SECOND AMENDMENT TO AGREEMENT BETWEEN BROWARD COUNTY AND OPTUMRX PBM OF ILLINOIS, INC., FOR PHARMACY BENEFIT MANAGEMENT SERVICES FOR BROWARD COUNTY BENEFIT ELIGIBLES (COVERED INSUREDS) (RFP# R1412304P1)

This is a Second Amendment ("Second Amendment") to the Agreement between Broward County, a political subdivision of the State of Florida ("COUNTY"), and OptumRx PBM of Illinois, Inc., a Delaware corporation and successor to OptumRx PBM of Wisconsin, LLC ("VENDOR") (collectively, the "Parties"), for Pharmacy Benefit Management Services for Broward County Benefit Eligibles (Covered Insureds).

RECITALS

A. The Parties entered into the original Agreement on September 28, 2016, as amended by the First Amendment dated December 3, 2019 (collectively, the "Agreement").

B. The Parties entered into a First Amendment on December 3, 2019, to exercise the First Renewal Term (as defined in the Agreement) and to modify certain terms and conditions in the Agreement.

C. The Parties now desire to amend the Agreement to exercise the Second Renewal Term (as defined in the Agreement) and further modify the Agreement as more fully described below.

Now, therefore, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

1. All defined and capitalized terms used in this Second Amendment shall have the same meaning as used in the Agreement unless expressly stated herein.

2. The effective date of this Second Amendment shall be the date of final execution by the Parties ("Second Amendment Effective Date"). Except as expressly amended in this Second Amendment, all terms and conditions of the Agreement remain in full force and effect.

3. The Parties hereby renew the Agreement for the Second Renewal Term as defined in Section 3.2 of the Agreement, which Second Renewal Term shall commence on January 1, 2021, and end at 11:59 p.m. on December 31, 2021, under the modified terms stated in this Second Amendment.

4. Modifications to the Agreement are indicated by use of strikethroughs to indicate deletions and underlining to indicate additions.

5. Exhibit A, Section (5)(e)(ii), is hereby amended as follows:

(ii) Guaranteed Rebates shall be provided for those Covered Drugs dispensed hereunder that are eligible for Rebates, as defined in Section 1.30 of this Agreement, and subject to the terms and conditions of Section 5(d) of this Exhibit. These guaranteed

Rebate amounts are not subject to a minimum days' supply (i.e. 30 or 90 day supply as set forth in Exhibit "B". VENDOR shall make payments to COUNTY on a per net paid brand claim basis ("Guaranteed Rebate Payment") based on the services provided under this Agreement, regardless of the amount of Rebates received by VENDOR. VENDOR shall provide COUNTY with quarterly reports identifying any and all rebates described above and make payment to COUNTY by check not later than one hundred and eighty days (180) after the close of each calendar quarter. In addition to the quarterly report described in this section, VENDOR shall provide a quarterly drug-level report on earned rebate dollars received by VENDOR from pharmaceutical manufacturers for medications dispensed to COUNTY's Members.

6. The Parties each consent to allow a portion of the Pharmacy Management Allowance, as described in Section A of Exhibit B-1, to be used to offset the costs associated with the Medication Therapy Management Program beginning January 1, 2021, through December 31, 2021, and the Adherence Program beginning December 1, 2020, through December 31, 2021, as reflected in Section C of Exhibit B-1.

7. Exhibit B, Fees/Discounts, is hereby deleted in its entirety and replaced with the attached Exhibit B-1. All references to Exhibit B in the Agreement shall now be deemed referenced to Exhibit B-1 during the entirety of the Second Renewal Term. The pricing and terms stated in Exhibit B-1 shall commence on January 1, 2021, except with regard to the use of a portion of the Pharmacy Management Allowance to offset the costs associated with the Adherence Program described in Section C of Exhibit B-1, which shall commence on December 1, 2020.

8. The Parties jointly prepared this Second Amendment and no provision herein shall be more strictly construed against either party.

9. This Second Amendment may be executed in multiple originals, and may be executed in counterparts, each of which will be deemed to be an original, but all of which, taken together, constitutes one and the same agreement.

