SERIAL 10082 RFP PHARMACY BENEFIT MANAGER SERVICES

DATE OF LAST REVISION: April 26, 2016 CONTRACT END DATE: June 30, 2017

CONTRACT PERIOD THROUGH JUNE 30, 2017

TO: All Departments

FROM: **Office of Procurement Services**

SUBJECT: Contract for **PHARMACY BENEFIT MANAGER SERVICES**

Attached to this letter is published an effective purchasing contract for products and/or services to be supplied to Maricopa County activities as awarded by Maricopa County on **August 31, 2011 (Eff. 07/01/12).**

All purchases of products and/or services listed on the attached pages of this letter are to be obtained from the vendor holding the contract. Individuals are responsible to the vendor for purchases made outside of contracts. The contract period is indicated above.

Wes Baysinger, Chief Procurement Officer
Office of Procurement Services

SD/**jl**
Attach

Copy to: **Office of Procurement Services**
~~Trish Georgeoff, Human Services~~
~~Max Porter, Public Health Services - PUBH~~
Chris Bradley, Business Strategies and Health Care (Employee Benefits)
Meg Blankenship, Business Strategies and Health Care (Employee Benefits)

CONTRACT PURSUANT TO 10082-RFP

SERIAL 10082-RFP

This Contract is entered into this 31st day of August, 2011 by and between Maricopa County ("County"), a political subdivision of the State of Arizona, and ~~Catalyst Rx~~ **Catamaran PBM of Maryland Inc.**, a Nevada corporation (hereinafter referred to as "Contractor") for the purchase of Pharmacy Benefit Management and associated Services.

1.0 CONTRACT TERM:

1.1 This Contract is for a term of Five (5) years, beginning on the first day of July 1, 2012 and ending the 30th day of June, 2017.

1.2 The County may, at its option and with the agreement of the Contractor, renew the term of this Contract for additional terms up to a maximum of Five (5) years, (or at the County's sole discretion, extend the contract on a month-to-month bases for a maximum of six (6) months after expiration). The County shall notify the Contractor in writing of its intent to extend the Contract term at least thirty (30) calendar days prior to the expiration of the original contract term, or any additional term thereafter.

2.0 FEE ADJUSTMENTS:

Any request for fee adjustments must be submitted by Contractor one hundred and eighty (180) days prior to the current Contract expiration date. Requests for adjustment in cost of labor and/or materials must be supported by appropriate documentation. If County agrees to the adjusted fee, County shall issue written approval of the change. The reasonableness of the request will be determined by comparing the request with the (Consumer Price Index) or by performing a market survey.

3.0 PAYMENTS:

3.1 As consideration for performance of the duties described herein, County shall pay Contractor the sum(s) stated in Exhibit "A." and "A-1".

3.2 Unless otherwise specifically stated, payment shall be made to Contractor upon the County's receipt of a properly completed invoice from Contractor.

3.3 Billing Procedure. Contractor shall invoice County (in accordance with Section 3.8 below) for the prescription benefit management service fees and rates in accordance with in Exhibit A and A-1 on a semi-monthly basis (or on a more frequent basis commensurate with any more frequent pharmacy payment requirements imposed by law).

3.4 County shall provide funds for payment of claims for Prescription Drug Services, including any taxes imposed in connection with the provision of such Prescription Drug Services, submitted by Participating Pharmacies or Participants. County is ultimately responsible for providing payment to Contractor under this Contract. The Parties acknowledge and agree that the provision of such funds to Contractor satisfies the County's obligation for payment of those claims for Prescription Drug Services. County shall indemnify, defend and hold harmless Contractor from any claims, liabilities or expenses asserted against Contractor by any Participating Pharmacy or

Participant for payment for Prescription Drug Services, except for any claim for which Contractor has received full reimbursement from County. Contractor shall indemnify, defend and hold harmless County from any claims by Participating Pharmacies or Participants for reimbursement for Prescription Drug Services to the extent County has transferred funds to Contractor for payment of the claims in dispute. Contractor expects County to diligently review its invoices for "Obvious Errors" and County shall have sixty (60) days to review invoices from Contractor and dispute any charges contained in Contractor invoice. After such sixty (60) day review period has elapsed, all invoices shall be considered final. If an error is discovered by County or its auditor during the course of an audit of Contractor, the County may recover the amount of such undisputed error from Contractor, subject to Section 6.1 of this Contract, so long as the error was not an "Obvious Error." An "Obvious Error" is one that can be seen on the face of the invoice such as an incorrect administrative fee billed.

3.5 Payment of Service Fees and Charges. Except as otherwise specifically provided in this Contract, payment of all Prescription Drug Service fees and charges (whether retail, mail or specialty) and clinical programs shall be due to Contractor within fifteen (15) days after the date the invoice is sent by Contractor to County. Payments for any ancillary service charges as described in Exhibit A-1 or the onsite pharmacy and clinic services set forth in Exhibit B-3 shall be due and payable within thirty (30) days from the date of invoice. Any payments not received by Contractor on the due date shall accrue interest at an annual rate based on Arizona State Statue. This interest shall be included on the next billing of service fees due, to be paid by County with the next month's fees. In addition to interest payments, County's failure to pay within the time period specified above shall be deemed a monetary default subjecting County to the termination provisions of Section 6.8.5.

3.6 Associated Costs Paid by County. In addition to other costs or fees specifically provided for elsewhere in this Contract, County shall be responsible for any costs associated mailing to Participants, cards, fulfillment materials, newsletters, or any other communications to Participants which have been requested by County (not to include the production of these materials).. County also shall be responsible for fees associated with additional services requested by County provided that they are not included in this Contract.

3.7 Effects of Changes in Law or Industry Practices. In the event of change in applicable law, regulation, administrative or judicial interpretation or ruling, or substantial changes in national industry practice, transition from AWP to another pricing benchmark or the level of any industry pricing benchmark ("External Event"), the Parties agree to a pricing neutral adjustment of the amounts owed to Contractor by County (including retail, mail and specialty pharmacy rates/fees and rate/fee guarantees as set forth in Exhibit A or A-1) and adjustment of any guarantees owed to County by Contractor under Exhibit A or A-1. Notwithstanding any provision to the contrary, the Parties agree that any adjustment pursuant to this paragraph shall result in each Party remaining in substantially the same economic position as before the External Event.

3.8 INVOICES:

3.8.1 The Contractor shall submit an electronic copy of their detailed invoice before payment(s) can be made. At a minimum, the invoice must provide the following information:

- Company name, address and contact
- County bill-to name and contact information
- Contract serial number
- Invoice number and date
- Payment terms
- Date of service
- Quantity
- Contract Item number(s)
- Description of service provided
- Pricing per unit of service

- Extended price
- Total Amount Due

3.8.2 Payment shall be made to the Contractor by Accounts Payable through the Maricopa County Vendor Express Payment Program. This is an Electronic Funds Transfer (EFT) process. After Award the Contractor shall fill out an EFT Enrollment form located on the County Department of Finance Website as a fillable PDF document (www.maricopa.gov/finance/)

3.8.3 EFT payments to the routing and account numbers designated by the Contractor will include the details on the specific invoices that the payment covers. The Contractor is required to discuss remittance delivery capabilities with their designated financial institution for access to those details.

4.0 AVAILABILITY OF FUNDS:

4.1 The provisions of this Contract relating to payment for services shall become effective when funds assigned for the purpose of compensating the Contractor as herein provided are actually available to County for disbursement. The County shall be the sole judge and authority in determining the availability of funds under this Contract. County shall keep the Contractor fully informed as to the availability of funds.

4.2 If any action is taken by any state agency, Federal department or any other agency or instrumentality to suspend, decrease, or terminates its fiscal obligations under, or in connection with, this Contract, County may amend, suspend, decrease, or terminate its obligations under, or in connection with, this Contract. In the event of termination, County shall be liable for payment only for services rendered prior to the effective date of the termination, provided that such services are performed in accordance with the provisions of this Contract. County shall give written notice of the effective date of any suspension, amendment, or termination under this Section, at least ten (10) days in advance.

5.0 DUTIES:

5.1 The Contractor shall perform the services stated in Exhibit "B General Scope of Services, Exhibit B-1, Governance of Services, and B-2 Vendor Responses from RFP and Exhibit B-3 Onsite Pharmacy and Clinic Operations", **Exhibit C (Service Level Agreement).**

6.0 TERMS and CONDITIONS:

6.1 INDEMNIFICATION:

6.1.1 To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless County, its agents, representatives, officers, directors, officials, and employees from and against all claims, damages, losses and expenses, including, but not limited to, attorney fees, court costs, expert witness fees, and the cost of appellate proceedings, relating to, arising out of, or alleged to have resulted from the negligent acts, errors, omissions, mistakes or malfeasance relating to the performance of this Contract. Contractor's duty to defend, indemnify and hold harmless County, its agents, representatives, officers, directors, officials, and employees shall arise in connection with any claim, damage, loss or expense that is caused by any negligent acts, errors, omissions or mistakes in the performance of this Contract by the Contractor, as well as any person or entity for whose acts, errors, omissions, mistakes or malfeasance Contractor may be legally liable.

6.1.2 The amount and type of insurance coverage requirements set forth herein will in no way be construed as limiting the scope of the indemnity in this paragraph.

6.1.3 The scope of this indemnification does not extend to the sole negligence of County. In addition, this Section 6.1 shall not apply to any lawsuits, damages, costs and/or expenses

arising out of or related to the onsite pharmacy and clinic operations. The Parties agree that the indemnification for said matters shall be in accordance with Exhibit B-3.

6.2 INSURANCE REQUIREMENTS:

6.2.1 With the exception of insurance coverage related to the services provided at the onsite pharmacy and clinic operations, Contractor, at Contactor's own expense, shall purchase and maintain the herein stipulated minimum insurance from a company or companies duly licensed by the State of Arizona and possessing a current A.M. Best, Inc. rating of A-, VII or higher. In lieu of State of Arizona licensing, the stipulated insurance may be purchased from a company or companies, which are authorized to do business in the State of Arizona, provided that said insurance companies meet the approval of County. The form of any insurance policies and forms must be acceptable to County.

6.2.2 All insurance required herein shall be maintained in full force and effect until all work or service required to be performed under the terms of the Contract is satisfactorily completed and formally accepted. Failure to do so may, at the sole discretion of County, constitute a material breach of this Contract.

6.2.3 Unless otherwise stated, Contractor's insurance shall be primary insurance as respects County, and any insurance or self-insurance maintained by County shall not contribute to it.

6.2.4 Any failure to comply with the claim reporting provisions of the insurance policies or any breach of an insurance policy warranty shall not affect the County's right to coverage afforded under the insurance policies.

6.2.5 The insurance policies may provide coverage that contains deductibles or self-insured retentions. Such deductible and/or self-insured retentions shall not be applicable with respect to the coverage provided to County under such policies. Contactor shall be solely responsible for the deductible and/or self-insured retention and County, at its option, may require Contractor to secure payment of such deductibles or self-insured retentions by a surety bond or an irrevocable and unconditional letter of credit.

6.2.6 County reserves the right to request and to receive, within 10 working days, certified copies of any or all of the herein required insurance certificates. County shall not be obligated to review policies and/or endorsements or to advise Contractor of any deficiencies in such policies and endorsements, and such receipt shall not relieve Contractor from, or be deemed a waiver of County's right to insist on strict fulfillment of Contractor's obligations under this Contract.

6.2.7 The insurance policies required by this Contract, except Workers' Compensation, and Errors and Omissions, shall name County, its agents, representatives, officers, directors, officials and employees as Additional Insureds.

6.2.8 The policies required hereunder, except Workers' Compensation, and Errors and Omissions, shall contain a waiver of transfer of rights of recovery (subrogation) against County, its agents, representatives, officers, directors, officials and employees for any claims arising out of Contractor's work or service.

6.2.9 Commercial General Liability.

Commercial General Liability insurance and, if necessary, Commercial Umbrella insurance with a limit of not less than $1,000,000 for each occurrence, $2,000,000 Products/Completed Operations Aggregate, and $2,000,000 General Aggregate Limit. The policy shall include coverage for bodily injury, broad form property damage, personal injury, products and completed operations and blanket contractual coverage, and shall not contain any provision which would serve to limit third party action over claims.

There shall be no endorsement or modification of the CGL limiting the scope of coverage for liability arising from explosion, collapse, or underground property damage.

6.2.10 Automobile Liability.

Commercial/Business Automobile Liability insurance and, if necessary, Commercial Umbrella insurance with a combined single limit for bodily injury and property damage of not less than $1,000,000 each occurrence with respect to any of the Contractor's owned, hired, and non-owned vehicles assigned to or used in performance of the Contractor's work or services under this Contract.

6.2.11 Workers' Compensation.

6.2.11.1 Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Contractor's employees engaged in the performance of the work or services under this Contract; and Employer's Liability insurance of not less than $100,000 for each accident, $1,000,000 disease for each employee, and $500,000 disease policy limit.

6.2.11.2 Contractor waives all rights against County and its agents, officers, directors and employees for recovery of damages to the extent these damages are covered by the Workers' Compensation and Employer's Liability or commercial umbrella liability insurance obtained by Contractor pursuant to this Contract.

6.2.12 Errors and Omissions Insurance.

Errors and Omissions insurance and, if necessary, Commercial Umbrella insurance, which will insure and provide coverage for errors or omissions of the Contractor, with limits of no less than $1,000,000 for each claim.

6.2.13 Certificates of Insurance.

6.2.11.3 Prior to commencing work or services under this Contract, Contractor shall furnish the County with certificates of insurance, or formal endorsements as required by the Contract in the form provided by the County, issued by Contractor's insurer(s), as evidence that policies providing the required coverage, conditions and limits required by this Contract are in full force and effect. Such certificates shall identify this contract number and title.

6.2.13.2.1 In the event any insurance policy (ies) required by this Contract is (are) written on a "claims made" basis, coverage shall extend for two (2) years past completion and acceptance of Contractor's work or services and as evidenced by annual Certificates of Insurance.

6.2.13.2.2 If a policy does expire during the life of the Contract, a renewal certificate must be sent to County fifteen (15) days prior to the expiration date.

6.2.14 Cancellation and Expiration Notice.

Insurance required herein shall not be permitted to expire, be canceled, or materially changed without thirty (30) days prior written notice to the County.

6.2.15 Insurance Requirements for Onsite Pharmacy and Clinic Operations.

Notwithstanding any provisions to the contrary, County and Contractor acknowledge and agree that the insurance requirements set forth in Exhibit B-3 shall apply to the services provided at the onsite pharmacy and clinic.

6.3 WARRANTY OF SERVICES:

6.3.1 The Contractor warrants that all services provided hereunder will conform to the requirements of the Contract, including all descriptions, specifications and attachments made a part of this Contract. County's acceptance of services or goods provided by the Contractor shall not relieve the Contractor from its obligations under this warranty.

6.3.2 In addition to its other remedies, County may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all the provisions of this Contract in the manner and to the same extent as services originally furnished hereunder.

6.4 INSPECTION OF SERVICES:

6.4.1 County has the right to inspect and/or audit the services called for by the Contract, to the extent practicable at all times and places during the term of the Contract. County shall perform inspections and/or audits in accordance with this Contract and in a manner that will not unduly delay or disrupt the services performed hereunder.

