with respect to the Plan, Protected Health Information ("PHI") and Electronic Protected Health Information subject to the Privacy Regulations and the Security Regulations, promulgated by the United States Department of Health and Human Services ("HHS") under the Health Insurance Portability and Accountability Act of 1996 (the "Regulations"), may be transmitted, created, received, and/or maintained; and

WHEREAS, to the extent required by the Regulations, the Business Associate and the Company desire to comply with the "Business Associate" requirements of the Regulations and to memorialize their agreements with respect to such compliance.

AGREEMENT

NOW, THEREFORE, for and in consideration of the mutual covenants and conditions set forth herein, and other good and valuable consideration, the receipt and adequacy of which hereby are acknowledged, the Business Associate and the Company agree as follows:

1. Definitions. Unless otherwise defined herein, capitalized terms shall have the same meanings as set forth in the Regulations.

2. Restrictions on Use and Disclosure of PHI. The Business Associate may Use PHI only to perform the permitted and required Uses and Disclosures as provided by this Agreement or as Required By Law. The Business Associate shall make reasonable efforts to limit PHI that is subject to this Agreement to the minimum amount that is necessary to accomplish the intended purpose of a required or permitted Use or Disclosure under this Agreement. To the extent practicable, Business Associate agrees that each use, disclose, or request of PHI shall be limited to PHI in a limited data set, as that term is defined at 45 C.F.R. § 164.514(e)(2). The Business Associate shall not Use or Disclose PHI received from the Company or any participant in the Plan in any manner that would constitute a violation of the Regulations if the Company made the same Use or Disclosure, except that the Business Associate may Use or Disclose such PHI for the Business Associate's proper management and administration and legal responsibilities.

The Business Associate may Disclose PHI for the purposes described in this Section 2 only in the following circumstances: such Disclosure is Required By Law; or the Business Associate 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 purpose for which it was Disclosed to the person, and the person agrees to notify the Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

3. Agents and Subcontractors Bound by Agreement. If any agent or subcontractor of the Business Associate (other than the Business Associate's Workforce) will have access to PHI that is received from, or created or received by the Business Associate on behalf of the Company, then the Business Associate will enter into an agreement with such agent or subcontractor whereby the agent or subcontractor agrees to be bound by the terms of this Agreement with respect to PHI.

4. Safeguards for Protection of PHI; Report of Unauthorized Use or Disclosure. The Business Associate agrees that it will implement and use appropriate safeguards to prevent any Use or Disclosure of PHI in violation of this Agreement. The Business Associate agrees that it will report to the Company any Use or Disclosure

of PHI, of which the Business Associate becomes aware, that is in violation of this Agreement, including breaches of unsecured PHI as required at 45 C.F.R. § 164.410 and any security incident of which it becomes aware. The Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a Use or Disclosure of PHI by the Business Associate in violation of this Agreement.

5. Cooperation by the Business Associate. The Business Associate agrees to cooperate with the Company in providing an accounting of Disclosures of PHI received under this Agreement as requested by an individual to whom it relates, except to the extent the Regulations provide otherwise. In the event that Business Associate uses or maintains an electronic health record, Business Associate agrees that such accounting shall include disclosures made to carry out treatment, payment, and health care operations through the use of such electronic health record. Upon receiving a request for an accounting of disclosures directly from an individual who has received an accounting of disclosures from Company, which provided a list of all business associates acting on behalf of the Plan, including Business Associate, Business Associate agrees to provide an accounting of its disclosures of PHI to such individual as required by the Privacy Regulations. In response to such a request from an individual, Business Associate may elect to provide either (i) an accounting of disclosures that includes disclosures of subcontractors and/or agents acting on behalf of Business Associate or (ii) an accounting of disclosures that are made by the Business Associate as well as a list of all subcontractors and/or agents acting on behalf of Business Associate, including contact information such as mailing address, phone, and email address. The Business Associate shall respond to requests from the Company for the information described in this Section 5 and make available such information to the Company within a reasonable period of time to enable the Company to timely respond to any request.

The Company agrees that the Business Associate will not maintain any Designated Record Sets on its behalf and that the Business Associate assumes no responsibility to respond to individuals' requests for access or amendments as provided in Sections 164.524 and 164.526 of the Regulations.

Business Associate agrees that the requirements of the Privacy Regulations shall be applicable to Business Associate in the performance of its obligations pursuant to the Agreement.

Business Associate agrees that it shall not directly or indirectly receive remuneration in exchange for any PHI, unless a valid authorization, as that term is defined at 45 C.F.R. § 164.508, is obtained or the purpose of the exchange meets one of the exceptions set forth in 45 C.F.R. 164.502(a)(5)(ii).

6. Documenting Disclosures. In order to cooperate with the Company in accordance with Section 5 above, the Business Associate agrees to document all Disclosures of PHI and information related to such Disclosures as would be required for the Company to respond to an individual's request for an accounting of Disclosures of PHI under Section 164.528 of the Regulations. Such documentation shall include: (a) the date of the Disclosure; (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a brief description of the PHI Disclosed; and (d) a brief statement of the purpose of the Disclosure (which would reasonably inform an individual of the basis for the Disclosure).

7. HHS. The Business Associate agrees to make its internal practices, books and records relating to the Use and Disclosure of PHI received from or created or received by the Business Associate on behalf of the Company available to the Secretary of HHS for purposes of determining the Company's compliance with the Regulations. Notwithstanding this Section 7, no attorney-client privilege or other privilege shall be deemed waived by the Company or the Business Associate.