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SECOND AMENDMENT TO AGREEMENT BETWEEN BROWARD COUNTY AND OPTUMRX PBM OF ILLINIOS, INC., FOR PHARMACY BENEFIT MANAGEMENT SERVICES FOR BROWARD COUNTY BENEFIT ELIGIBLES (COVERED INSUREDS) (RFP# 1412304P1)

VENDOR

WITNESSES:

_____
Signature

_____
Print Name of Witness

_____
Signature

_____
Print Name of Witness

OptumRx PBM of Illinois, Inc.

By: Jeff Grosklags
Authorized Signor

Jeff Grosklags CFO
Print Name and Title

_____ day of 9/30/2020, 2020

ATTEST:

_____
Corporate Secretary or other person authorized to attest

(CORPORATE SEAL OR NOTARY)

IN WITNESS WHEREOF, the Parties have made and executed this Second Amendment to the Agreement: BROWARD COUNTY, through its BOARD OF COUNTY COMMISSIONERS, signing by and through its Mayor or Vice-Mayor, authorized to execute same by Board action on the ___ day of _____, 2020, and OptumRX PBM of Illinois, Inc., signing by and through its _____, duly authorized to execute same.

COUNTY

ATTEST:

_____
Broward County Administrator, as
ex officio Clerk of the Broward County
Board of County Commissioners

BROWARD COUNTY, by and through
Its Board of County Commissioners

By: _____
Mayor

_____ day of _____, 2020

Approved as to form by
Andrew J. Meyers
Broward County Attorney
Governmental Center, Suite 423
115 South Andrews Avenue
Fort Lauderdale, Florida 33301
Telephone: (954) 357-7600
Telecopier: (954) 357-7641

By: SANDY STEED Digitally signed by SANDY STEED Date: 2020.10.01 12:01:44 -04'00'
Sandy Steed (Date)
Assistant County Attorney

By: Danielle W. French 10/1/2020
Danielle W. French (Date)
Deputy County Attorney

SS
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EXHIBIT "B-1"

FEES/DISCOUNTS

A. CREDITS AND ALLOWANCES

Pharmacy Management Allowance. COUNTY shall receive a Pharmacy Management Allowance (PMA) credit of up to $10.00 per member, which must be utilized within the contract term. This PMA credit is to be used by COUNTY to offset the cost of actions intended to maximize the value of the pharmacy program. Funds may be used for items including, but not restricted to, programming for customization, design and implementation of clinical or other programs, communications, documented expenses related to staff education and industry conference attendance, auditing, data integration and analytics, consulting fees, and engagement of relevant vendors that impact the pharmacy program strategy and results. COUNTY will be required to submit documentation to support the expenses for which it seeks reimbursement. The Parties acknowledge that the credit provided by VENDOR for such services represents fair market value. If COUNTY terminates this Agreement for reason of breach before the end of the initial term ending December 31, 2019, COUNTY shall refund to VENDOR within 30 days after the effective date of such termination the full PMA credit applicable to the year of termination. It is the intention of the Parties that, for the purposes of the Federal Anti-Kickback Statute, this PMA credit shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C. § 1320a-7b(b)(3)(A).

B. SERVICE FEES

1. COUNTY will pay VENDOR for the services provided herein pursuant to the following table:

PASS-THROUGH TRANSPARENCY PRICING SCHEDULE

	2017	**2018**	**2019**	**2020**	**2021**
Pharmacy Administrative Fee	**Per Net Paid Claim**	**Per Net Paid Claim**	**Per Net Paid Claim**	**Per Net Paid Claim**	**Per Net Paid Claim**
Base Fees					
Retail 30:	$1.65	$1.65	$1.65	$1.05	$1.05
Retail 90:	$1.65	$1.65	$1.65	$1.05	$1.05
Mail Service:	$1.65	$1.65	$1.65	$1.05	$1.05
Specialty:	$1.65	$1.65	$1.65	$1.05	$1.05

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Pharmacy Rebates

VENDOR will pay COUNTY the greater of 100% of all Rebates or the minimum guarantees as shown below.