6.4.2 If any of the services do not conform to Contract requirements, County may require the Contractor to perform the services again in conformity with Contract requirements. When the defects in services cannot be corrected by re-performance, County may:

6.4.3.1 Require the Contractor to take necessary action to ensure that future performance conforms to Contract requirements; or

6.4.3.2 Reduce the Contract price to reflect the reduced value of the services performed.

6.4.3 If the Contractor fails to promptly perform the services again or to take the necessary action to ensure future performance in conformity with Contract requirements, County may:

6.4.4.1 By Contract or otherwise, perform the services and charge to the Contractor any cost incurred by County that is directly related to the performance of such service; or

6.4.4.2 Terminate the Contract for default.

6.5 NOTICES:

All notices given pursuant to the terms of this Contract shall be addressed to:

For County:

Maricopa County
Office of Procurement Services
Attn: **Chief Procurement Officer**
320 West Lincoln Street
Phoenix, Arizona 85003-2494

For Contractor:

~~Catalyst Rx~~	~~Catamaran PBM of Maryland Inc.~~
~~800 King Farm Blvd., 4th Floor~~	~~2441 Warrenville Road, Suite 610~~
~~Rockville, MD 20850~~	~~Lisle, IL 60532-3642~~
	~~Phone: (630) 577-3100~~
	~~Fax; (630) 328-2189~~
~~Attn: General Counsel~~	~~Attention: Contract Administration~~
	~~E-mail: legal@catamaranrx.com~~

Catamaran PBM of Maryland Inc.
1600 McConnor Parkway
Schaumburg, IL 60173
Fax: (224) 231-1932
Attention: Legal Department
E-Mail: legal@catamaranrx.com

Notwithstanding any provision to the contrary, any notices related to the operation of the onsite pharmacy and clinic shall be sent to Contractor with a copy addressed as follows:

Walgreens -Take Care Employer Solutions
104 Wilmot Road
Deerfield, IL 60015
Attn: Health Law Divisional Vice President

6.6 REQUIREMENTS CONTRACT:

6.6.1 Contractor signifies its understanding and agreement by signing this document that this Contract is a requirements contract. This Contract does not guarantee any purchases will be made (minimum or maximum).

6.7 TERMINATION FOR CONVENIENCE:

The County reserves the right to terminate the Contract, in whole or in part at any time, when in the best interests of the County without penalty or recourse. Upon receipt of the written notice, the Contractor shall immediately stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the County. Notwithstanding the foregoing, the County acknowledges and agrees that the subcontractor providing onsite pharmacy and clinic services will be allowed a commercially reasonable time period to wind down and/or terminate operations at the onsite location. In the event of termination under this paragraph, all financial documents, data and reports related to the County's drug spend and prescription volume and prepared specifically by the Contractor under the Contract shall become the property of and be delivered to the County upon written demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination. Notwithstanding any provision to the contrary, County acknowledges and agrees that Contractor may retain 100% of any rebate related payments that have not been remitted to the County (for the current contract year) as of the date of termination of the Contract pursuant to this Section 6.7.

6.7.1 The County at its sole option may terminate Exhibits B-3 (Take Care Clinic and Pharmacy with 180 Days notice.

6.8 TERMINATION FOR DEFAULT:

6.8.1 In addition to the rights reserved in the Contract, the County may terminate the Contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the Contract, to acquire and maintain all required insurance policies, applicable licenses and permits, or to make satisfactory progress in performing the

Contract. The Procurement Officer shall provide written notice of the termination and the reasons for it to the Contractor.

6.8.2 Upon termination of this Contract pursuant to this paragraph, all goods, materials and any financial documents, data or reports related to the County's drug spend and prescription volume and prepared by the Contractor under the Contract shall become the property of and be delivered to the County on written demand. In addition, the subcontractor providing onsite pharmacy and clinic services will be allowed a commercially reasonable time period to wind down and/or terminate operations at the onsite location.

6.8.3 The County may, upon termination of this Contract, procure, on terms and in the manner that it deems appropriate, materials or services to replace those under this Contract. The Contractor shall be liable to the County for any excess costs incurred by the County in procuring materials or services in substitution for those due from the Contractor.

6.8.4 The Contractor shall continue to perform, in accordance with the requirements of the Contract, up to the date of termination, as directed in the termination notice.

6.8.5 Contractor may terminate this Contract for non-payment of any undisputed invoices due hereunder upon thirty (30) days written notice to the County.

6.9 STATUTORY RIGHT OF CANCELLATION FOR CONFLICT OF INTEREST:

Notice is given that pursuant to A.R.S. §38-511 the County may cancel this Contract without penalty or further obligation within three years after execution of the contract, if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County is at any time while the Contract or any extension of the Contract is in effect, an employee or agent of any other party to the Contract in any capacity or consultant to any other party of the Contract with respect to the subject matter of the Contract. Additionally, pursuant to A.R.S §38-511 the County may recoup any fee or commission paid or due to any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County from any other party to the contract arising as the result of the Contract.

6.10 OFFSET FOR DAMAGES:

In addition to all other remedies at law or equity, the County may offset from any money due to the Contractor any amounts Contractor owes to the County for damages resulting from breach or deficiencies in performance under this contract.

6.11 ADDITIONS/DELETIONS OF SERVICE:

The County reserves the right to add and/or delete products and/or services provided under this Contract. If a requirement is deleted, payment to the Contractor will be reduced proportionately to the amount of service reduced in accordance with the proposal price. If additional services and/or products are required from this Contract, prices for such additions will be negotiated between the Contractor and the County.

6.12 RELATIONSHIPS:

In the performance of the services described herein, the Contractor shall act solely as an independent contractor, and nothing herein or implied herein shall at any time be construed as to create the relationship of employer and employee, partnership, principal and agent, or joint venture between the District and the Contractor.

6.13 SUBCONTRACTING:

Contractor will provide core services to the County under this Contract; however, Contractor may utilize subcontractors to perform certain services under this Contract. Contractor shall remain responsible for the performance of any subcontractor. The parties acknowledge that Contractor's network of retail, mail and specialty pharmacy providers are not deemed to be or considered as subcontractors for the purpose of this Contract. Contractor may not assign this Contract to another party for performance of the terms and conditions hereof without the written consent of the County. The Parties agree that the prohibitions set forth in this Section 6.13 shall not apply to the onsite pharmacy and clinic services provided hereunder.

~~The Contractor may not assign this Contract or subcontract to another party for performance of the terms and conditions hereof without the written consent of the County. NO ASSIGNMENT SHALL BE ACCEPTABLE OR APPROVED FOR THE FIRST THREE (3) YEARS OF THE CONTRACT. Notwithstanding the forgoing, the parties acknowledge that Contractor's network of retail, mail and specialty pharmacy providers are not deemed to be or considered as subcontractors for the purpose of this Contract. All correspondence authorizing subcontracting must reference the Proposal Serial Number and identify the job project. The Parties agree that the prohibitions set forth in this Section 6.13 shall not apply to the onsite pharmacy and clinic services provided hereunder.~~

6.14 AMENDMENTS:

All amendments to this Contract shall be in writing and approved/signed by both parties. Maricopa County **Office of Procurement Services** shall be responsible for approving all amendments for Maricopa County.

6.15 ACCESS TO AND RETENTION OF RECORDS FOR THE PURPOSE OF AUDIT AND/OR OTHER REVIEW:

6.15.1 In accordance with section MCI 367 of the Maricopa County Procurement Code the Contractor agrees to retain all books, records, accounts, statements, reports, files, and other records and back-up documentation relevant to this Contract for six (6) years after final payment or until after the resolution of any audit questions which could be more than six (6) years, whichever is latest. The County, Federal or State auditors and any other persons duly authorized by the Department shall have full access to, and the right to examine, copy and make use of, any and all said materials.

6.15.2 If the Contractor's books, records , accounts, statements, reports, files, and other records and back-up documentation relevant to this Contract are not sufficient to support and document that requested services were provided, the Contractor shall reimburse Maricopa County for the services not so adequately supported and documented.

6.16 AUDIT DISALLOWANCES :

If at any time, County determines that a cost for which payment has been made is a disallowed cost, such as overpayment, County shall notify the Contractor in writing of the disallowance. County shall also state the means of correction, which may be but shall not be limited to adjustment of any future claim submitted by the Contractor by the amount of the disallowance, or to require repayment of the disallowed amount by the Contractor. The parties agree that this provision shall not apply to any issues arising out of an audit of prescription drug claims.

6.17 ALTERNATIVE DISPUTE RESOLUTION:

6.17.1 After the exhaustion of the administrative remedies provided in the Maricopa County Procurement Code, any contract dispute in this matter is subject to compulsory

arbitration. Provided the parties participate in the arbitration in good faith, such arbitration is not binding and the parties are entitled to pursue the matter in state or federal court sitting in Maricopa County for a de novo determination on the law and facts. If the parties cannot agree on an arbitrator, each party will designate an arbitrator and those two arbitrators will agree on a third arbitrator. The three arbitrators will then serve as a panel to consider the arbitration. The parties will be equally responsible for the compensation for the arbitrator(s). The hearing, evidence, and procedure will be in accordance with Rule 74 of the Arizona Rules of Civil Procedure. Within ten (10) days of the completion of the hearing the arbitrator(s) shall:

a) Render a decision;

b) Notify the parties that the exhibits are available for retrieval; and

c) Notify the parties of the decision in writing (a letter to the parties or their counsel shall suffice).

6.17.2 Within ten (10) days of the notice of decision, either party may submit to the arbitrator(s) a proposed form of award or other final disposition, including any form of award for attorneys' fees and costs. Within five (5) days of receipt of the foregoing, the opposing party may file objections. Within ten (10) days of receipt of any objections, the arbitrator(s) shall pass upon the objections and prepare a signed award or other final disposition and mail copies to all parties or their counsel.

6.17.3 Any party which has appeared and participated in good faith in the arbitration proceedings may appeal from the award or other final disposition by filing an action in the state or federal court sitting in Maricopa County within twenty (20) days after date of the award or other final disposition. Unless such action is dismissed for failure to prosecute, such action will make the award or other final disposition of the arbitrator(s) a nullity.

6.18 SEVERABILITY:

The invalidity, in whole or in part, of any provision of this Contract shall not void or affect the validity of any other provision of this Contract.

6.19 RIGHTS IN DATA:

The County shall have the use of all data and reports resulting from this Contract without additional cost or other restriction except as provided by law. Each party shall supply to the other party, upon request, any available information that is relevant to this Contract and to the performance hereunder.

6.20 INTEGRATION:

This Contract represents the entire and integrated agreement between the parties and supersedes all prior negotiations, proposals, communications, understandings, representations, or agreements, whether oral or written, express or implied.

6.21 VERIFICATION REGARDING COMPLIANCE WITH ARIZONA REVISED STATUTES §41-4401 AND FEDERAL IMMIGRATION LAWS AND REGULATIONS:

6.21.1 By entering into the Contract, the Contractor warrants compliance with the Immigration and Nationality Act (INA using e-verify) and all other federal immigration laws and regulations related to the immigration status of its employees and A.R.S. §23-214(A). The contractor shall obtain statements from its subcontractors certifying compliance and shall furnish the statements to the Procurement Officer upon request. These warranties shall remain in effect through the term of the Contract. The Contractor and its subcontractors

shall also maintain Employment Eligibility Verification forms (I-9) as required by the Immigration Reform and Control Act of 1986, as amended from time to time, for all employees performing work under the Contract and verify employee compliance using the E-verify system and shall keep a record of the verification for the duration of the employee's employment or at least three years, whichever is longer. I-9 forms are available for download at USCIS.GOV.

6.21.2 The County retains the legal right to inspect contractor and subcontractor employee documents performing work under this Contract to verify compliance with paragraph 6.21.1 of this Section. Contractor and subcontractor shall be given reasonable notice of the County's intent to inspect and shall make the documents available at the time and date specified. Should the County suspect or find that the Contractor or any of its subcontractors are not in compliance, the County will consider this a material breach of the contract and may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or debarment of the Contractor. All costs necessary to verify compliance are the responsibility of the Contractor.

~~6.22 VERIFICATION REGARDING COMPLIANCE WITH ARIZONA REVISED STATUTES §§35-391.06 AND 35-393.06 BUSINESS RELATIONS WITH SUDAN AND IRAN:~~

~~6.22.1 By entering into the Contract, the Contractor certifies it does not have scrutinized business operations in Sudan or Iran. The contractor shall obtain statements from its subcontractors certifying compliance and shall furnish the statements to the Procurement Officer upon request. These warranties shall remain in effect through the term of the Contract.~~

~~6.22.2 The County may request verification of compliance for any contractor or subcontractor performing work under the Contract. Should the County suspect or find that the Contractor or any of its subcontractors are not in compliance, the County may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or debarment of the Contractor. All costs necessary to verify compliance are the responsibility of the Contractor.~~

6.23 CONTRACTOR LICENSE REQUIREMENT:

6.23.1 The Contractor shall procure all applicable permits, insurance, licenses and pay the charges and fees necessary and incidental to the lawful conduct of his/her business, and as necessary complete any required certification requirements, required by any and all governmental or non-governmental entities as mandated to maintain compliance with and in good standing for all permits and/or licenses. The Contractor shall keep fully informed of existing and future trade or industry requirements, Federal, State and Local laws, ordinances, and regulations which in any manner affect the fulfillment of this Contract and shall comply with the same. Contractor shall immediately notify both **Office of Procurement Services** and the using agency of any and all changes concerning permits, insurance or licenses.

6.24 CERTIFICATION REGARDING DEBARMENT AND SUSPENSION:

6.24.1 The undersigned (authorized official signing for the Contractor) certifies to the best of his or her knowledge and belief, that the Contractor, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

6.24.1 are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

6.24.2 have not within 3-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a

criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statues or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

6.24.3 are not presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (2) of this certification; and

6.24.4 Have not within a 3-year period preceding this Contract had one or more public transaction (Federal, State or local) terminated for cause of default.

6.24.5 Should the Contractor not be able to provide this certification, an explanation as to why should be attached to the Contact.

6.24.6 The Contractor agrees to include, without modification, this clause in all lower tier covered transactions (i.e. transactions with subcontractors) and in all solicitations for lower tier covered transactions related to this Contract.

6.25 PRICES:

Contractor warrants that prices extended to County under this Contract are no higher than those paid by any other similar situated customer with respect to size, composition and/or prescription volume for these or similar services.

6.26 GOVERNING LAW:

This Contract shall be governed by the laws of the state of Arizona. Venue for any actions or lawsuits involving this Contract will be in Maricopa County Superior Court or in the United States District Court for the District of Arizona, sitting in Phoenix, Arizona.

6.27 ORDER OF PRECEDENCE:

In the event of a conflict in the provisions of this Contract and the incorporated Exhibits the terms of this Contract shall prevail.

6.28 **INFLUENCE**

As prescribed in MC1-1202 of the Maricopa County Procurement Code, any effort to influence an employee or agent to breach the Maricopa County Ethical Code of Conduct or any ethical conduct, may be grounds for Disbarment or Suspension under MC1-902.
An attempt to influence includes, but is not limited to:

6.28.1 **A Person offering or providing a gratuity, gift, tip, present, donation, money, entertainment or educational passes or tickets, or any type valuable contribution or subsidy,**

6.28.2 **That is offered or given with the intent to influence a decision, obtain a contract, garner favorable treatment, or gain favorable consideration of any kind.**

If a Person attempts to influence any employee or agent of Maricopa County, the Chief Procurement Officer, or his designee, reserves the right to seek any remedy provided by the Maricopa County Procurement Code, any remedy in equity or in the law, or any remedy provided by this contract.

6.29 INCORPORATION OF DOCUMENTS:

The following are to be attached to and made part of this Contract:

6.29.1 Exhibit A, A-1 Pricing;

6.29.2 Exhibit B, Scope of Work;

6.29.3 Exhibit B-1 (Governance of Pharmacy Benefit Management Services)

6.29.4 Exhibit B-2 (Vendor Responses from RFP)

6.29.5 Exhibit B-3 (Onsite Pharmacy and Clinic Operations)

6.29.6 **Exhibit C (Service Level Agreement)**

IN WITNESS WHEREOF, this Contract is executed on the date set forth above.