8. Termination. Company and Business Associate shall each have the right to immediately terminate this agreement upon the violation by the other of a material term of this Agreement or of the Regulations, including violations relating specifically to the permitted and required Uses and Disclosures of PHI by the Company or Business Associate; provided, however, that the breaching party shall be provided the opportunity to cure the breach to the satisfaction of the other within a reasonable period of time. If the breaching-party does not cure the default, the non-breaching party shall be entitled to terminate this Agreement or if it is not feasible to terminate this Agreement, report the problem to the Secretary of HHS.

Upon termination of this Agreement, the Business Associate and the Company agree to determine whether the return or destruction of PHI received from, or created or received by, the Business Associate under this Agreement

is feasible. If such return or destruction is mutually determined to be feasible, the Business Associate shall promptly return or destroy all such PHI received from or created or received by the Business Associate under this Agreement. If such return or destruction is mutually determined to not be feasible, the protections of this Agreement shall continue to apply to such PHI after termination (including the Business Associate's obligations in Section 5), and further Uses and Disclosures of such PHI shall be restricted to only those purposes that make the return or destruction of the information infeasible. If mutual agreement is not made as to the feasibility of any return or destruction of PHI, the parties agree to use mediation to resolve this issue.

9. Term of Agreement. The term of this Agreement shall be such period of time as the Business Associate is performing the Services. In the event that such Services are terminated, this Agreement also shall terminate, except that the provisions of Sections 8 and 15 shall survive any termination of this Agreement.

10. Notice. All written communications, demands, and notices between the parties hereto must be posted by first class mail, postage paid or express mail to the following addresses:

To the Business Associate:	To the Company:
RxBenefits, Inc. Attn: Legal 3700 Colonnade Parkway, Suite 600 Birmingham, AL 35243	County of Sonoma Attn: _____ 575 Administration Drive, Suite 116B Santa Rosa, California 95403 United States

11. Entire Agreement. This Agreement supersedes all previous contracts and constitutes the entire agreement of whatever kind or nature existing between the parties with respect to the subject matter hereof, and no party shall be entitled to benefits other than those specified herein. As between the parties, no oral statement or prior written material not specifically incorporated herein shall be of any force and effect; and the parties specifically acknowledge that in entering into and executing this Agreement, the parties rely solely upon the representations and agreements contained in this Agreement and no others. This Agreement may be amended only by an instrument in writing executed by the parties hereto and may be supplemented only by documents delivered in accordance with the express terms hereof.

12. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but which together shall constitute one and the same instrument.

13. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein or therein confer, upon any person other than the Company and the Business Associate and their respective successors or assigns in interest, any rights, remedies, obligations, or liabilities whatsoever.

14. Modification For Change in Law. Upon the occurrence of changes or amendments to the Regulations or other law that affect the legality of or any provision in this Agreement, the Company and the Business Associate agree to modify this Agreement to comport with such changes or amendments. Any such modification of this Agreement shall be in writing and signed by the Company and the Business Associate.

15. Indemnification. Each party to this Agreement hereby agrees to indemnify, defend, and hold harmless the other party (including, but not limited to, its directors, employees, officers, and agents) from and against any and all claims, causes of action, liabilities, damages, costs, or expenses (including, but not limited to, attorneys' fees) incurred by the party as a result of the other party's (or any party acting by or through the party) gross negligence or willful misconduct or failure to perform any of its duties or obligations under this Agreement.

16. Security. The Business Associate shall:

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Company as required by the Regulations;

(b) Ensure that any agent, including any subcontractor, to whom the Business Associate provides such Electronic Protected Health Information agrees in writing to implement reasonable and appropriate safeguards to protect it;

(c) Report to the Company any security incident of which the Business Associate becomes aware; provided that the parties acknowledge that probes and reconnaissance scans are commonplace in electronic information systems and the parties therefore acknowledge and agree that, to the extent such probes and reconnaissance scans constitute security incidents under the Security Rule, this Section 16(c) constitutes notice to the Company of the ongoing existence and occurrence of such security incidents for which no additional notice shall be required. Probes and reconnaissance scans include, without limitation, pings and other broadcast attacks on the Business Associate's firewall, port scans, and unsuccessful log-on attempts, as long as such probes and reconnaissance scans do not result in unauthorized Use or Disclosure of PHI;

(d) Make its policies and procedures and documentation required by the Regulations relating to such administrative, physical, and technical safeguards, available to the Secretary of HHS for purposes of determining the Company's compliance with the Regulations;

(e) Acknowledge its obligation to comply with the Security Regulations in using and disclosing Electronic Protected Health Information, including but not limited to 45 C.F.R. §§ 164.308 (Administrative safeguards), 164.310 (Physical safeguards), 164.312 (Technical safeguards), and 164.316 (Policies and procedures and documentation requirements) of the Security Regulations.

(f) Notify the Company without unreasonable delay in writing of the occurrence of a breach, as that term is defined at 45 C.F.R. § 164.402, of which Business Associate becomes aware. Business Associate shall also promptly provide Company such other information required to be provided to individuals under 45 C.F.R. § 164.404(c) as it becomes available after such breach.

17. Governing Law. This Agreement shall be governed by and construed under the laws of the State of California without regard to the principles of conflicts of laws of said state.

IN WITNESS WHEREOF, the parties herein have caused this Business Associate Agreement to be executed by their duly authorized representatives as of the date first written above.

PLAN:	**County of Sonoma's Health Plan**
	By: _____
	Its: _____
COMPANY:	**County of Sonoma**
	By: _____
	Its: _____
BUSINESS ASSOCIATE:	**RxBenefits, Inc.**
	By: _____
	Its: Vice President of Compliance & Legal Affairs