	2017 Rebates Per Net Paid Brand Claim	**2018 Rebates Per Net Paid Brand Claim**	**2019 Rebates Per Net Paid Brand Claim**	**2020 Rebates Per Net Paid Brand Claim**	**2021 Rebates Per Net Paid Brand Claim**
All Brand Drugs (Preferred & Non-Preferred)					
Retail 30 Minimum:	$85.00	$90.00	$100.00	$125.30	$140.00
Retail 90 Minimum:	$200.00	$205.00	$210.00	$421.95	$550.00
Mail Minimum:	$200.00	$205.00	$210.00	$421.95	$550.00
Specialty Minimum:	$550.00	$600.00	$650.00	$1,110.10	$1,505.00
Pharmacy Discount Percentage (% discount from AWP)					
Brand Formulary for Retail 30	17.5%	17.5%	17.5%	17.75%	17.85%
Generic Formulary for Retail 30	80.0%	80.5%	81.0%	82.25%	82.35%
Brand Formulary for Retail 90	23.5%	23.5%	23.5%	24.5%	24.6%
Generic Formulary for Retail 90	82.5%	83.0%	83.5%	84.5%	84.5%
Brand Drugs Mail Service Network	25.0%	25.0%	25.0%	25.25%	25.25%
Generic Drugs Mail Service Network	84.5%	85.0%	85.5%	86.0%	86.0%
Specialty Drugs (Exclusive Network)	18.0%	18.0%	18.0%	19.5%	19.65%
	2017	**2018**	**2019**	**2020**	**2021**
Dispensing Fees	**Per Net Paid Claim**	**Per Net Paid Claim**	**Per Net Paid Claim**	**Per Net Paid Claim**	**Per Net Paid Claim**
Retail 30:	$0.60	$0.60	$0.60	$0.50	$0.50
Retail 90:	$0.00	$0.00	$0.00	$0.00	$0.00
Mail Service:	$0.00	$0.00	$0.00	$0.00	$0.00
Specialty Drugs:	$0.00	$0.00	$0.00	$0.00	$0.00

** VENDOR will pay COUNTY 100% of Rebates it (or any affiliate or subsidiary) directly or indirectly receives that can be attributed to allowable utilization of Members hereunder.*

2. Under the Pass-Through Transparency Pricing, other than for Claims handled via direct member reimbursement, COUNTY shall pay the actual retail pharmacy rates paid by VENDOR for prescriptions processed and dispensed to a Member through VENDOR's retail pharmacy network, which are estimated to be the rates set forth above. For Claims processed via Direct Member Reimbursement, VENDOR will pass through to COUNTY any Rebates actually received in connection with such Claims.

3. Each contract year VENDOR will perform a reconciliation or "True-Up" of the previous year's mail and retail pharmacy reimbursement rates versus invoiced rates and each such reconciliation or True-Up shall be made no later than 180 days after the close of the contract year. Any net positive spread realized by VENDOR, measuring Brand Name Drugs in the aggregate and Generic Drugs in the aggregate, will be credited to COUNTY within 30 days from VENDOR's completion and COUNTY's acceptance of the True-Up. Notwithstanding the foregoing, COUNTY acknowledges that the True-Up will be net of any amounts owed to COUNTY under OVERALL DISCOUNT RECONCILIATION below.

4. OVERALL DISCOUNT RECONCILIATION: VENDOR will measure all financial guarantees each contract year ("Measurement Period") and will report on net performance. Discount calculations are measured using original ingredient cost (i.e., MAC, discounted AWP, or usual retail charge, as applicable), which excludes any increases to co-pays or minimum reimbursements. Ingredient cost also excludes sales taxes and dispensing fees, provided that where usual retail charge is adjudicated, the calculation will subtract the contracted dispensing fee amount, if any.

a. All results will be measured and reported by VENDOR to County annually. The annual reconciliation is by channel (i.e., Retail 30, Retail 90, Mail Service pharmacy, and Specialty Drug pharmacy) and component within each channel (i.e., Brand Drugs, Generic Drugs, and Specialty Drugs). No excess discount delivered in one component may be credited to another component within that channel or another channel (i.e., no offsetting is permitted). Results will include Net Paid Claims with the exception of over-the-counter products, Compound Drugs, direct member reimbursement Claims, 340B Claims, Indian Health Service and/or Tribal Claims, long-term care Claims, home infusion Claims, coordination of benefit Claims, ancillary charges associated with Claims (e.g., fees for the administration of a Covered Drug or vaccines), and Claims filled outside VENDOR's retail pharmacy network. Specialty Drugs will be included in the annual reconciliation as a separate channel. Additionally, drugs in short supply,

as published within the FDA's Current and Resolved Drug Shortages and Discontinuations Report to FDA index, shall be excluded from all guarantees and, to the extent applicable, for on-site pharmacy Claims, VENDOR will review Brand Drug and Generic Drug prescription Claims that were filled during the Measurement Period to determine whether financial guarantees were achieved. The Overall Generic Guarantees, Brand Effective Rates, and dispensing fee guarantees are contingent upon COUNTY receiving VENDOR's services for the entire length of the applicable Measurement Period. COUNTY acknowledges that any amounts owed to COUNTY pursuant to this section (OVERALL DISCOUNT RECONCILIATON) will be net of any amounts owed to COUNTY as a result of the True-Up. VENDOR will pay COUNTY any undisputed amounts due pursuant to this section within thirty (30) days after the reconciliation report date.