CONTRACTOR

Richard A Bates

AUTHORIZED SIGNATURE

9/16/11

DATE

Richard A Bates

PRINTED NAME AND TITLE

800 King Farm Blvd., 4th Floor, Rockville, MD 20850

ADDRESS

MARICOPA COUNTY

SEP 26 2011

CHAIRMAN, BOARD OF SUPERVISORS

DATE

ATTESTED:

Fran McCarroll

CLERK OF THE BOARD 093111

SEP 26 2011

DATE

APPROVED AS TO FORM:

Scott Benton

LEGAL COUNSEL

Sept 22, 2011

DATE

EXHIBIT A
PRICING

Removed Eff. 07/01/14

~~SERIAL 10082-RFP~~	
~~NIGP CODE: 94872~~	
~~RESPONDENT'S NAME:~~	~~Catalyst RX- Catamaran PBM of Maryland Inc.~~
~~COUNTY VENDOR NUMBER :~~	~~2011001143 0~~
~~ADDRESS:~~	~~14309 Collection Center Drive 2441 Warrenville Road, Suite 610 Chicago, IL. 60693- Lisle, IL 60532-3642~~
~~P.O. ADDRESS:~~	~~N/A~~
~~TELEPHONE NUMBER:~~	~~847-572-7793 (630) 577-3100~~
~~FACSIMILE NUMBER:~~	~~847-964-6954 (630) 328-2189~~
~~WEB SITE:~~	~~catalystrx.com~~
~~CONTACT (REPRESENTATIVE):~~	~~Shannon Ross Contract Administration~~
~~REPRESENTATIVE'S E-MAIL ADDRESS:~~	~~Shannon.Ross@catalystrx.com legal@catamaranrx.com~~

~~PAYMENT TERMS.~~

~~[X] NET 15 DAYS~~	~~PRESCRIPTION DRUGS~~
~~[X] NET 30 DAYS~~	~~ANCILLARY AND TAKE CARE CLINIC~~

~~1.0 PRICING (RETAIL):~~		
~~1.1 RETAIL NETWORK~~		
~~1.1.1 BRAND AWP LESS DISCOUNT (30 DAY)~~	~~18.5%~~	
~~1.1.2 DISPENSING FEE~~	~~$1.00~~	~~PER PRESCRIPTION~~
~~1.1.3 GENERIC DISCOUNT~~	~~72.15%~~	
~~1.1.4 BRAND AWP LESS DISCOUNT (90 DAY)~~	~~22%~~	
~~1.1.5 ADMINISTRATIVE FEE~~	~~$0.00~~	~~PER PRESCRIPTION~~
~~1.1.6 GENERIC DISCOUNT~~	~~72.15%~~	
~~1.1.7 REBATE ON ALL BRAND PRESCRIPTIONS~~	~~$4.00 minimum guarantee; 100% Pass-through~~	~~PER PRESCRIPTION~~
	~~$15.50 per Brand (30 day supply)*~~	~~Not guaranteed~~
	~~$28.50 per Brand (90 day supply)*~~	~~Not guaranteed~~
~~1.2 MAIL ORDER~~		
~~1.2.1 BRAND AWP LESS DISCOUNT~~	~~22%~~	
~~1.2.3 GENERIC DISCOUNT~~	~~72.15%~~	
~~1.2.2 DISPENSING FEE~~	~~$0.00~~	~~PER PRESCRIPTION~~
~~1.2.4 ADMINISTRATIVE FEE~~	~~$0.00~~	~~PER PRESCRIPTION~~
~~1.2.5 REBATE ON ALL BRAND PRESCRIPTIONS~~	~~$4.00 minimum guarantee~~	~~PER PRESCRIPTION~~
	~~$38.00 per Brand*~~	~~Not guaranteed~~

~~1.3 SPECIALTY/INFUSION/INJECT ABLE DRUGS~~

	~~MINIMUM PER DRUG~~	~~AWP - 17.5% represents the overall aggregate specialty discount. Please refer to the specialty price schedule provided in WHI's initial submittal for drug-specific pricing. Drug-specific pricing is not guaranteed.~~	
~~1.3.1 BRAND AWP LESS DISCOUNT~~			
~~1.3.2 DISPENSING FEE~~	~~$0.00~~		~~PER PRESCRIPTION~~

~~1.3.3 GENERIC DISCOUNT~~		~~17.50%~~	~~MINIMUM PER DRUG~~
~~1.3.4 ADMINISTRATIVE FEE~~		~~$0.00~~	~~PER PRESCRIPTION~~
~~1.3.5 REBATE ON ALL BRAND PRESCRIPTIONS~~		~~$4.00 minimum guarantee~~	~~PER PRESCRIPTION~~
		~~$18.00 per Brand~~	~~Not guaranteed~~
~~1.4 GENERIC DISCOUNT~~			
~~1.4.1 SINGLE SOURCE~~		~~49%~~	
~~1.4.2 NON MAC DISCOUNT~~		~~49%~~	
~~1.4.3 OVERALL EFFECTIVE GUARANTEED DISCOUNT~~	~~30 day~~	~~72.15%~~	
	~~90 day~~	~~72.15%~~	
~~1.5 DME EQUIPMENT/COLONOSCOPY SUPPLIES/WOULD CARE (PURCHASE)~~		~~10%~~	~~OFF RETAIL PRICE~~
~~1.6 REBATES~~		~~10% retail baseline discount, with the option of partnering on establishing a service/billing model which is beneficial to both parties.~~	
~~1.6 GUARANTEED OVERALL REBATES ON ALL PRESCRIPTIONS~~		~~$4.00 minimum guarantee~~	~~PER PRESCRIPTION~~

EXHIBIT A
PRICING

Removed Eff. 02/26/15
~~New Pricing Effective as of 07/01/14~~

~~SERIAL 10082-RFP~~
~~NIGP CODE: 94872~~

~~RESPONDENT'S NAME:~~	~~CATAMARAN PBM OF MARYLAND INC.~~
~~COUNTY VENDOR NUMBER :~~	~~2011001143~~
~~ADDRESS:~~	~~2441 WARRENVILLE ROAD, SUITE 610~~
	~~LISLE, IL. 60532-3642~~
~~P.O. ADDRESS:~~	~~N/A~~
~~TELEPHONE NUMBER:~~	~~630-577-3100~~
~~FACSIMILE NUMBER:~~	~~630-328-2189~~
~~WEB SITE:~~	~~CATAMARANRX.COM~~
~~CONTACT (REPRESENTATIVE):~~	~~Shannon Ross~~
~~REPRESENTATIVE'S E-MAIL ADDRESS:~~	~~Shannon.Ross@catalystrx.com~~

~~PAYMENT TERMS.~~

~~[X] NET 30 DAYS~~ ~~ANCILLARY AND TAKE CARE CLINIC~~

~~1.0 PRICING (RETAIL):~~
~~1.1 RETAIL NETWORK~~

~~1.1.1 BRAND AWP LESS DISCOUNT (30 DAY)~~	~~20.0%~~	
~~1.1.2 DISPENSING FEE~~	~~$0.00~~	~~PER PRESCRIPTION~~
~~1.1.3 GENERIC DISCOUNT~~	~~74.25%~~	
~~1.1.4 BRAND AWP LESS DISCOUNT (90 DAY)~~	~~20%~~	
~~1.1.5 ADMINISTRATIVE FEE~~	~~$0.00~~	~~PER PRESCRIPTION~~
~~1.1.6 GENERIC DISCOUNT~~	~~74.25%~~	
~~1.1.7 REBATE ON ALL BRAND PRESCRIPTIONS~~	~~$4.00 minimum guarantee; 100% Pass-through~~	~~PER PRESCRIPTION~~

~~1.2 MAIL ORDER~~

~~1.2.1 BRAND AWP LESS DISCOUNT~~	~~20%~~	
~~1.2.3 GENERIC DISCOUNT~~	~~74.25%~~	
~~1.2.2 DISPENSING FEE~~	~~$0.00~~	~~PER PRESCRIPTION~~
~~1.2.4 ADMINISTRATIVE FEE~~	~~$0.00~~	~~PER PRESCRIPTION~~
~~1.2.5 REBATE ON ALL BRAND PRESCRIPTIONS~~	~~$4.00 minimum guarantee~~	~~PER PRESCRIPTION~~

~~1.3 SPECIALTY/INFUSION/INJECT ABLE DRUGS~~

	~~MINIMUM PER DRUG~~	~~AWP - 17.75% represents the overall aggregate specialty discount. Please refer to the specialty price schedule provided in WHI's initial submittal for drug-specific pricing. Drug-specific pricing is not guaranteed.~~	
~~1.3.1 BRAND AWP LESS DISCOUNT~~			
~~1.3.2 DISPENSING FEE~~	~~$0.00~~		~~PER PRESCRIPTION~~
~~1.3.3 GENERIC DISCOUNT~~	~~17.75%~~		~~MINIMUM PER DRUG~~
~~1.3.4 ADMINISTRATIVE FEE~~	~~$0.00~~		~~PER PRESCRIPTION~~
~~1.3.5 REBATE ON ALL BRAND PRESCRIPTIONS~~	~~$4.00 minimum guarantee~~		~~PER PRESCRIPTION~~
	~~$18.00 per Brand~~		~~Not guaranteed~~

~~**1.4 GENERIC DISCOUNT**~~		
~~1.4.1 SINGLE SOURCE~~		~~49%~~
~~1.4.2 NON MAC DISCOUNT~~		~~49%~~
~~1.4.3 OVERALL EFFECTIVE~~	~~30 day~~	~~74.25%~~
~~GUARANTEED DISCOUNT~~	~~90 day~~	~~74.25%~~

EXHIBIT A
PRICING

New Pricing Effective as of 02/26/15

SERIAL 10082-RFP
NIGP CODE: 94872

RESPONDENT'S NAME:	CATAMARAN PBM OF MARYLAND INC.
COUNTY VENDOR NUMBER :	2011001143
ADDRESS:	1600 MCCONNORPARKWAY
	SCHAUMBURG, IL 60173
TELEPHONE NUMBER:	800-282-3232
FACSIMILE NUMBER:	224-231-1901
WEB SITE:	catamaranrx.com
CONTACT (REPRESENTATIVE):	Shannon Ross
REPRESENTATIVE'S E-MAIL ADDRESS:	Shannon.Ross@catamaranrx.com

PAYMENT TERMS.

[X]	NET 15 DAYS	PRESCRIPTION DRUGS
[X]	NET 30 DAYS	ANCILLARY

1.0 PRICING (RETAIL):

1.1 RETAIL NETWORK

1.1.1 BRAND AWP LESS DISCOUNT (30 DAY)	20.0%	
1.1.2 DISPENSING FEE	$0.00	PER PRESCRIPTION
1.1.3 GENERIC DISCOUNT	74.25%	
1.1.4 BRAND AWP LESS DISCOUNT (90 DAY)	20%	
1.1.5 ADMINISTRATIVE FEE	$0.00	PER PRESCRIPTION
1.1.6 GENERIC DISCOUNT	74.25%	
1.1.7 REBATE ON ALL BRAND PRESCRIPTIONS	$4.00 per net paid claim minimum guarantee; 100% pass-through	

1.2 MAIL ORDER

1.2.1 BRAND AWP LESS DISCOUNT	20%	
1.2.3 GENERIC DISCOUNT	74.25%	
1.2.2 DISPENSING FEE	$0.00	PER PRESCRIPTION
1.2.4 ADMINISTRATIVE FEE	$0.00	PER PRESCRIPTION
1.2.5 REBATE ON ALL BRAND PRESCRIPTIONS	$4.00 per net paid claim minimum guarantee; 100% pass-through	

1.3 SPECIALTY/INFUSION/INJECT ABLE DRUGS

1.3.1 BRAND AWP LESS DISCOUNT	MINIMUM PER DRUG: AWP - 17.75% represents the overall aggregate specialty discount. Please refer to the specialty price schedule provided in WHI's initial submittal for drug-specific pricing. Drug-specific pricing is not guaranteed.	
1.3.2 DISPENSING FEE	$0.00	PER PRESCRIPTION
1.3.3 GENERIC DISCOUNT	17.75%	
1.3.4 ADMINISTRATIVE FEE	$0.00	PER PRESCRIPTION
1.3.5 REBATE ON ALL BRAND PRESCRIPTIONS	$4.00 per net paid claim minimum guarantee; 100% pass-through	

1.4REBATES

1.4.1 GUARANTEED OVERALL REBATES ON ALL PRESCRIPTIONS	$4.00 minimum guarantee	PER PRESCRIPTION

EXHIBIT A-1
PRICING

ADDITIONAL PRICING If requested by County, Contractor will provide the following additional services in the table below at the fees indicated:

Service	**Fee**	
Claims submitted for Direct Member Reimbursement or other post-service adjudication (e.g. subrogation claims)	$1.50	Per "clean" claim
ID Card Re-issuance	$0.80	Per package (includes 2 cards)
Coordination of Benefits	$2.00	Per "clean" claim
Plan Prior Authorization	$0.00	Per entry when entered by the County (if applicable)
Plan Prior Authorization	$1.00	Per entry when entered by WHI
Internal Clinical Appeal Review	$250	Per appeal review
External Tier 1 Clinical Appeal Review	$325	Per appeal review
External Tier 2 Clinical Appeal Review	$350	Per appeal review
Federal External Reviews for 2011	$475	Per appeal review
Manual Paper Eligibility Submission	$0.75	Per record
Individual Mailings*	$1.50	Postage per mailing
Deductibles	$0.00	Fee is waived
Benefit Maximums	$0.00	Fee is waived
Claim Billing Tape (standard)	$100	Per tape
Claim Billing Tape (non-standard)	TBD	Per tape
Claim Billing Data	$0.00	Via FTP
Non-Return of Tape	$175	Per tape
Online Client Access to *PBS*	$0.00	Includes 9 Logon IDs

Complex Ad Hoc Report programming	$125/hr.	Minimum of 4 hours, *if programming required*	
Additional Logon ID for *PBS* or *RxVision*	$50	Per user per month	
Adjustment to previous paid Rx	$0.75	Per claim	
Add/Return Management Report	$100	Per report, plus $0.05 per page	
Member Detail Report	$0.02	Per claim	
ID card distribution	TBD	County is responsible for actual postage expenses if not bulk shipped to one location for distribution to members	
Clinical Program		**Fee for Service Pricing**	
Concurrent DUR		Included	
Prospective DUR *Informed Prescribing*		Included	
Retrospective Drug Utilization Review		Included	
MedMonitor®24		$0.30	per claim
Clinical Prior Authorizations		$40	per review request
Step Care Therapy		$40	per review request
Formulary Copay Override		$40	per intervention
Cost Ceiling Prior Authorization Program		$40	per intervention
Formulary Delete Letter		No Charge	
MedMonitor®XR MTM		$0.03	per claim
Accompanied by a guaranteed 1.5 to 1 ROI, when combined with MedMonitor24.		$70 Polypharmacy	per intervention
		$25 Inappropriate Medication in the Elderly	per intervention
		$25 Appropriateness of Therapy	per intervention
		$17 Compliance & Persistency	per intervention
Polypharmacy Assessment		$40	per intervention

Polypharmacy Consultation		$40	per consultation
Blueprint for Wellness™ Comprehensive		$96	per participant
Other Blueprint for Wellness™ Services			
- PSA		$8.90	per participant
- Waist Circumference		$1.20	per participant
- Cotinine Serum		$18.00	per participant
- Fecal Occult		$40.80	per distributed kit
- Fecal Occult Returned Kit		$6.00	per kit tested and returned
Flu and Pneumonia Immunizations		$28.50	per shot
		$34.99	per nasal vaccine
		$54.99	per pneumonia vaccine
Walgreens Optimal Wellness™		$500	per participant/year
Voluntary Tablet Splitting		$1.90	per intervention
Free and Clear™ Quit for Life		$409	per participant
(includes medication costs for nicotine replacement)			
Healthful Living Tobacco Free Program		$225	per participant/year
Any services not listed above may be provided by Contractor on a mutually agreed upon service fee.			

EXHIBIT B
SCOPE OF WORK

1.0 INTENT:

It is the intent of Maricopa County to contract with a Pharmacy Benefit Manager to provide all services in section 2.0 of this document.

Other governmental entities under agreement with the County may have access to services provided hereunder (see also Section 2.17 below)

2.0 SCOPE OF SERVICES:

Contractor is proposing an enterprise-wide wellness solution that maximizes the synergistic opportunities available by combining retail, mail and 90-day pharmacy networks with an on-site pharmacy and health center, specialty pharmacy, infusion, wellness services, durable medical equipment and Ryan White program administration.