b. Notwithstanding the foregoing, COUNTY acknowledges that certain factors beyond VENDOR's control may affect VENDOR's ability to achieve the guaranteed discounts including, but not limited to, significant changes in: (i) COUNTY's plan design; (ii) the brand/generic status of certain highly utilized drugs; and (iii) applicable law or regulations (collectively, "Changes"). If at any time VENDOR, in its reasonable discretion, determines that any Changes are likely to materially and negatively affect VENDOR's ability to meet the guaranteed discount, the Parties shall, upon VENDOR's request, negotiate a mutually acceptable alternative guarantee or other financial arrangement. If the Parties fail to reach any such agreement in writing concerning the aforementioned Changes within forty-five (45) calendar days after the date the Parties begin negotiations, VENDOR shall not be bound by any of the obligations in this Exhibit "B" regarding such Changes during the Measurement Period in which the renegotiation was requested, or during any future Measurement Period based upon Changes requiring renegotiations.

5. The discounts and the dispensing fees set forth above are effective annual average rates. Pricing assumes the continuation of the current plan design and mandatory 90-day supply for maintenance medications. Three (3) retail fills allowed before mandatory 90-day supply requirement.

6. Vendor will not engage in repackaging for pharmaceutical products.

7. VENDOR's compensation for its services shall be the Pharmacy Administration Fee set forth above and other fees in amounts agreed to in writing

by the parties for any additional services authorized by County. OptumRx and its affiliates disclose that they have entered, and will continue to enter, into agreements with drug manufacturers to receive Manufacturer Administrative Fees of up to five percent (5%) of the Wholesale Acquisition Cost (WAC) of the products dispensed or administered. VENDOR and COUNTY agree that for purposes of this Agreement, all such Manufacturer Administrative Fees are considered Rebates and VENDOR that will pass such fees through to COUNTY in the same manner as any other Rebate. Additionally, VENDOR discloses that its affiliates, operating as Mail Service pharmacy, Specialty Drug pharmacy, and home infusion pharmacy, may purchase Covered Drugs from drug manufacturers and receive certain discounts and purchase rebates from drug manufacturers in connection with these purchases. Such discounts and purchase rebates received by these specific affiliates of VENDOR are not included in the definition of Rebates and are not passed through to COUNTY.

VENDOR may retain any Claims processor or other fees received from Participating Pharmacies in connection with the Covered Drugs dispensed to Members under the Plan, including: (a) a per Claim communications charge for on-line electronic Claims processing by point-of-service communication; (b) a charge for each Claim submitted to VENDOR via paper, tape, or a medium other than point-of-service communication; (c) surcharges for canceled or reversed Claims; (d) a charge if a Participating Pharmacy requests an evidence of benefits report in a tape medium; and (e) charges for marketing and administrative services.

8. "Net Paid" when referencing any type of Claim means all paid Claims minus reversals or rejections for a single prescription fill.

9. "PMPM" means Per Member Per Month.

10. Dispensing fee refers to the amount paid to the participating pharmacy for filling a prescription.

11. Certain drugs that become available on the market from time to time will not be subject to the mail service pricing rate due to, among other things, a drug's high cost, nominal or negative margin, extraordinary shipping requirements, or generics that have recently come off patent with a six month exclusivity, and may not be available through VENDOR's mail service pharmacy.

12. "Single source generics" and/or "Non-MAC generics" include all generic drugs that have recently come off patent and do not generate discounts

traditionally delivered by generic drugs, in their period of exclusivity or generics with an exclusive pharmaceutical manufacturer. Single source generics will be included in the overall generic drug guarantee.

13. The effective overall generic discount rate is the only generic rate guaranteed for purposes of retail and mail service pharmacy rates.

14. Newly available Specialty Drugs approved for coverage as described in the definition of Specialty Drug, will be billed and reimbursed at the default rate of AWP – 14% and will be included for financial reconciliation purposes in the aggregate Specialty Drug discount guarantee provided in this exhibit.

15. VENDOR negotiates rebates based on market share over its aggregate book of business and not solely on behalf of COUNTY. Rebates shall be based upon Net Paid Claims submitted on behalf of COUNTY. The three-tier rebate guarantees (Retail 30, Retail 90 and Mail Service, and Specialty Drug) above apply to a qualified three tier plan design with a minimum differential of $15 between preferred and non-preferred brand drugs and COUNTY's 100% compliance with VENDOR's Formulary. COUNTY's CDHP and HDHP plans as in effect on July 1, 2016 will be included in the rebate calculations and disbursements. Should the COUNTY implement a different plan design, claims with less than 50% of the total drug cost covered by the plan, or where there is a 100% copay for brands (for example, a discount card plan) will be excluded from rebate calculations and disbursements. COUNTY agrees to discuss any proposed plan design changes or new plan designs with VENDOR prior to implementation so that VENDOR can review the proposed changes and advise the COUNTY of any impact those changes will have on the pricing structure, rebates, and any other key terms of the Agreement, including the Scope of Services, Performance Guarantees, Minimum Rebate Guarantees, the Broward County MAC List, and the Formulary and Specialty Pharmacy Drug List.

16. Effective date of any changes to rebate arrangements shall be at the beginning of a calendar quarter following the Effective Date of the Agreement.

17. Except as noted in this section, VENDOR's affiliated Specialty Drug pharmacy shall be the exclusive specialty providers under this Agreement for Members.

B. CLINICAL SERVICES

Fees for these services are included under the additional services section below.

1. MEDICATION MANAGEMENT PROGRAM

a. COUNTY desires that VENDOR provide a medication management program that is consistent with the prior authorization requirements, under the benefit design COUNTY currently offers to Members ("Medication Management Program"). The Medication Management Program is designed to promote appropriate utilization of potentially expensive, misprescribed, and/or abused medications based upon generally accepted current pharmacy practices. Accordingly, pursuant to COUNTY's direction, commencing January 1, 2017, and continuing for a mutually agreeable time period, VENDOR will implement the Medication Management Program on COUNTY's behalf and in accordance with the protocols, criteria, forms, and related documents approved by COUNTY ("Approved Protocols"). The Approved Protocols are hereby incorporated into this Agreement.

b. Upon presentation by a Member of a prescription that requires prior authorization pursuant to the Medication Management Program, VENDOR will attempt to have the Member's prescriber respond to questions specific to the prescription presented ("Physician Form"). Completed Physician Forms will be reviewed by VENDOR's pharmacist and compared to the Approved Protocols for the applicable medication category. Based upon the results, COUNTY hereby directs VENDOR's pharmacists either to authorize or deny coverage of the medication, and VENDOR will notify the Member accordingly. COUNTY will pay according to the fee schedule set forth below for the Medication Management Program bundle as described below, subject to any additional charges resulting through the COUNTY's selection of additional programs and to be incorporated herein. A Medication Management Program review will be deemed to have occurred whenever VENDOR has initiated a prior authorization following request and attempted to have the Member's prescriber complete the applicable Physician Form. If after two attempts VENDOR is unable to obtain a completed Physician Form from the Member's prescriber, COUNTY directs VENDOR's pharmacists to deny the coverage of the medication and to notify the Member accordingly.

c. It is expressly understood that COUNTY is solely responsible for construing the terms and conditions of its health benefit plan and the selection of

medications that are part of the Medication Management Program. Further, COUNTY retains complete discretionary and final authority to make all determinations regarding its pharmacy benefit plan and prior authorization requests that are part of the Medication Management Program, including, without limitation: (i) payment of claims; (ii) provision of benefits; (iii) review and/or denial of prior authorization claims or requests by Members; and (iv) resolution of Member complaints, including the establishment of an appeal and/or grievance process. COUNTY will comply with all Federal and State laws, rules, and regulations regarding the denial of benefits.