2.1 Retail Network Services

Contractor will provide the County with its choice of either a Preferred Network composed exclusively of 6,250 Walgreen community pharmacies or a Non-Preferred Network that includes a majority of chain and independent pharmacies including Walgreens. Either network will serve as a convenient resource for prescription drugs, trusted pharmacy advice and healthcare information. Our network pharmacies also provide the County with other clinical program management services such as concurrent drug utilization review, retrospective drug utilization review, therapeutic interventions, step care therapy and prior authorizations.
Our MedMonitor®XR MTM promotes face-to-face encounters with members at the pharmacy, thereby leading to a higher percentage of cost-efficient clinical interventions. MedMonitorXR focuses on managing patients who are at high risk for drug-related problems that can result from taking multiple medications for several chronic conditions. We offer four different components including Polypharmacy, Inappropriate Medication in the Elderly, Appropriateness of Therapy and Compliance and Persistency. With over 15,000 participating MTM pharmacies, we are uniquely positioned to help the County realize positive outcomes in the years to come.
Contractor will also offer the County a program that enhances member choice by giving your members with the freedom to obtain a 90-day supply of medications from over 7,650 Walgreen community pharmacies. The 90 day program is a value-added product that gives members taking long-term (maintenance) medications, a viable alternative to mail service *at equivalent rates.* Along with convenience, we have found that generic utilization is higher with 90 retail than mail; in part, due to a closer pharmacist/member relationship.

2.2 Mail Order Services **Pharmacy** **Contractor shall provide the following services from its mail service pharmacy:**

(i) receive prescriptions from Participants via U.S. mail or commercial carrier at an address as specified by Contractor from time to time, subject to and in accordance with the County's Plan.

(ii) fill prescriptions during normal business hours, subject to the professional judgment of the dispensing pharmacist, provided that the prescription is accompanied by the correct capay, deductible, or coinsurance amount as applicable;

(iii) provide Participants toll-free telephone access to a pharmacist and customer service representative;

(iv) provide to County promotional materials that explain to Participants how to use the mail service program, as well as any other materials Participants may require to begin using the mail service program and County shall distribute such information to Participants;

(v) provide computerized drug interaction monitoring of Participants based upon the Participant profile, programs for generic substitution and therapeutic intervention, pharmaceutical cost containment services and safety edits, and subject to prescriber approval, clinical appropriateness, the terms of the Plan and applicable law; and

(vi) ship all prescription orders to Participants via U.S. Postal Setvice or other appropriate carrier to the address provided by County and/or the Participant, as long as such addresses are located in the United States;

~~Contractor will continue to provide the County with home delivery from the Walgreens mail facility located in Tempe, Arizona. Opened in June of 1994, this facility is capable of dispensing approximately 10.5 million prescriptions per year or 35,000 per day. With 3.1 million prescriptions dispensed every year, the mail facility will continue to address the County's mail service needs.~~

2.3 Specialty Drugs

Contractor will continue offering the County specialty pharmacy options and synergies unparalleled in the industry. We believe you will benefit from Contractor's global approach – a unique, continuous model that connects specialty pharmacy injectables, infused medications and clinical services. Contractor's suite of services provides detailed account management; compassionate patient care; patient education, consultation, and support; prescriber/care giver/case manager communications; enrollment, reimbursement, and patient assistance programs; delivery coordination; clinical monitoring; proven therapy management programs, compliance tracking, and patient follow-up.
County members will continue receiving specialized, in-depth care from dedicated care teams with specific knowledge and understanding of specialty management. Contractor's proven clinical management programs create a unique offering to ensure competitive drug acquisition costs, appropriate utilization and carefully coordinated treatment. Our programs were established to treat complex conditions where prescribers may have a greater propensity to discontinue and/or adjust therapy based on multiple indicators such as patient's response, patient status or weight change. These programs have been developed with input from thought leaders such as physicians and clinicians who have extensive expertise in the related condition.

2.4 Injectable Drug Services

Our specialty program encompasses injectables, therefore a separate program is not being offered at this time.

2.5 Wellness Services

Contractor, through a subcontract arrangement with Walgreens can provide the County with a suite of wellness services that will help you achieve your long-term goals. These services include immunizations, smoking cessation initiatives, Comprehensive Biometric Screenings and Walgreens Optimal Wellness. We also offer several new programs through your onsite health center.

2.6 On-Site Pharmacy Services

Contractor, through a subcontracted arrangement with Walgreens/Take Care Employee Solutions will continue to provide your employees and family members with service from the pharmacy and on-site health center located within the County Administration Building on Jefferson Street. When it first opened in January 2009, the County was the first employer in Arizona to offer an integrated onsite pharmacy and health center. Through the County's innovative wellness philosophy and Walgreens expertise, thousands of County employees and their dependants can visit a nurse practitioner, get immunizations, receive health screenings and fill their prescriptions. The on-site professionals take a proactive approach to care that is customized to the County's

unique environment and needs. The result is a flexible, completely integrated healthcare approach that proactively optimizes employee health, productivity and job satisfaction, all while positioning your company as an employer of choice and saving you money. Further information can be found in Exhibit B-3 (#174).

2.7 Clinical Programs

County agrees to participate in Contractor's Medication Management Program. The Parties agree that the current clinical programs listed on Schedule B-1 attached hereto are hereby incorporated into this Contract. The Medication Management Program is designed to promote appropriate utilization of potentially expensive, misprescribed, and/or abused medication based upon generally accepted current pharmacy practices. The Medication Management Program operates any time a Participant presents a prescription that requires a prior authorization. Contractor will attempt to have the prescriber respond to questions specific to the prescription presented via a prescriber form. Completed prescriber forms will be reviewed by a Contractor pharmacist and compared to the approved protocols for the applicable medication category. Based upon the results, County hereby directs Contractor's pharmacists either to authorize or deny coverage of the medication and Contractor will notify the Participant accordingly. It is expressly understood that County is solely responsible for construing the terms and conditions of its 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 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 Participants; and (iv) resolution of Member complaints, including the establishment of an appeal and/or grievance process. Client will comply with all Federal and State laws, rules, and regulations regarding the denial of benefits. Additionally, County will pay for the Medication Management Program in accordance with the applicable approved Clinical Billing & Routing Sheet incorporated herein.

2.8 SCOPE OF SERVICES (PBM GENERAL):

2.8.1 Contractor shall provide the prescription benefit management services described in this proposal and/or as otherwise mutually agreed to by the parties in writing, including, but not necessarily limited to, general support and consultative services regarding pharmacy benefit design and implementation, formulary management, network and rebate management, administrative and claims processing services, standard reporting packages, marketing, customer service, quality management and utilization management functions. In addition, Contractor may develop and implement certain additional clinical intervention and cost-saving (e.g. voluntary tablet splitting) programs that may be desired by the County, subject to terms and conditions to be agreed in writing between the parties. Contractor shall manage the current pharmacy benefit plan designs (multiple-tier coinsurance plan with minimum and maximum costs per tier, and a multiple-tier pharmacy reimbursement account) or future innovative plan designs, Notwithstanding the foregoing or any termination rights set forth in this Agreement, Contractor may immediately terminate or refrain from implementing any formulary management or other clinical program services in any geographic area (in their entirety or for specific drugs only) if, in Contractor's sole determination, the implementation or continued provision of such services is or may be in violation of applicable laws, rules, or regulations governing the practice of pharmacy or prescription benefits management, or may otherwise present an issue related to the practice of pharmacy or prescriptions benefits management.

Confirmed.

2.8.2 Contractor shall make membership eligibility/enrollment, copayment/coinsurance and benefit coverage information, supplied by the County or its designated agent in mutually agreed upon format, available to network Pharmacies on a weekly basis at the time of dispensing through the online electronic transmission link maintained between Contractor and Participating Pharmacies. Subject to Contractor's responsibility to load all such data received from County in a timely manner (within 48 hours of receipt), County is solely responsible for the accuracy, completeness, reliability, and timeliness of all information

provided to Contractor and acknowledges Contractor's reliance thereupon. Any errors or omissions in the information are the sole responsibility of County. County may not deny claims submitted by any Participating Pharmacy for payment subsequent to such Participating Pharmacy receiving approval via the online eligibility system.

Confirmed.

2.8.3 Identification cards shall be produced by Contractor and mailed to the Participant's home address within seven (7) calendar days from receipt of enrollment information. Such cards will serve only the purpose of Participant identification, not Participant eligibility. Eligibility as stated will be established at the time of dispensing through the Online Eligibility System.

Confirmed.

2.8.4 Contractor, as the authorized prescription benefit manager, shall perform formulary management, rebate sharing and other clinical services described herein. These services will include, but not necessarily limited to, prior authorization, step-therapy, systematic prospective, concurrent and retrospective drug utilization review and other measures that are deemed appropriate to effectuate formulary management. Accordingly, County authorizes Contractor, as its prescription benefit manager, to perform formulary management and other services described in this Request for Proposals.

Confirmed.

2.8.5 Contractor shall provide access to the online eligibility, claims payment and/or standard and ad hoc reporting system(s) (collectively, the "System") which will allow the County's specified personnel to view, enter, extract and/or manipulate information residing on the System on an individual, plan level, and account structure basis. The County asks for nine (9) access codes to be included. Training will be provided via the County's day-to-day local account management team.

Confirmed.

2.8.6 In addition to the identification cards, Contractor shall provide its standard introductory materials for issuance to Participants. Where appropriate and mutually agreed upon, various materials shall also be available in Spanish, either via paper or electronic media. This includes mail service order forms, program brochures, newsletters, mail service promotional materials, generic usage education pieces and retail pharmacy prescription labels. Any correspondence to membership shall be pre-approved by the County.

Confirmed.

2.8.7 Contractor shall be responsible for all costs associated with its development and printing of standard marketing materials that Contractor provides to County in connection with this Agreement; provided, however, that all costs associated with the distribution of such materials to Participants are the sole responsibility of County.

Confirmed.

2.8.8 With regard to billing, Contractor shall invoice the County following the close of each twice-monthly billing cycle. Such invoices shall include, but not necessarily be limited to, individual prescription claims, administrative fees and/or any other costs and charges specified in the agreement. County will pay Contractor all invoiced amounts within 15 days of receipt of invoice therefore. Contractor shall pay claims independently for services provided by Pharmacies; provided that Contractor has no obligation to make such payments until applicable funds have first been received from County.

Confirmed.

2.8.9 Contractor's Clinical Pharmacist and Account Manager shall work with the County in Contractor's commitment to satisfy the County's reporting needs. This will include but not necessarily be limited to standard management reports, provider profiling and analysis (e.g., identifying drug patterns), ad hoc reporting needs, recommendations on drug coverage, exclusions, plan designs and cost-controlling methods.

Confirmed.

2.8.10 Contractor's clinical staff shall work with the County to incorporate disease management and medication therapy management programs or other clinical programs that are deemed appropriate for the County and that have a return on investment for the County. As with all programs, mutually agreeable terms for specialized programs will be discussed and agreed upon.

Confirmed.

2.8.11 The following relates to Contractor's commitment of providing support personnel, and general onsite educational assistance throughout the term of the Contract.

2.8.11.1 Maricopa County shall have a dedicated, mutually agreed upon, local Contractor pharmacy consultant who will be the County's key clinical pharmacist and strategist.

Confirmed.

2.8.11.2 Maricopa County shall have a dedicated local Contractor Account Manager, who will be the point of contact for Maricopa County.

Confirmed.

2.8.11.3 Local Contractor Account Manager shall correspond with Maricopa County's Employee Benefits Division regarding service issues through the County's Contact Relationship Manager (CRM) case documentation system. The Contractor shall pay for the number of licenses needed to service the County.

Confirmed.

2.8.11.4 Local staff within Contractor shall provide onsite staffing by knowledgeable service personnel to support Open Enrollment, from April through July. Support hours expected are 10 hours/week in April - June and 40 hours/week in July. Contractor also commits to support annual enrollment meetings with retirees at a minimum of 3 geographical locations designated by the County.

Confirmed.

2.8.11.5 Contractor shall commit to participate in joint operating meetings with the County's other health benefit vendors on a quarterly basis.

Confirmed.

2.8.11.6 Contractor shall commit to attend a minimum of five (5) initial rollout meetings with elected and appointed officials and department heads.

Confirmed.

2.8.11.7 Contractor shall send the Account Manager to the County's Monthly Service Meetings as well as providing an onsite staffing commitment of two (2) hours per month for New Employee Orientation.

Confirmed.

2.8.11.8 At the start-up of the program Contractor shall commit to performing "Welcome Calls" to the County retirees (approximately 250) and COBRA participants (approximately 350).

Confirmed.

2.8.12 Contractor shall conduct an annual County-specific plan-specific member satisfaction survey with tabulated results each January.

A sample of County members will be included in our annual survey, with results returned to the County annually.

2.8.13 Reporting. CONTRACTOR shall:

2.8.13.1 Report number and dollar amounts of claims processed each month on a summary and detail level by plan and account structure.
Confirmed.

2.8.13.2 Monthly, and year-to-date utilization reports by plan and all plans combined, totals of: top 100 drugs by number of prescriptions filled and by cost; generic, single-source brand and multi-source brand dispensing rate and average ingredient costs; cost details (plan, member and total, PMPM and PEPM, average ingredient cost, average dispensing fee, average discount percentage, and generic efficiency).
Confirmed.

2.8.13.3 Annual utilization and trend report including overall and plan- level performance analysis and recommendations for improvements. Report must also include analysis of customer complaints and appeals.
Confirmed.

2.8.13.4 Quarterly specialty utilization dashboard and summary of activity, and clinical and economic impact by prevalent diseases.
Confirmed.

2.8.13.5 Provide advance notification of each fund transfer, date and amounts.
Confirmed.

2.8.13.6 Provide annually a Service Organization Control Report (SOC1 report, formerly known within the industry as a SAS70 Audit Report) and other reports as required by the County's annual internal and/or external auditor.
Confirmed.

2.8.13.7 Provide monthly call center metrics reports including answer speed, call abandonment rate, number of calls answered, number of calls resolved in one call, type of calls (specific to Maricopa County members, per Maricopa's vanity line), and call quality monitoring results.
Confirmed.

2.8.13.8 Provide monthly appeal reports including summary and detail level of all levels (complaint, grievance, appeal) of appeal activity including the number received, pended and resolved, and results with a summary of causes/reasons on all internal and external levels.
Confirmed.

2.8.13.9 Provide online access to 'ad hoc' report writer and standard reports, and access to create data drill down by plan and account structure.
Confirmed.

2.8.13.10 Provide quarterly performance guarantee metrics, to be documented by County and Contractor on an annual basis.
Confirmed.

2.8.14 Claims Processing. Contractor shall:

2.8.14.1 Agree to have data utilization edits in place that identifies and denies duplicate claims, claims filed too soon, claims requiring authorization when such authorization is not in place (prior authorization or step-care), as well as messages to the pharmacist for review and approval or denial of the claim due to safety issues.
Confirmed.

2.8.14.2 Provide refunds at the retail pharmacy within a minimum of seven days in the case of a member paying for a claim that should have been processed and approved through the claim system.
Confirmed.

2.8.14.3 Provide a process for reimbursing members through submission of a paper reimbursement request form. Maricopa County prefers the ability to process such reimbursements through the Contractor's online claims system.
Confirmed.

2.8.14.4 Have the ability to electronically bill the medical insurance carrier for pharmacy provided wellness services (e.g., flu and pneumonia shots).
Confirmed.

2.8.15 Appeals/Grievances. Contractor shall:

2.8.15.1 Supply the appeals policy and procedure for the internal and external appeal process in compliance with provisions and guidelines of the Health Care Reform legislation (currently the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act).
Confirmed.

2.8.15.2 Handle the internal and external appeal process through external level.
Confirmed.

2.8.16 Customer Service. Contractor shall:

2.8.16.1 Provide customer service staff that are fully trained on Maricopa County's benefit plan designs and are available to employees 24 hours per day, 7 days per week.
Confirmed.