2. MEDMONITOR RETRODUR PROGRAM.

COUNTY currently participates in VENDOR's MedMonitor RetroDUR Program. The MedMonitor RetroDUR Program consists of VENDOR (in conjunction with necessary third parties) performing a retrospective review of Members' prescription claims and medical data (if available and agreed to by the parties) to evaluate the appropriateness of a Member's therapy based upon generally accepted current clinical pharmacy practices. In the event VENDOR identifies clinical concerns in the judgment of a clinical pharmacist regarding a Member's drug regimen, VENDOR will communicate its findings to the Member's Prescriber in the form of a clinical alert letter. COUNTY will pay for the MedMonitor RetroDUR Program at the rates stated below.

a. MedMonitor® MTM Program. COUNTY will participate in VENDOR's MedMonitor® MTM Program. The MedMonitor® MTM Program consists of VENDOR (in conjunction with necessary third parties) performing a medication therapy management review designed to ensure that medications prescribed to participants are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse medication interactions at the rates set forth below. VENDOR will identify participants and will, if applicable, recommend changes in such participants' drug regimens to the prescribing physicians and/or the dispensing pharmacists, and if applicable, to the participants. COUNTY will pay VENDOR for the MedMonitor® MTM Program in accordance with the fees outlined in below.

C. **ADDITIONAL SERVICES**

Certain services as indicated below are not included in the standard Pharmacy Administrative Fee and are available for an additional charge. This is not an inclusive list. VENDOR may charge for any products or services not specifically represented herein as may be requested

in writing by County.

Additional Services	**Billable Amount:**
Paper Claim Fee:	$2.00 per Claim
Reports:	
Standard Reporting	$0.00
Ad Hoc Reporting	$150.00/Hour, after 100 hours per year at no charge; $500.00 minimum
Customized Reports	$150.00 per Hour, after 100 hours per year at no charge; $500.00 minimum
Actuarial Reporting and Associated Fees	$0.00
Standard Format FTP (Billing Transmission)	$0.00
Online Management Reports	$0.00
ID Cards:	
Welcome Package - ID Cards (2 cards) inclusive of postage with VENDOR formulary and intro package including mail order form.	$0.00
Member/Participant ID Cards – Replacements; inclusive of postage	$1.20
Formulary Management:	
Standard Formulary Management Services	$0.00
Custom Formulary Materials	$180.00 per Hour
Customized Formulary Management Services	$180.00 per Hour
Claim Management:	
Manually submitted paper claims (includes subrogated and direct member reimbursement claims), per submitted claim	$2.00 per Claim
Electronic Claims Processing	$0.00
Prior Authorization Administrative Overrides	$0.00
Coordination of Benefits (COB) per Member submitted claim	$0.00
Audit Administration (On-site)	$0.00
Eligibility:	
Manual Eligibility Updates	$0.50 per Record
Eligibility - Direct Access	$0.00
Group Setup Fees	$0.00
Communications Campaign:	
Customized Letters to Members Step Therapy or CPA Letters Industry Events Communication Letter	$0.00

VENDOR Formulary Conversion/Delete Letter	$0.00
VENDOR New Generic Announcement Letter	$0.00
Member Communication - Printing	$0.00
Member Communication - Mailing (e.g. postcards, etc.)	$0.00
Annual Summary of Benefits (ASB)	$0.00
HIPAA-Related Correspondence, per request, per Member	$0.00
Explanation of Benefits (EOB)	$0.00
Clinical Management:	
Drug Utilization Review Programs	$0.00
Medication Management Clinical Prior Authorization (CPA) Program Bundle	$0.47 PMPM
Compliance and Persistency (C&P)	$0.23 PMPM

Outreach Campaigns	**Additional Cost per Unit**
Cost Mgmt Products (e.g. Therapeutic Interchange, Generic Substitution, Dosage Optimization, Mandatory Maintenance, etc.)	Licensing Fee: $0.05/PMPM Mailing & Postage: Pass-through to Client
Medication Therapy Management (MTM) Program	**Additional Cost per Unit**
Medication Therapy Management Program >5K - 50K Members: Includes-Comprehensive Medication Review, Appropriateness of Therapy, High Risk Medications and Compliance & Persistency	Will be paid from the Pharmacy Management Allowance for the 12-month period of January 1, 2021 to December 31, 2021
RetroDUR Program	**Additional Cost per Unit**
RetroDUR >5K - 20K members: Safe & Appropriate Utilization	$0.20 per Rx
RetroDUR >5K - 20K members: Gaps in Care	$0.08 per Rx
RDUR for Workers Compensation: Safe & Appropriate Utilization	$0.20 per Rx
Diabetes Management Program	**Additional Cost per Unit**
Standard Price Structure ($0 member copay meter & supplies)	$73.00 per enrolled member per month
	$65.00 per enrolled Member that discontinues the program prior to the end of the twelve-month period following the enrolled Member's receipt of a blood glucose meter
	$65.00 per replacement meter for damaged, lost or stolen meters
Alternative Price Structure ($0 member copay meter & supplies)	$68.00 per enrolled Member per month + $65 per meter
	$0 per enrolled Member that discontinues the program prior to the end of the twelve-month period following the enrolled Member's receipt of a blood glucose meter
	$65.00 per replacement meter for damaged, lost or stolen meters
Adherence Program	**Additional Cost per Unit**
Program 1: Member Outreach: >5,000 to 10,000 members	Will be paid from the Pharmacy Management Allowance for the 13-month period of December 1, 2020 to December 31, 2021

Program 2: Member & Prescriber Outreach: >5,000 to 10,000 members	$0.37 PMPM
Fraud Waste & Abuse Program	**Additional Cost per Unit**
Clinical Fraud, Waste & Abuse Program: 5,001 - 10,000 Members	$0.18 PMPM
Comprehensive Fraud, Waste & Abuse Program – Intensive Audit and Investigation: Shared Savings Intensive Audit Arrangement	25% of all identified recoveries + tiered fee shown above
ePrescribing - 5,000 - 25,000 Members	$0.16 per eligibility & medication history transaction
Hospital Transition Program	$150 per intervention
Analytics Services	**Additional Cost per Unit**
Ad-Hoc clinical analysis or custom analysis	$200 per hour with a $5,000 minimum
Custom Formulary Analysis	$5,000 per analysis
Clinical Analytic Solutions - Medication Adherence Implementation Setup Fee**	$1500 Implementation Setup Fee (*Only applied once with initial Adherence Module Setup)
Clinical Analytic Solutions - Medication Adherence: 5,001 - 10,000 Adherence - Late to refill	$0.05 PMPM (*Implementation Setup Fee May Apply)
Clinical Analytic Solutions - Medication Adherence: 5,001 - 10,000 Adherence - Low adherence	$0.05 PMPM (*Implementation Setup Fee May Apply)
Clinical Analytic Solutions - Medication Adherence: 5,001 - 10,000 Adherence - New to therapy	$0.05 PMPM (*Implementation Setup Fee May Apply)
Clinical Analytic Solutions - Medication Adherence: 5,001 - 10,000 Adherence - Primary non-adherence	$100 Per month (*Implementation Setup Fee May Apply; **Requires New to therapy to implement)
Clinical Analytic Solutions - RetroDUR: 5,001 - 20,000 RDUR - Gaps in Care	$0.06 per Rx
Clinical Analytic Solutions - RetroDUR: 5,001 - 20,000 RDUR - Safe & Appropriate Use	$0.15 per Rx
Clinical Analytic Solutions - Fraud, Waste & Abuse: 5,001 - 20,000 FWA - Abused Medications	$0.04 per Rx

Custom Formulary & Utilization Management Services	**Additional Cost per Unit**
A) Full Custom Formulary - Full Custom applies when a client requests a formulary or utilization management program completely different from what VENDOR offers or when a client requests over 40% customization of an existing VENDOR formulary or utilization management program (40% of formulary brand and generic drugs). Full Custom also applies to adopting an incumbent's formulary or utilization management program.	$62,000 per formulary for development $6,000 per formulary per month for maintenance
B) Partial Custom Formulary - Partial Custom applies to when a client requests a customized version of an existing VENDOR formulary. The range of partial customization is from 5 single drug customizations to 40% of an existing VENDOR formulary/UM (40% of formulary brand and generic drugs). Requests of over 40% customization become a Full Custom.	$28,000 per formulary for development. $2,800 per formulary per month for maintenance.

C) Single/AdHoc Custom Formulary Request - Single/AdHoc Custom applies to when a client requests a single drug change (adding or removing) to an existing VENDOR formulary. The costs are a multiple of the number of single deviations. If customizations exceed 4 single deviations, the Partial Custom rates will be used.	$6,500 per deviation for development. $100 per deviation per month for maintenance.