2.8.16.2 Provide Contractor's customer service program description including the hours of operations, locations, training plan, call quality program, scoring tool and quality standards, production expectations (number of calls per day, time spent in Available status, etc.), production and quality metrics, staffing ratio, number of bi-lingual staff, and available services to handle a diverse population.
Confirmed.

2.8.16.3 Maricopa County prefers a dedicated customer service team available during the hours of 7 AM to 6 PM. Such team will have thorough training in the County's benefit plan designs.
Confirmed.

2.8.17 Implementation Plan

Contractor will provide annually, a detailed implementation plan with mutually agreed upon tasks assignments, including a fee to offset costs.
Confirmed.

2.8.18 Formulary Changes

Contractor shall provide advance written notice to Maricopa County no later than 90-days and to the home address of adversely impacted members no later than 60-days when drug tier level changes are made to the formulary. Additionally, Contractor shall notify members no later than 60-days in advance in writing to their home address of the

expiration date of a prior authorization and for industry events (e.g., significant Black Box Warnings, drug withdrawals when significant impact is expected, etc.)

Confirmed.

2.8.19 Education Support:

Contractor shall provide Maricopa County with an array of educational material and web-based tools that will help educate members on each product's plan design and assist them in calculating and tracking the cost and utilization of their drugs based on product (Coinsurance or Pharmacy Reimbursement Account) through all delivery channels (retail 30, retail 90, specialty, and mail service). The tool(s) must also provide alternative suggestions for more cost-effective medication within the same therapeutic class.

Confirmed.

2.8.20 Data Sharing

Contractor shall support Maricopa County's request for full program data integration by transferring complete Eligibility, Paid Claims and Prescriber (e.g., name, address, phone number, specialty, DEA and NPI numbers) Data to County's other vendors (benefit administration, medical, behavioral health, data warehouse, etc.) on a monthly basis in a mutually agreed upon format, subject to a mutually agreeable fee between Contractor and vendor for any format changes Contractor is required to make. Appropriate mutually agreeable terms and security language will be put in place to protect the integrity of the data transfer and to insure compliance with all applicable privacy rules and regulations.

Confirmed.

2.9 MAIL ORDER:

Mail order prescriptions for an 84-91 day supply of maintenance medication shall be sent to Members at Member's home address, work address or to a local Network pharmacy from the Participating Mail Service Pharmacy via United Parcel Service, United States Postal Service, or any other method the Participating Mail Service Pharmacy may select. Risk of loss or damage to covered drugs provided hereunder is on the Participating Mail Service Pharmacy until such prescription drugs have been delivered to Member. Certain products that require cold-pack shipping methods as recommended by the manufacturer will be handled appropriately. The cost of shipping will be borne by the Participating Mail Service Pharmacy. Members will pay, or reimburse Participating Mail Service Pharmacy, as applicable, for all additional expenses due to expedited delivery requested by Member. In addition, to the extent Contractor's shipping costs significantly increase after the effective date of the rates set forth in this Agreement as a result of rate increases by the United States Postal Service or private mail package handlers, the parties will negotiate in good faith to reach agreement on an adjustment to the rates to compensate Contractor for its increased costs. Member must transmit with the order to the Participating Mail Service Pharmacy the applicable copayment fee for each prescription or refill covered by this Proposal.

Confirmed.

2.10 NETWORK:

With regard to the actual dispensing process involving the contracted providers in Contractor's network, services will be provided to Members upon the following terms and conditions:

2.10.1 Upon presentation by a Member or his/her agent of the identification card, receipt of appropriate prescriptions, and any required copayment or coinsurance, the Pharmacy shall compound and dispense all qualified prescriptions and covered drugs pursuant to the pharmacy benefit plan design and eligibility information provided by the County to Contractor and communicated by Contractor to such Pharmacy via the Online Eligibility and Claim System at the time of dispensing, subject to legal restrictions and professional ethics and professional judgment.

Confirmed.

2.10.2 Pharmacy shall collect any applicable minimum or maximum copayment, coinsurance or deductible amount from each Member for each covered prescription. As indicated by the Online

Eligibility and Claims System at the time of dispensing. When the Participating Pharmacy's usual and customary charge or retail cash price for the prescription is less than the minimum copayment or coinsurance, the Participating Pharmacy will collect the lowest amount in lieu of the minimum copayment or coinsurance indicated by the Online Eligibility and Claims system.

Confirmed.

2.10.3 Pharmacy may withhold prescription services to a Member for good cause, including, but not necessarily limited to, County's nonpayment for prescription services provided to Members; the Member's failure to pay for services rendered (e.g., copayment or coinsurance); requests by Member for quantities of drugs in excess of prescribed amounts or refill limitations pursuant to the pharmacy benefit information; quantities of maintenance drugs in lesser than a three-month supply (after two 30-day fills),or where, in the professional judgment of the dispensing pharmacist, the prescription should not be filled.

Confirmed.

2.10.4 Pharmacy shall attempt to dispense generic equivalent drugs in lieu of prescribed brand name drugs if commercially available, meet quality rating standards, and if consistent with the prescriber's orders and the dispensing pharmacist's professional judgment and state and federal law.

Confirmed.

2.10.5 PREFERRED NETWORK:

It is expected that PBM will propose a preferred network of retail pharmacies where the County will receive a greater discount from AWP and the employee will have lower out-of-pocket costs. This network may be revised or discontinued at the County's sole option on a bi-annual basis

Confirmed.

2.10.6 SECONDARY NETWORK:

The County shall require a network with that includes the maximum number of retail pharmacies. Employee out-of-pocket costs will be higher at this network. This is applicable only if the County selects a preferred network option in the future.

Confirmed.

2.11 SPECIALTY DRUGS:

Contractor shall provide a cost-effective Specialty Pharmacy Program with either centralized distribution or multi-channel distribution that is national, convenient, consistent and flexible. Specialty pharmaceuticals are generally high-cost medications that are usually prescribed for people with complex or chronic medical conditions, i.e., multiple sclerosis, hemophilia, hepatitis, and rheumatoid arthritis. Medications typically exhibit one or more of the following characteristics: are injected or infused, however some may be taken orally; have unique monitoring, storage or shipment requirements; require additional education and support from a health care professional; and are usually not available at retail pharmacies.

The Program must have developed services to meet the unique challenges of dispensing and monitoring these medications. The Program must provide cost-effective care and positive patient outcomes through increased adherence, as well as provide an enhanced patient experience through the convenience of scheduled delivery, disease management programs and compliance monitoring employing a care-coordination model. In care coordination, licensed clinicians (nurses, pharmacists, and physicians) provide comprehensive clinical management services. Clinical professionals support patients with education, training and mental health support (e.g., behavioral health, case management or disease management referral). The plan of care will address education, interventions, compliance, monitoring parameters, and goals and outcomes of therapy. Non-adherence or non-compliance and the rationale must be communicated to the prescribing physician.

The Program must contain provisions addressing preferred specialty medications and biosimilars.

Confirmed.

2.12 INFUSION THERAPY (OPTIONAL)

Proposer may propose a separate Specialty Infusion Program that features cost containment and cost avoidance to reduce and manage inappropriate utilization of services, decrease cost drivers associated with location of care, and identify cost-effective, convenient, coordinated care. The program must improve member health and well-being by providing access to accurate, objective and relevant healthcare information, improve member quality of life, and decrease absenteeism. The program must demonstrate a defined return on investment for the County and proven positive outcomes for members. The specific details of these services shall be set forth in an additional Exhibit to be added at a future date.

Confirmed.

2.13 INJECTABLES (OPTIONAL)

Proposer may propose a program to manage the cost of injectable medication (including self-injectables and those administered in a physician's office or hospital) through the PBM. The program must demonstrate a defined return on investment for the County and proven positive outcomes for members. The specific details of these services shall be set forth in an additional Exhibit to be added at a future date.

Confirmed.

2.14 WELLNESS PROGRAMS (OPTIONAL):

Proposer may propose any Wellness Programs including health screenings where there is a defined return on investment for the County. The specific details of these services shall be set forth in an additional Exhibit to be added at a future date.

Confirmed.

2.15 ON-SITE PHARMACY AND CLINIC

The County requires that the successful proposer shall have an on-site Pharmacy in the County Administration Building, 301 West Jefferson Street, Phoenix AZ. 85003. It is also expected that the successful proposer shall operate an Acute Care Convenience Clinic at this site, to be staffed by a Nurse Practitioner or Physician Assistant at no Cost to the County. Both of these services shall be open to the general public in addition to County employees. Proposers shall all propose how they will be able to leverage these services to other County campuses listed below. If respondent proposes to sub-contract this service the qualifications of the sub-contractor shall be included in the response including a copy of the sub-contractors contract.

2.15.1 Durango Street Campus

2.15.2 Southeast Campus

Contractor, through its subcontractor Walgreens, will continue to operate an employee on-site health center and pharmacy within the County Administration Building. This solution would be incorporated into the overall cost of the pharmacy benefit. Our integrated healthcare solution was designed to focus on the specific needs of County members and their families rather than the general public. At the County's option the Pharamcy and Clinic may be open to the public or other groups. We are open to exploring potential opportunities for expansion of space and services to serve your members. For further details see Exhibit B-3.

2.16 DURABLE MEDICAL EQUIPMENT (DME), Ostomy and Wound supples.(OPTIONAL)

Proposer may propose a DME Program for DME available at a retail pharmacy store where there is a defined return on investment for the County. This program shall include Equipment, Wound Care, Ostomy Supplies, Nebulizers, Respiratory Aids and Incontinence Supplies. This service should be able to be adjudicated through the pharmacy Claims System or a fully integrated Point of Sale System. The specific details of these services shall be set forth in an additional Exhibit to be added at a future date.

~~Schedule B-1~~
Replaced (12-4-12)

~~The Parties agree that the following Clinical Billing Routing Sheets are hereby incorporated into this Contract.~~

1. ~~Maricopa_Appeal_Billing_And_Routing_Sheets_2011.doc~~
2. ~~#2229_Maricopa County-Updating MedMonitor XR pricing criteria, effective 01012010.pdf~~
3. ~~Care Management (BFW) 2011.pdf~~
4. ~~Clinical Routing Sheets-June – Maricopa County- Add Med Monitor.doc~~
5. ~~Clinical Routing Sheets-Oct06 – Maricopa Voluntary Tablet Splitting Plan A.doc~~
6. ~~Clinical Routing Sheets-Oct06 – Maricopa Voluntary Tablet Splitting Plan C.doc~~
7. ~~Exhibit M-MEDICATION MANAGEMENT BILLING & ROUTING SHEET.doc~~
8. ~~Exhibit N-MEDICATION MANAGEMENT BILLING & ROUTING SHEET.doc~~
8. ~~Maricopa County – rebate_reduction_routing_sheet.xls~~
9. ~~Maricopa County – Specialty Pharmacy RS_May09.pdf~~
10. ~~Maricopa County-WHI Flu and Pneumonia BRS-July 09.pdf~~
11. ~~Maricopa HCR Preventive Drug List Routing Sheet 112610.doc~~
12. ~~Formulary Delete and Clinical Letters Routing Sheet.doc~~
13. ~~Non-ERISA Routing Sheet.doc~~

SCHEDULE B-1

The Parties agree that the following Clinical Billing Routing Sheets are hereby incorporated into this Contract. The Parties further agree that any subsequent County-approved Clinical Billing Routing Sheets describing the clinical programs to be provided to County that are not set forth in the list below that are signed by both Parties are incorporated by reference into this Contract as if listed on this Schedule B-1.

1. **Maricopa_Appeal_Billing_And_Routing_Sheets_2011.doc**
2. **#2229_Maricopa County-Updating MedMonitor XR pricing criteria, effective 01012010.pdf**
3. **Care Management (BFW) 2011.pdf**
4. **Clinical Routing Sheets-June – Maricopa County- Add Med Monitor.doc**
5. **Clinical Routing Sheets-Oct06 – Maricopa Voluntary Tablet Splitting Plan A.doc**
6. **Clinical Routing Sheets-Oct06 – Maricopa Voluntary Tablet Splitting Plan C.doc**
7. **Exhibit M-MEDICATION MANAGEMENT BILLING & ROUTING SHEET.doc**
8. **Exhibit N-MEDICATION MANAGEMENT BILLING & ROUTING SHEET.doc**
9. **Maricopa County – rebate_reduction_routing_sheet.xls**
10. **Maricopa County 00 Specialty Pharmacy RS_May09.pdf**
11. **Maricopa HCR Preventive Drug List Routing Sheet 112610.doc**
12. **Formulary Delete and Clinical Letters Routing Sheet.doc**
13. **Non-ERISA Routing Sheet.doc**
14. **Legacy_WHI_Catalyst Rx Vaccine Program Routing Sheet 09_26_2012.doc**

EXHIBIT B-1

GOVERNANCE OF PHARMACY BENEFIT MANAGEMENT SERVICES

1.0 Definitions. For purposes of this Contract, the following terms shall have the meanings set forth below:

1.1. "Average Wholesale Price" or "AWP" means the average wholesale price, as determined by the current edition of the Medi-Span Master Drug Data Base, including any supplements.

1.2. "Brand Name Drug" means drug that has a trade name and is protected by a patent. A Brand Name Drug may only be produced and sold by the pharmaceutical company holding the patent or a pharmaceutical company that has been licensed and authorized by the patent holder to produce and sell the drug.

1.3. "Contractor Services" means those services provided by Contractor to County under this Contract as specifically set forth in Section 2 below.

1.4. "Copayment" or "Coinsurance" means a dollar amount or percentage of cost that a Member is responsible for paying for a specific prescription medication or other supply or service designated as "covered" under the pharmacy benefit, as set forth in the Plan Design Profile, and includes, but is not limited to, coinsurance, copayment and deductible.

1.5. "Drug Utilization Review" (DUR) is a program designed to measure and to assess, on a retrospective and prospective basis, for the proper use of medication based on predetermined standards. Used to ensure correct prescribing by detecting inappropriate or unnecessary drug therapy through edits monitoring individual drugs, drug classes or specified disease states.

1.6. "Formulary" means the Contractor preferred drug list developed, maintained and amended from time to time, by Contractor's Pharmacy & Therapeutics Committee.

1.7. "Generic Drug" means a drug that is therapeutically equivalent (identical in strength, concentration, and dosage form) to a Brand Name Drug and that generally is made available when patent protection expires on the Brand Name Drug.

1.8. "Implementation Date" means July 1, 2012 or such other date as the Parties mutually agree in writing that Contractor shall begin to provide Prescription Drug Services to County.

1.9. "Maximum Allowable Cost" or "MAC" means the upper limit price charged to the County, as applicable, for generic prescription drugs available from multiple manufacturers. It is designed to (1) increase generic dispensing, (2) to ensure the pharmacy dispenses economically, and (3) control future cost increases.

1.10. "Participant" means any individual who is, or becomes, eligible for and covered by any of County's Plans during the term of this Contract.

1.11. "Participating Pharmacy" means a pharmacy, which has entered into a Contract with Contractor under which it has agreed to provide prescription drug services to Participants.

1.12. "Plan" means any health care benefit plan that includes Prescription Drug Services and is offered or marketed by County. A Plan shall not include: (1) Medicare Advantage Prescription Drug Plans and Prescription Drug Plans under Medicare Part D, (2) a Medicaid state plan or Consumer Driven Health Plans (CDHP), or (3) any other Federal Health Care Program as defined by 42 U.S.C. 1320a-7b(f) or federal or state pharmaceutical assistance program unless such Plan (a) receives payments pursuant to a risk contract under Section 1903(m) of the Social Security Act, (b) is a qualified retiree prescription drug plan that meets the requirements of 42 C.F.R. § 423.882 or (c) is a Hospice even though the Hospice may receive per diem payments from a federal or state health program, as the Hospice is at financial risk.

1.13. "Plan Design Profile" means the benefit summary document prepared by Contractor in conjunction with County and approved in writing by County, which is used by Contractor in processing prescription drug claims in connection with this Contract.