Administration of COUNTY's custom formulary including the following services:

- Initial custom formulary build in RxBuilder
- Weekly, Quarterly and AdHoc Changes/maintenance (determinations/additions)
- Printed formulary files
- Custom coverage and Exclusion List maintenance and creation
- Negative change notification collaboration
- UM documentation or adjudication in RxBuilder
- UM updates in RxBuilder
- Verification of category class counts versus benchmark(s) - annually & upon formulary changes*
- Creation of custom submission template*
- Deficiency Window review, changes and suggestions*
- P&T Support - P&T Formulary Review - delegated (fees noted under - OptumRx P&T Committee Consultation)

**Only Applies to EHB/QHP formularies*

Administration of Client's custom UM programs:	
Prior Authorization	$750 per custom criteria upon development and each revision.
Step Therapy	$750 per custom criteria upon development and each revision.
Quantity Limit	$750 per custom criteria upon development and each revision.
Access to individual OptumRx coverage policies if OptumRx is not providing PA review services	$750 per coverage policy annually
Formulary Override Exception Program	$0 for the development and maintenance of program.
P&T Support Services	**Additional Cost per Unit**
OptumRx P&T Support: Standard	
New Drug Review	$1,500 per review
New Drug Review, Abbreviated	$750 per review
Therapeutic Class Review *(includes Executive Summary)*	$4,000 per review
Annual fee for access to all standard P&T monographs & class reviews	$95,000
OptumRx P&T Support: Custom	
New Drug Review	$2,500 per review
New Drug Review, Abbreviated	$1,500 per review
Therapeutic Class Review *(includes Executive Summary)*	$6,000
OptumRx P&T Clinical Consultant Support of Client's P&T Committee	Per Pharmacist: $15K annually, up to 40 hours of consultation and 4 on-site meetings per year. Consultations beyond 40 hours will be billed $200/hr. On-site meetings beyond 4 per year will require additional fees.
OptumRx P&T Committee Consultation (Delegated P&T support specific for use of OptumRx P&T Committee to review custom formulary & UM)	$10K annually, up to 40 hours of consultation. Consultations beyond 40 hours will be billed $200/hr.
Custom Publication Support Services	**Additional Cost per Unit**
Clinical Publications: Co-Branding	

RxWeekly News for each weekly issue published	$250
RxBulletin for each issue published	$250
RxCounselor for each issue published	$500
RxHighlights for each monthly issue published	$1,000
RxOutlook Digest for each quarterly series published	$4,500
RxOutlook Recap for each monthly issue published	$1,000
RxOutlook Spotlight on a Drug in Development	$750
RxOutlook Spotlight on Drug Class	$1,500
Annual fee for access to all clinical publications	$70,000
Clinical Publications: Re-Branding	
RxWeekly News for each weekly issue published	$500
RxBulletin for each issue published	$500
RxCounselor for each issue published	$750
RxHighlights for each monthly issue published	$1,500
RxOutlook Digest for each quarterly series published	$6,000
RxOutlook Recap for each monthly issue published	$1,500
RxOutlook Spotlight on a Drug in Development	$1,000
RxOutlook Spotlight on Drug Class	$2,000
Annual fee for access to all clinical publications	$95,000
Quantity Limits with a CPA	$0.00
Clinical Prior Authorization (not included in the Medication Management CPA Program Bundle)	$50.00 per review
Step Therapy	$0.00
Online Products:	
Online Access - Reports Tool (Minimum of seven (7) Access IDs)	$0.00
Online Access - Claims Platform (Minimum of seven (7) Access IDs)	$0.00
Online Access - Query Tool (Minimum of seven (7) Access IDs)	$0.00

Appeals:	
First level internal non-urgent clinical appeal	$40.00 per appeal
Second level internal non-urgent clinical appeal	$100.00 per appeal
External non-urgent clinical appeal	$325.00 per event
First level internal urgent clinical appeal	$40.00 per appeal
Second level internal urgent clinical appeal	$100.00 per appeal
External urgent clinical appeal	$325.00 per event
Medicare D Drug Subsidy Program:	
RDS Actuarial Attestation	$1,500.00 per year
Subsidy Enrollment Update File (Monthly Submission to RDS)	$1,500.00 per year
Interim Cost Report Monthly Submission for RDS and Summary for COUNTY	$1,500.00 per year
Annual Reconciliation File to RDS	$2,000.00 per year
Creditable Coverage Letters	$1.50 per letter

Miscellaneous:	
24-hour Call Center support for participant callers	$0.00

END OF EXHIBIT B-1