1.14. "Prescription Drug Services" means the pharmacy benefit management and prescription drug services or supplies that are covered by the Plan as reflected in the Plan Design Profile.

1.15. "Rebates" means all base, formulary, incentive and market share rebates, as well as related considerations received from pharmaceutical manufacturers that are directly attributable to prescription drug services provided to members and are a part of administering formulary and rebate management services.

1.16. "Usual and Customary" or "U&C" means the amount a Participating Pharmacy would charge to a cash paying customer for same strength, quantity, and dosage form of a covered drug, as of the date the prescription is filled.

1.17. "Wholesale Acquisition Cost" or "WAC" means the wholesale acquisition cost of a prescription drug, as determined by the current edition of the Medi-Span Master Drug Data Base, including supplements thereto, or any other nationally recognized publication that Contractor may designate from time to time.

1.18. "Specialty Drugs" refers to certain drug products available on the market that due to reasons such as, but not limited to, nonstandard administration, necessity for case management, limited availability, unique shipping or handling requirements, and specialized manufacturer process or purchase arrangements. Examples of Specialty Drugs include, but are not limited to, biotechnology drugs and certain compounds.

2.0 Services Provided by Contractor. Beginning on the Implementation Date, Contractor shall commence providing Prescription Drug Services to County as described herein.

2.1 Plan Administration.

2.1.1 Claims Processing Services. Contractor shall provide the following claims processing services related to claims for prescriptions dispensed on or after the Implementation Date:

2.1.1.1 Claims from Participating Pharmacies Upon receipt of a prescription claim from a Participating Pharmacy, Contractor shall process the claim in accordance with the Participating Pharmacy's contract for providing Prescription Drug Services to Participants.

2.1.1.2 Participant Claims. County (or its designee) shall provide Participants with a claim form approved by Contractor for use in submitting claims for Prescription Drug Services not submitted on-line by a Participating Pharmacy. When a claim is submitted on the approved form by a Participant, Contractor shall process the claim in accordance with the standard operating procedure mutually agreed upon by County and Contractor.

2.1.2 Claims Payment Procedures. Contractor shall notify County (or its designee) on a semi- monthly basis, via standard reports or otherwise, of the amount of County's liability for claims processed in accordance with this Contract at the rates set forth in Exhibit A of the Contract. In no event shall Contractor have any obligation to forward any claims payments unless and until County (or its designee) has transferred the funds necessary for such payments.

2.2 Inquiries.

2.2.1 Participant Inquiries. Contractor shall respond to inquiries from Participants regarding the services provided by Contractor under this Contract through a dedicated Contractor toll- free telephone line.

2.2.2 Participant Appeals. Contractor shall use commercially reasonable efforts to

provide County with assistance and guidance in coordinating and responding to formal complaints or appeals from Participants under the Plan; however, Contractor shall not be responsible or liable in any way for County's compliance with the terms and conditions of the Plan or applicable laws or regulations regarding responding to Participants' complaints or appeals. The County is responsible for the final review and appeal of denied claims and for the final resolution of complaints from Participants.

2.2.3 Reporting. Contractor shall provide County with those reports selected by County from Contractor's standard reporting list. Such standard reports may be available to County in either CD-ROM or DVD; provided, however, that electronic copies shall be provided in an encrypted data format to be mutually agreed upon by the Parties. Upon County's request, Contractor agrees to continue to timely provide such reports to County for a commercially reasonable time period following the termination of this Contract. Data may be archived after two (2) years. For all archived data reports, the Parties will need to negotiate in good faith for all actual costs (including developer and engineer's time, data recovery costs, secure tape shipping, data storage space requirement, and etc.) to generate standard reports.

2.3 Cost Containment and Clinical Services.

2.3.1 Participating Pharmacies.

2.3.1.1 Contractor Participating Pharmacies. Contractor has created a network of Participating Pharmacies under contract with Contractor (the "National Pharmacy Network"). The National Pharmacy Network shall provide Prescription Drug Services to Participants, provided they present appropriate identification cards to the Participating Pharmacies. Contractor makes no representations or promises regarding the continued availability of a specific Contractor Participating Pharmacy. Contractor will attempt to contract with all current pharmacy providers of County. Deletions from or additions to the Contractor National Pharmacy Network may be made at Contractor's sole discretion.

2.3.1.2 Pharmacy Inquiries. Contractor shall respond to inquiries from Participating Pharmacies regarding the services provided by Contractor under this Contract through a Contractor toll-free telephone line.

2.3.1.3 Pharmacy Audits. Contractor may, at County's request, audit Participating Pharmacies to ensure the Participating Pharmacies' compliance with their contracts with Contractor. Selection of Participating Pharmacies and the method of audit shall be determined by Contractor. Contractor in its discretion may perform the audit or select an outside firm to perform the audit. County shall pay for the cost of the audit, as outlined in Exhibit A-1, and County shall receive 100% of audit recoveries from County's utilization.

2.3.2 Prior Authorization Services. Contractor shall provide advice to County regarding drugs which the Plan may require to be "prior authorized" for coverage. Contractor shall make available to County prior authorization services in connection with those Prescription Drug Services mutually agreed to by Contractor and County. In the event County requests in writing and upon reasonable notice that Contractor provide prior authorization review services, Contractor's staff, under the supervision of its clinical pharmacists, shall review Participants' prescriptions for those drugs requiring prior authorization review in accordance with criteria, definitions and procedures mutually agreed by the Parties and subscribed to by County. When Contractor provides prior authorization review services, the terms of paragraph 2.2.2 shall apply to those services.

2.3.3 Drug Formulary. At County's request, County may access and use the Formulary. County understands and agrees that such right is limited solely to County's own use of the Formulary in connection with providing Prescription Drug Services and other services to County and its Participants under this Contract. County further understands and agrees that, except in connection with such limited use, County shall at no time copy, distribute,

sell or otherwise provide the Formulary to any third party without Contractor's prior written approval. In addition, in no event may County request or demand that the onsite pharmacy and clinic subcontractor take any action, including adjust any drug formulary or agree to any pharmacy benefit management contract term, that would violate or breach said subcontractor's agreements with any pharmaceutical manufacturers and/or suppliers. Nothing in this Contract shall prevent Contractor from administering County's proprietary formulary; however, County acknowledges and agrees that failure to administer and use the Formulary may increase County's costs and/or reduce the amount of rebates due to County under this Contract. Contractor and County shall jointly analyze the potential cost savings from County's anticipated use of the Formulary.

2.3.4 Mail Order Pharmacy. During the term of this Contract, Participants shall have the option of filling prescriptions through the use of Contractor's mail order pharmacy provider. Contractor shall determine eligibility for such claims and adjudicate claims in accordance with its standard procedures, and may, where appropriate and in compliance with applicable law, provide generic equivalents to Participants. Contractor shall provide refills in accordance with applicable physician instructions, up to a ninety (90) day supply. Contractor shall follow all Plan rules regarding co-payments and deductibles and shall provide Participants using the mail order pharmacy with refill reminders and access to Contractor's online ordering system.

2.4 Rebates.

2.4.1 County shall be eligible to participate in Contractor's rebate program and receive payments in accordance with Exhibit A upon meeting the requirements of this Section 2.4 and Exhibit A. Failure to comply with these requirements will make any guarantees stated in Exhibit A null and void.

2.4.2 County's conformance to the Formulary under the rebate program and any Plan Design requirements associated therewith (for example, implementation of therapeutic substitution programs and/or qualifying incented co-payment benefit designs).

2.4.3 Distribution of the Formulary (or a summary thereof) to Participants and/or physicians, as applicable.

2.4.4 County's compliance with such other reasonable and generally applicable requirements for participation in the rebate program and associated parameters, as may be communicated by Contractor to County from time to time.

2.4.5 County understands that its eligibility to receive payments for rebates may change over time due to changes in its Plans; changes in contracts with pharmaceutical manufacturers or rebate intermediaries; changes in laws (including regulations or administrative or judicial rulings), including but not limited to laws affecting prescription drug benefits; benefits structure; pricing (including rebates); the selection of certain Contractor services, such as prior authorization or open formulary management; or any change in Formulary, Plan Design Profile or Prescription Drug Services. County further acknowledges and agrees that certain Participant-submitted claims, all 100% copayment plans, discount card programs, claims for which the Participant deductible or copayment covers 50% or more of the Plan's Price for the Prescriptions Drug Service, coordination of benefits ("COB") claims whereby Contractor is the secondary payor, and Participant claims filled at Participating Pharmacies that are also receiving purchasing price concessions, such as pharmacies who qualify for 340B pricing under section 340B of the Public Health Services Act or pharmacies that are members of group purchasing organizations ("GPOs") are not eligible for rebates.

2.4.6 Subject to Paragraphs 2.7.1 and 2.7.2, below, Contractor shall pay to County an amount from the rebates (and other payments if specified in Exhibit A) it receives through drug manufacturers or intermediaries and that are directly attributable to Prescription Drug Services utilized by Participants (including any prescriptions dispensed at the onsite pharmacy and clinic), all as provided for and in accordance with Exhibit A.

Rebate and other payment amounts received by Contractor through manufacturers or intermediaries may differ from the amount Contractor agrees to pay County under Exhibit A. County acknowledges and agrees that it shall not have a right to interest on, or the time value of, any rebate or other payments received by Contractor during the collection period for monies payable to County under this paragraph. County acknowledges that rebate payments from manufacturers or intermediaries are received on a periodic basis by Contractor (usually quarterly) and relate to claims from approximately six (6) to nine (9) months earlier

2.4.7 County agrees that during the term of this Contract, it shall not utilize the services of another entity to provide the services Contractor has agreed to perform under this Contract. County acknowledges that it may be eligible for rebate payments under Exhibit A only so long as County, its affiliates, and its agents do not contract directly or indirectly with anyone else for discounts, utilization limits, rebates or other financial incentives on pharmaceutical products or formulary programs without Contractor's prior written consent. In the event that County negotiates or arranges with a pharmaceutical manufacturer or intermediary for rebates or similar discounts, but without limiting Contractor's right to other remedies, Contractor may immediately terminate County's participation in the rebate program or terminate this Contract according to the terms of material default set forth herein, and/or recover from County all rebates paid by Contractor for claims submitted by County (or on behalf of County) other than through Contractor for rebates from manufacturers or intermediaries.

2.4.8 County hereby represents and warrants, and shall recertify on a periodic basis in a form acceptable to Contractor, with respect to any Plan which receives funding from Medicare/Medicaid, Title V, Children's Medical Services, or another government healthcare program as defined in Section 1128(h) of the Social Security Act (or any successor thereto) ("Government Programs") and for which the County receives rebates attributable to such Plan, each such Plan is operating under a risk contract with the Centers for Medicare and Medicaid Services or a state Medicaid program, and operates in accordance with §§ 1876(g) or 1903(m) of the Social Security Act, under a federal statutory demonstration authority or successor statute or authority. County agrees to notify Contractor in writing of any such Plan that does not meet any of the criteria set forth herein, and Contractor, in compliance with applicable law, shall not submit prescription drug claims for any Participants in such Plan for prescriptions filled by a Participating Pharmacy. Nothing herein prohibits a County that receives the retiree drug subsidy ("RDS") from the Centers for Medicare and Medicaid Services ("CMS") for eligible Plan Participants under the Medicare Part D Rules (42 C.F.R. Part 423, Subpart R) from receiving rebates relating to such eligible Plan Participants prescription drug claims under this Contract.

The Parties acknowledge and agree that any rebate reimbursement provided to County pursuant to this Contract is a "discount" under 42 U.S.C. § 1320a-7b (b) (3) and 42 C.F.R. § 1001.952(h) (the "Discount Safe Harbor"). For the purpose of complying with the Discount Safe Harbor, Contractor shall clearly denote in invoices and other statements amounts that constitute rebate reimbursement. County shall properly disclose and appropriately reflect all rebate reimbursement in the costs claimed or the charges made to any Government Program. Without limiting the foregoing, if County claims a subsidy from the Centers for Medicare and Medicaid Services ("CMS") for eligible Plan Participants under the Medicare Part D Rules (42 C.F.R. Part 423, Subpart R), County shall properly disclose and appropriately reflect any rebate reimbursement paid by Contractor to County in the Allowable Retiree Costs (as defined at 42 C.F.R. § 423.882) and other information submitted to CMS for payment of such subsidy in accordance with the Medicare Part D Rules, all applicable sub regulatory guidance and CMS policies.

2.5 Provision of Information. County or County's designee shall provide eligibility files to Contractor at County's expense which shall include any information reasonably required by Contractor to perform its services, including but not limited to information regarding the Plans, Participants, and County's participating physicians and other providers, if any. County shall be solely responsible for the accuracy and timeliness of all information. County or County's designee shall provide all necessary Participant information in Contractor's standard format and in accordance with Contractor's standard specifications or such other format as the Parties mutually agree. All Participant information furnished by County or County's designee to Contractor shall be provided via electronic media (e.g., electronic data interface, magnetic tape, and cartridge). Electronic or hard-copy submission of Participant information shall be submitted by County or County's designee only to support emergency situations and shall include the use of Contractor's standard enrollment forms. Contractor shall be entitled to rely entirely upon the benefit plan summary and eligibility data provided by County or County's designee. County shall be solely liable for communications with Participants, and shall communicate (directly or through County's designee) initial Plan Design and any changes to Contractor in writing at least thirty (30) days prior to implementation of any such Plan Design changes. County shall indemnify and hold harmless Contractor from any claims, damages, liabilities or expenses (including attorneys' fees) arising out of the provision by County of inaccurate, incomplete or untimely information.

2.6 Participant Census. For purposes of this Contract, the identity and number of Participants at any given time shall be based on information taken from Contractor's enrollment report. The information in the Contractor enrollment report is based on eligibility files provided by County or County's designee to Contractor. County agrees that the County or County's designee will provide Contractor with regular and timely enrollment updates and Contractor and the Participating Pharmacies are entitled to rely on the accuracy and completeness of enrollment information provided to Contractor by County or County's designee in the eligibility files.

2.7 Participant Materials. Contractor shall provide County with identification cards for Participants, containing County's group name and the appropriate BIN number and other information required to provide Prescription Drug Services.

2.8 Ownership and Access to Records.

2.8.1 Protection of Proprietary Information. County and Contractor shall take all reasonable steps to protect the other Party's trade secrets and confidential information. Except as specifically provided in this Contract, such information shall not be disclosed to third parties without the express written consent of the Party to whom the information belongs. The Parties shall not utilize trade secret or confidential information or any material or property protected by patent, trademark, service mark or copyright belonging to the other Party other than as expressly permitted by this Contract or otherwise in writing. All use of the other Party's intellectual property shall be used in a manner that is not likely to confuse ownership or licensure of such intellectual property, and in a manner that does not state or imply in any manner that the Party or its intellectual property endorses another product, company or service. County acknowledges that Contractor's methods of doing business and the documentation of those methods are proprietary to Contractor and County shall not use such methods or documentation except in connection with this Contract. Neither Party shall be required to keep confidential any information or data, which is or becomes publicly available without breach of this Contract, is already known or is independently developed by such Party outside the scope of this Contract, or is rightfully obtained from a third party.

2.8.2 Claims Audit Rights. The Parties shall maintain appropriate records relating to their responsibilities under this Contract. Once per Contract year and once during the year immediately following termination of this Contract, the County may have reasonable access to the records of the Contractor relating to the Contractor's performance under this Contract during normal business hours and upon reasonable notice. The scope of an audit will be limited to Participant claims adjudicated during the Contract term. A third party may be allowed or designated to conduct an audit with the prior written

consent of the Contractor, which consent shall not be unreasonably withheld; provided, however, that the Contractor shall have the right to refuse the County's auditor if the proposed auditor reasonably may acquire a competitive advantage by gaining access to the Contractor's confidential information as defined herein. In addition, the third-party auditor shall enter into a reasonable confidentiality agreement with the audited Party prior to conducting such audit.

Contractor will provide unrestrictive operational and financial audit rights, including the ability to audit paid claims data, the Contractor's claims processing system, performance guarantees, Medicare Part D, security and appropriate access to MAC rates and the formulary rebate program, including the processes for reporting data to manufacturers, accounting for rebates earned and allocating rebate payments to the County. The County (or their designee), will be granted the ability to audit the specialty program, including any and all documented patient and provider interventions to verify degree of intervention. It is understood that appropriate confidentiality and HIPAA agreements would be undertaken. Contractor agrees to provide the County with an audit allowance in the amount of $50,000 that may only be applied to any third party audits performed during the initial five year term of this Contract.

If an audit by County or its third party auditor reveals that County paid Participant claims at rates higher than those outlined in Exhibit A, Contractor will pay to County the difference between the rates charged and the rates outlined in Exhibit A within thirty (30) business days following notice by County and acceptance by Contractor. County may recover undisputed errors identified during the course of an audit of Contractor as follows:

2.8.2.1 Contractor will reimburse County for undisputed discrepancies in the ingredient cost or dispensing fee charged County for a Participation's Prescription Drug Services claim if the claim was processed in the 24 months immediately preceding Contractor's receipt of County's written audit notice. Contractor will not reimburse County for undisputed discrepancies in the ingredient cost or dispensing fee charged County for a Participation's Prescription Drug Services claim if the claim was not processed in the 24 months immediately preceding.

2.8.2.2 Contractor will reimburse County for undisputed discrepancies in administrative fees related to a Participant's Prescription Drug Services claim if the claim was processed in the 24 months immediately preceding Contractor's receipt of County's written audit notice. Contractor will not reimburse County for undisputed discrepancies in administrative fees related to a Participant's Prescription Drug Services claim if the claim was not processed in the 24 months immediately preceding Contractor's receipt of County's written audit notice unless the circumstances involve willful misconduct or fraud on the part of Contractor or its employees, agents or representatives or the discrepancy resulted from an error that was not an "Obvious Error," as defined in Section 3.4 of this Contract.

2.8.3 Right to Aggregate Data. County acknowledges and agrees that Contractor shall have the right to aggregate de-identified Participants' Prescription Drug Services claims data and that Contractor shall have ownership rights to all such de-identified data and resulting statistics.

2.8.4 Confidentiality Regarding Participants.

2.8.4.1 The Parties shall maintain the confidentiality of any information relating to Participants in accordance with any applicable laws and regulations. It is contemplated by this Contract, however, that confidential information about Participants shall be obtained by Contractor in providing services under this Contract and that such confidential information shall be obtained from and/or distributed to County, Participating Pharmacies, Participants, third parties to the

extent necessary to fulfill the Parties' duties under this Contract and Participants' physicians and Participants for drug utilization evaluation and other purposes relating to the Plan. County shall be responsible for obtaining, to the extent necessary, adequate release from Participants with regard to any information relating to Participants provided to Contractor or by Contractor to its subcontractors or agents, Participating Pharmacies, Participants or Participant's physicians as contemplated by this Contract or at the request of County, and County agrees to indemnify, defend and hold harmless Contractor from any and all claims, penalties, liabilities, losses, damages, settlements or costs which may arise from Contractor's provision of such Participant information to County or to third parties as contemplated by this Contract.

2.8.4.2 Contractor and County acknowledge that the U.S. Department of Health and Human Services published final medical records privacy regulations under 45 CFR Part 164 on December 28, 2000, as amended August 14, 2002 (the "HIPAA Rules"). County recognizes that it is designated a Covered Entity under the HIPAA Rules and Contractor recognizes that, in its capacity as a pharmacy benefit manager contracting with County, it may be considered a "Business Associate" under the HIPAA Rules. Each party shall use its reasonable best efforts to work with the other during the implementation period to ensure that the Parties comply with all applicable requirements of the law.

2.8.4.3 Impossibility of Performance. Neither County nor Contractor shall be deemed to be in violation of this Contract if prevented from performing any obligation under this Contract due to any cause beyond its reasonable control, including any act of war or natural disaster.

2.8.5 Independent Contractors. The relationship between the Parties is solely one of independent contractors and nothing in this Contract shall be construed or deemed to create any other relationship between the Parties, including one of employment, agency or joint venture. County further agrees and acknowledges that Contractor is not responsible for and shall have no liability for the professional errors of the onsite pharmacy and clinic subcontractor or any Participating Pharmacies (including without limitation errors in compounding, dispensing, labeling and advising Participants of potential interactions of prescription drugs); the failure of Participating Pharmacies (each an independent contractor), collectively or individually, to provide pharmacy benefit services to County or Participants; or the failure of the onsite pharmacy and clinic subcontractor to provide the services set forth in Exhibit B-3.

2.8.6 Regulatory Compliance and Fiduciary Responsibility.

2.8.6.1 General Compliance. Each Party shall be responsible for ensuring its compliance with any laws and regulations applicable to its business.

2.8.6.2 Plan Design Profile. County shall be responsible for Plan Design and the regulatory compliance of its Plans and the Plan Design Profile. County understands and acknowledges that the Plan is not an underwritten pharmacy benefit program or any form of insurance.

2.8.6.3 Fiduciary Responsibilities. Where applicable, County acknowledges that the Plan is an "employee welfare benefit plan" as defined in the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq. County is responsible for establishing and maintaining the Plan. County shall comply and ensure that the Plan complies with ERISA where applicable. Contractor shall provide advice to County regarding the contents of the Plan Description and Summary Plan Description, including consultation regarding the prescription drug services covered by the Plan and which persons will be eligible for coverage. County shall be responsible for the final content of

the Plan Document and Summary Plan Description, and for ensuring that they are consistent with the Plan Design Profile and this Contract, except that any reference in the documents to Participating Pharmacies or to Contractor or services provided by Contractor must be approved in writing by Contractor before any distribution of the documents to Participants. County shall not name Contractor or represent that Contractor is, and Contractor shall not be, a Plan Administrator or a named fiduciary of the Plan as those terms are used in ERISA. County acknowledges and agrees that Contractor does not have discretionary authority to manage or administer the Plan. County acknowledges and agrees that Contractor does not act as a fiduciary of the Plan for purposes of ERISA when Contractor contracts with Participating Pharmacies, or when Contractor exercises any other cost-containment functions described in this Contract. No amounts that are to be or are transferred to Contractor shall be considered Plan assets. County acknowledges and agrees that: (i) neither the Plan nor any Participant has a preferential claim against or beneficial interest in any funds paid to Contractor; (ii) the funds paid to Contractor do not in any way constitute security for the obligation to pay benefits under the Plan; (iii) Contractor is not required to segregate the payments that it receives from the Plan or otherwise to identify these payments separately from Contractor's general assets; (iv) Contractor may retain certain payments received from or through pharmaceutical manufacturers or intermediaries, some of which may be attributable to, or calculated with reference to, Prescription Drug Services or Contractor Services used by Participants; (v) the rates paid by County for Prescription Drug Services under this Contract may differ from the rates paid by Contractor; (vii) any communication from the County to Participants will be consistent with the foregoing propositions.

2.8.6.4 Government Charges. In the event that the Plan, County, or the arrangement established by this Contract, or any payments for claims for Prescription Drug Services or fees to Contractor for Contractor Services, are subjected to any form of governmental or regulatory charges, including any premium taxes, insolvency fund fees, guarantee fund fees, licensing fees, sales taxes or any similar charges, such charges shall be the sole responsibility of the Plan and County shall indemnify, defend and hold harmless Contractor from the payment of any such charges.

2.9 PAYMENT TERMS

2.9.1 Retail Services

County shall pay to Contractor the reimbursement rates set forth in Exhibit A (net of any co-payments, coinsurances or deductible amounts), plus any applicable sales or excise tax or other governmental charge, for the corresponding Prescription Drug Services obtained from the Contractor National Pharmacy Network of Participating Pharmacies.

2.9.2 Mail Order Services

County shall pay to Contractor the reimbursement rates set forth in Exhibit A (net of any co-payments, coinsurances or deductible amounts), plus any applicable sales or excise tax or other governmental charge, for the corresponding Prescription Drug Services obtained from the designated Contractor mail order pharmacy provider.

2.9.3 Specialty Drug Services

County acknowledges that Specialty Drugs will not be reimbursed at mail order rates. A representative list of Specialty Drugs is attached hereto as Schedule B-1A to this Contract; however, Schedule B-1A is only representative, and the drug products

considered Specialty Drugs listed therein are subject to change with thirty (30) days' prior notice. County shall pay Contractor the reimbursement rates for Specialty Drug claims dispensed within the specialty network (net of any co-payments, coinsurances or deductible amounts), plus any applicable sales or excise tax or other governmental charge, for the corresponding specialty drug Prescription Drug Services delivered by Contractor's designated specialty pharmacy in accordance with Exhibit A.

If County requires Contractor to include certain pharmacies as Participating Pharmacies, and Contractor is unable to obtain rates from any of such pharmacies at or below those set forth above, County agrees to pay Contractor the higher amount charged by such pharmacies. In such an event, County acknowledges and agrees that Contractor may adjust the rebate guarantees based upon the inclusion and/or exclusion of certain Participating Pharmacies from the network.

The rates, fees and guarantees set forth above regarding "Retail Services", "Mail Order Services" and "Specialty Drug Services" are subject to conditions set forth in this Contract. In addition, certain conditions such as pharmacies with "most favored pricing" obligations, remote area pharmacies, in- house or County-owned pharmacies, and County requests for additions to a selected network may result in a rate change or differential with respect to the affected pharmacy(ies) that will be passed on to County, plus an administrative fee.

2.9.4 Onsite Pharmacy and Clinic Services.

County shall promptly reimburse Contractor the invoiced costs for all Brand Name and Generic Drugs dispensed at the onsite pharmacy and clinic as well as all other management fees and/or costs set forth in Exhibit B-3.

2.9.5 Clinical Programs and Related Services.

County shall pay to Contractor the fees and/or charges set forth in the applicable Clinical Routing Sheet for any clinical programs or related services provided by Contractor hereunder.

2.9.6 Overall Effective Generic **and Brand** Discount.

Contractor guarantees that the overall effective guaranteed discount of all generics dispensed hereunder for each channel will be as set forth in Exhibit A (hereinafter referred to as the "Generic Discounts"). Contractor guarantees that the overall effective guaranteed discount of all brands dispensed hereunder for each channel will be as set forth in Exhibit A (hereinafter referred to as the "Brand Discounts").The Generic Discounts and Brand Discounts are collectively referred to herein as the "Overall Effective Discounts." Contractor will measure Overall Effective Discounts from A WP in accordance with its standard methodology, which includes the following procedures. All generic claims (MAC list and non MAC list generics) that are filled during each contract year will be included in the Generic Discounts ("Measurement Period") and all brand claims that are filled during each contract year will be included in the Brand Discounts. Over-the-counter products, compound drug products, 340B claims, Indian Health Service and/or Tribal claims, direct member reimbursement claims, coordination of benefit claims, long term care claims, horne infusion claims, vaccines, claims filled outside Contractor's network of pharmacies, and Specialty Pharmacy Drugs are excluded. Discount calculations are measured using original ingredient cost (i.e., MAC, discounted A WP, 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. Calculations for all distribution channels (e.g., retail-30, retail-90, mail) with the same Generic Discount will be combined. All results will be measured and

reported annually. The Overall Effective Discounts apply for any Measurement Period only if County has received Contractor's services for the full 12 months of such Measurement Period, provided this Contract has been executed by both parties prior to such Measurement Period. In the event the achieved Overall Effective Discounts are less favorable for County than the Overall Effective Discounts set forth in Exhibit A, Contractor will credit County's invoice for the difference between the proposed Overall Effective Discounts and the achieved Overall Effective Discounts within 30 days of Catamaran's completion and County's acceptance of each annual reconciliation.

~~Contractor guarantees that the overall effective guaranteed discount of all generics dispensed hereunder will be as set forth in Exhibit A, Section 1.4.3 (hereinafter referred to as the "Generic Discount"). Contractor will measure generic discounts from AWP in accordance with its standard methodology, which includes the following procedures. All generic claims (MAC list and non-MAC list generics) that are filled during each contract year will be included ("Measurement Period"). Over the counter products, compound drug products, and Specialty Pharmacy Drugs are excluded. 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. Calculations for all distribution channels (*e.g.*, retail 30, Advantage90, mail) with the same Generic Discount will be combined. All results will be measured and reported annually. The Generic Discount applies for any Measurement Period only if County has received Contractor's services for the full 12 months of such Measurement Period provided this Contract has been executed by both parties prior to such Measurement Period. In the event the achieved generic discount is less favorable for County than the Generic Discount, Contractor will credit County's invoice for the difference between the Generic Discount and the achieved generic discount within 30 days of Contractor's completion and County's acceptance of each annual reconciliation.~~

Notwithstanding the foregoing or any provision to the contrary, County acknowledges that certain factors beyond Contractor's control may affect Contractor's ability to achieve the Generic Discount, including, but not limited to, significant changes in (a) County's plan design, (b) brand/generic market status of certain highly utilized drugs, and (c) applicable law or regulation (collectively, "Changes"). If at any time Contractor, in its reasonable discretion, determines that any Changes are likely to materially and negatively affect Contractor's ability to meet the Generic Discount, the parties will, upon Contractor's request, negotiate a mutually acceptable alternative guarantee or other financial arrangement. If the parties fail to reach any such agreement in writing within 45 days of the Change, notwithstanding anything contained in this Contract to the contrary, Contractor will not be bound by any of the obligations above, during the Measurement Period in which the renegotiation was requested or any future Measurement Periods, and Contractor will have no additional liability in connection therewith.

2.10 **Financial/Pricing Terms.** The Parties agree that the following provisions will be utilized for the sole purpose of clarifying and/or interpreting any ambiguous financial and/or pricing term set forth in this Contract.

2.10.1 The annual brand discount guarantee (in aggregate) will be, exclusive of U&C claims (retail only) and the impact of MAC on multi-source brand claims.

2.10.2 The annual overall effective generic discount (in aggregate) will be, inclusive of Contractor's pricing on MAC and non-MAC generics and U&C claims (retail only).

2.10.3 Subject to Section 2.4 of this Exhibit, all rebate proposals will include a "per claim" guarantee, inclusive of both brand and generic claims at retail and mail order (including all claims regardless of generic exclusivity status.

2.10.4 Base administrative fees will be quoted on a per paid prescription basis only (e.g., no charges for reversed or denied claims).

2.10.5 Contractor guaranteed rebates will not be impacted by the loss of patent protection of brand name drugs. Contractor will factor the estimated impact into the underwriting of all guarantees.

2.10.6 Contractor will agree to use the same source used for pricing as that used to designate and price brand and generic drugs. Contractor will confirm that if a member pays 100% of the cost of a prescription, County will not be billed for any portion of the claim, exclusive of any applicable administrative fees.

2.10.7 Contractor will adjudicate all mail order claims according to the "lower of" logic, such that County members always pay the lower of the:

2.10.7.1 Applicable plan design co-payment; or

2.10.7.2 Discounted AWP/MAC, plus dispensing fee

2.10.8 Contractor will not implement and/or adjudicate mail order claims based upon a minimum mail order copayment.

2.10.9 Contractor agrees that County will not be responsible for any member contributions (e.g., deductible, coinsurance or copays) owed to Contractor. Collecting such fees will be the sole responsibility of the Contractor.

2.10.10 Compounds and zero balance claims will not be processed at a 100% discount.

2.10.11 Contractor agrees that all compound drugs dispensed at retail and mail order will be priced based upon the specialty reimbursement rate set forth in Exhibit A-1.

2.10.12 All non MAC retail claims will be adjudicated at the lesser of either

2.10.12.1 The guaranteed AWP discount plus dispensing fee; or

2.10.12.2 The provider's submitted U&C amount (including sales price, if any).

2.10.13 All non-MAC mail order claims will be adjudicated at the lesser of:

2.10.13.1 The guaranteed AWP discount plus dispensing fee; or

2.10.13.2 MAC plus dispensing fee.

2.10.14 Contractors agree to use the same MAC list at retail and mail order. However, County acknowledges that unit pricing may vary by dispensing channel.

2.10.15 Contractor will not charge County a higher AWP price for any re-packaged products assigned a new NDC number by a re-packager, a manufacturer, or at mail order, than the original manufacturer/labeler AWP price for the same product (drug name, form, and strength).

2.10.16 Contractor will adjudicate Specialty Drug claims that process through the specialty pharmacy provider, according to the specialty pricing schedule set forth in Exhibit A.

2.10.17 All mail order shipping costs (standard delivery) will be underwritten into the proposed mail order pricing. Administrative or dispensing fees may not be adjusted during the contract term for postage rate increases.

2.10.18 Contractor will provide a quarterly rebate report with associated claim counts.

2.10.19 Unless otherwise stated herein, Contractor agrees to pay/credit rebates within 180 days after the end of each quarter based on the per script rebate guarantees, with a full annual

reconciliation provided within 180 days after the end of the year. County may request the rebate payments be made in the form of a separate check and not applied as an offset to a billing invoice at no cost.

2.10.20 Unless otherwise stated herein, all rebate guarantees will be evaluated and reported quarterly and paid and reconciled annually against averaged actual results and will be backed, dollar-for-dollar, such that County is made whole if any quarterly guarantee fails to be met; Contractor will pay/credit County 100% of any shortfall, with County retaining 100% of any additional savings achieved above the guarantee. Shortfalls in one component guarantee may not be offset by overages in another component guarantee, with the exception of cross subsidization of retail and mail order rebates.

2.10.21 Contractor agrees to immediately notify County of any impending material litigation involving its company, officers, subsidiaries or subcontractors that directly relates to this Contract and impairs Contractor's ability to provide the services contemplated herein.

2.10.22 Contractor will provide necessary data files to respond to government requests or respond to class action lawsuits, for the length of the contract. Contractor will be willing to complete the required claim forms and file on behalf of County throughout the contract. Such services will be provided at standard programmer bill rates mutually agreed upon by the parties.

2.10.23 **The Participating Pharmacy rates may vary and the amount paid to the Participating Pharmacy may not be equal to the amount billed to the County and Contractor shall retain any difference.**

2.10.24 **"Net Paid Claim" means all paid Claims minus reversals for a single prescription fill.**

2.10.25 **Dispensing fee refers to the amount paid to the Participating Pharmacy for filling a prescription.**

2.10.26 **"Single source generics" or "Non-MAC generics" are Generic Drugs that have either recently come off patent and do not generate discounts traditionally delivered by Generic Drugs, or have an exclusive pharmaceutical manufacturer. Single source generics will be included in the overall generic drug guarantee.**

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

2.10.28 **Contractor may, from time to time, receive reimbursement from pharmacies for its costs in connection with transmitting claims and discounts on its own behalf from wholesalers and manufacturers as a purchaser of pharmaceutical products for its mail service and specialty pharmacies.**

2.10.29 **Contractor negotiates Rebates based on market share over its aggregate book of business and not on behalf of any client. Rebates shall be based upon per Net Paid Claims submitted on behalf of County, allocable to County. The three-tier Rebate** guarantees **above apply to a qualified three tier plan design with a minimum differential of $15 between preferred and non-preferred brand drugs and the County's 100% compliance with Contractor's preferred drug Formulary. Contractor and affiliated or unaffiliated third party contractors may retain reasonable administrative fees for its role in securing Rebates.**

2.10.30 **County shall comply with other reasonable, generally applicable requirements for participation in the Rebate program and associated program parameters, as are communicated by Contractor to County from time to time, and must adhere to a Generic Dispense Rate (GDR) that is within 2% of the baseline GDR in place at**

the beginning of this Contract in any given quarter to retain rebate guarantees provided by Contractor. If the GDR change exceeds more than 2% in any given quarter, rebate guarantees may need to be modified. "Generic Dispense Rate" means, in any fiscal quarter, the number of Generic Drug prescriptions divided by the total number of all prescriptions for such contract quarter. County will earn rebates only on valid NDC's as identified as a valid NDC in the Medi-Span Drug Database.

2.10.31 **Effective date of any changes to Rebate arrangements shall be at the beginning of a fiscal quarter following the Effective Date of the Contract.**

2.10.32 **Contractor specialty pharmacies shall be the exclusive specialty providers under this Contract and County Participants shall utilize only Contractor specialty providers. The provided Specialty Drug List may be updated from time to time.**

EXHIBIT B-2

VENDOR QUALIFICATION RESPONSES

Prescription Drugs

Please complete each item in the Questionnaire completely and in the order shown. If answers vary based on the plan you are proposing, please provide the answers separately. Clear reference to readily accessible back-up material (e.g., plan documents, reports, etc.) is acceptable. Incomplete or inaccurate answers may result in the disqualification of the proposal.

1. **Provide history and ownership of the prescription benefit management firm including parent company, year PBM established, number of PBM employees involved in account management, membership count, number of group plans in force, number of group plans added and terminated in the past 12 months, the number, nature and status of any outstanding legal actions pending against your organization, general and professional liability coverage in force, acquisitions or divestitures in the past 12 months, staff reorganizations and relocations, computer or telephone system changes in the past 12 months, and any major changes to your organization or structure anticipated in the next 24 months.**

   Incorporated in October 1995, Walgreens Health Initiatives, Inc. (WHI) is a wholly owned subsidiary of Walgreen Co., a publicly traded corporation. As the pharmacy benefit manager within the Walgreens Health and Wellness division, WHI is responsible for developing and delivering an array of pharmacy benefit solutions, including fully integrated retail, mail and specialty pharmacy services, dependable claims processing, proactive client service and personalized clinical programs.

   We presently have 131 employees (not including call center representatives) dedicated to serving 293 group plans. During the past 12 months nine groups were added while 84 terminated. As part of Walgreen Co., WHI has a General Liability policy with a limit of $2 million per occurrence, $2 million aggregate. WHI also requires its contracted pharmacies to maintain insurance at their sole expense (either via commercial policies or self-insurance) for professional and general liability at levels deemed appropriate by WHI ($1 million for each claim or $3 million in the aggregate). The network pharmacies are contractually obligated to notify WHI of material changes in their insurance policies or financial status, as applicable. In addition, the network pharmacies are contractually obligated to comply with all laws and regulations applicable to the practice of pharmacy, including licensure and certification requirements. A description of legal actions against our organization during the last five years can be found in *Attachment L.*

   On April 9, 2010 Walgreens completed its acquisition of the Duane Reade pharmacy chain in New York. This is a strategic decision that aligns with our vision for transforming community pharmacy. On September 3, 2010 Walgreens sold its long-term care facilities to Omnicare, Inc. in exchange for eight of Omnicare's home care facilities. The deal is aligned with Walgreens long-term strategy and is expected to close in November.

   Like so many companies affected by economic conditions, in the last year Walgreens has undergone a new examination of its structure. This has touched many departments including those

that serve our clients. These changes will only serve to improve the level of service we currently provide the County.

With respect to system improvements, our PBS claim adjudication application runs on an AIX operating system and Oracle database. Between 1/1/11 and 3/31/11, WHI will be upgrading the AIX Operating System to version 6.1 and upgrading the database from Oracle 10g to Oracle 11g. System updates and enhancements are ongoing and are executed in a manner that will not disrupt service to our clients or members.

Lastly, it is important to realize that neither Walgreens nor WHI are in any way owned or aligned with a pharmaceutical manufacturer. We are a proud subsidiary of "The Healthcare Provider America Trusts." In addition to following a 110-year-old tradition of conducting honest and transparent business, WHI has the financial backing of a company that has been one of Fortune's "Most Admired Companies in America" for 15 straight years; has recorded 35 consecutive years of record sales and earnings growth, leading the chain drugstore industry in sales since 1983; and saw sales of over $67 billion in Fiscal 2010. With 8,000 points of care, we will continue to leverage our relationship with Walgreen Co. to offer the County 90-day retail prescriptions (if requested), an immunization program, Medication Therapy Management, Walgreens Optimal Wellness, an onsite pharmacy and worksite health center, infusion services, durable medical equipment distribution, Ryan White pharmacy services, injectables, and access to in-store Take Care clinics. Our relationship with Walgreen Co. will expand your access to care and develop member/pharmacist relationships that result in enhanced medication management, fewer hospitalizations and healthier lives for your employees and their families.

2. Provide an organizational chart and career profile for all staff involved in the sale, service and financial relationship with the County. Where are each of these individuals located?

The County will continue to be served by a dedicated team of account professionals locally-based in Phoenix, Arizona. These professionals are well-versed in the County's healthcare philosophy and have helped implement your on-site pharmacy and other solutions that aggressively manage your trend. Should our relationship continue, you will be introduced to an expanded team designed to address specific facets of your program. Key professionals will include a medical director, a director of site operations, a pharmacy manager and a nurse practitioner.

Under the onsite model we propose, a medical director will provide oversight of all medical aspects of the County's health center services, including the operation of quality assurance programs. This position reports to a director of site operations (DSOs) for non-clinical issues and to a regional medical director for all medical issues. The site medical director will also have a dotted line reporting relationship to the County's designated official. These individuals will be named to your team following close consultation with the County. When possible, we will also attempt to recruit the contract medical director from the local medical community in order to continue positive local relationships.

3. Which sales office will handle the general servicing of this account for retail, mail order and specialty pharmacy programs? What are the days and hours of operation for the sales and service office?

All aspects of the County's account will continue to be served from our Western Sales and Service office at 101 N. 1st Avenue in downtown Phoenix. Located one mile from your office and blocks

from your on-site pharmacy in the County Administration Building, our office is open 8:00 am to 5:00 pm, Monday through Friday.

4. **Can you administer the current benefit plan designs (multi-tier coinsurance plan with minimum and maximum costs per tier, and a multiple-tier pharmacy reimbursement account) described in the Pharmacy Benefit Plan Description available at www.maricopa.gov/benefits, under the pharmacy tab? If not, please explain what provisions you cannot administer.**

   Yes. We will continue administering the County's benefit plan designs.

5. **Does the PBM or another organization perform the following functions? If another organization performs the function, please include its name and address.**

   - **Formulary Management including appeals and utilization management**

     WHI performs this function internally. Certain appeal reviews are conducted by:

     MCMC, LLC
     88 Black Falcon Avenue, Suite 353
     Boston, MA 00210

   - **Formulary Pharmacy and Therapeutics Committee**

     WHI performs this function internally.

   - **Drug Manufacturer rebate contracting and invoicing/accounting**

     Express Scripts, Inc.
     One Express Way
     St. Louis, MO 63121

     As of January 1, 2011 Express Scripts perform s rebate aggregating and some formulary management services. They will contract with pharmaceutical manufacturers, and calculate payments based on member utilization.

   - **Retail Pharmacy Network contracting**

     WHI performs this function internally.

   - **Member Services including toll-free phone lines, and web site**

     WHI performs this function internally.

   - **Mail Order drug purchasing and dispensing**

     This service will continue to be provided by Walgreens Mail Service.

   - **Ownership of Electronic Claim Payment System**

     WHI performs this function internally.

   - **Client Management reporting tools and standard report production**

WHI performs this function internally.

- **Other (Please describe)**

SourceCorp Business Process Solutions Texas, LLP
2200 Chemsearch Boulevard
Irving, TX 75062

We subcontract selected Direct Member Reimbursement functions to SourceCorp, BPS.

Fiserv (formerly Personix)
2465 Centerline Industrial Drive
Maryland Heights, MO 63043

We subcontract selected printing projects, such as member identification cards Fiserv.

PrudentRx
100 Corporate Pointe, Suite 220
Culver City, CA 90230

We mitigate the potential for self-dealing through the formation of an independent audit process for network pharmacies with a third party, PrudentRx.

Pharm/DUR, Inc.
1419 West Oregon Avenue
Philadelphia, PA 19145

Pharm/DUR, Inc. provides independent onsite auditing of network pharmacies.

InnerWorkings, LLC
600 West Chicago Avenue, Suite 850
Chicago, IL 60610

We subcontract certain invoice printing services to InnerWorkings, LLC.

Quest Diagnostics Incorporated
10101 Renner Boulevard
Lenexa, KS 66219

Quest Diagnostics is a leading provider of diagnostic testing, information and services. Quest will perform Health Risk Assessment testing if you choose this service.

MCMC, LLC
88 Black Falcon Avenue, Suite 353
Boston, MA 00210

Fiduciary assignment and certain claim appeals are administered through an Independent Review Organization (IRO), MCMC, LLC.

Alere® Medical, Inc.
595 Double Eagle Court, Suite 1000
Reno, Nevada 89521

Smoking cessation programs are currently being provided through Alere. As of August 1, 2011 we will offer this service through The American Cancer Society - Free and Clear™ Quit

for Life Program. Free and Clear, Inc. specializes in web-based learning and is a wholly-owned subsidiary of Alere.

Genpact Limited
200 Wilmot Rd.
Deerfield, IL 60015

Genpact will provide general accounting back office functions. Genpact is a leader in accounting support for major corporations and health care organizations.

Our subcontractors have consistently met high standards for service and are evaluated and approved through reference ratings, economic appraisals and quality and reliability measures.

6. Indicate the most recent ratings for your organization:

	Rating	Date
Standard & Poor	Long Term Debt A Commercial Paper A-1	10/24/10
Duff & Phelps	Not Applicable	Not Applicable
Moody's	Long Term Debt A2 Commercial Paper P-1	10/24/10

7. Please give your current financial position and the date for which such data is determined for the following items:

a. Members

WHI has 8.2 million lives.

b. Assets

As a wholly owned subsidiary of Walgreen Co. WHI does not prepare independent financial statements. Walgreens total assets as reported in its 2010 Annual Report were $26.2 billion.

c. Liabilities

As a wholly owned subsidiary of Walgreen Co. WHI does not prepare independent financial statements. Walgreens total current liabilities as reported in its 2010 Annual Report were $11.8 billion.

d. Net worth (assets – liabilities)

As a publicly traded company, Walgreens Co. assets minus liabilities , including shareholder equity equals zero. For further details, please see the Walgreen Co. 2010 Annual Report included on CD-ROM.

8. Do you agree to meet with Maricopa County on at least a monthly basis to discuss operational issues?

Yes. We will continue to play an active role as your pharmacy benefit advisor and look forward to meeting with you on a monthly basis or more frequently, if needed.

9. Do you agree to meet with the various benefit vendors on an ad hoc and quarterly basis to resolve data exchange issues and to partner for improved drug, medical, and behavioral health outcomes?

Yes. Senior Account Executive Lisa Cuellar and other members of your team will meet with you on a quarterly and ad hoc basis to explore new strategies for achieving positive health outcomes.

10. Do you agree to provide a dedicated, mutually agreed upon, local clinical pharmacy consultant who will be the County's key clinical pharmacist and strategist?

Yes. Suzanne Moyer, Pharm D, MBA will continue to serve as the County's clinical confidante. As part of your expanded clinical services team that will include a medical director, nurse practitioner and director of site operations, Suzanne will offer her clinical expertise on current programs and reports, as well as cost-containment strategies. Suzanne is based in Phoenix and will have access to the County's data as well as Walgreens vast array of healthcare resources.

11. Do you agree to provide a dedicated, local account manager who will be the point person for Maricopa County?

Yes. Lisa Cuellar will lead your locally-based account team and be the point person for strategic initiatives and contract management. Lisa will work hand-in-hand with your administrators to develop enterprise-wide healthcare strategies that promote wellness throughout the County.

12. Do you agree to provide a dedicated customer service team for Maricopa County between the hours of 7 AM – 5 PM, Monday – Friday (with back-up customer service 24/7)?

Yes. The County will be among a select number of strategic clients assigned to our top tier Customer Care Professional (CCP) team. Each member of the team will complete training on the County's plan and the unique needs of your members. With an average seniority of over two years, this group of 40 elite CCPs will be responsible for addressing calls from the County members.

13. Do you agree to provide onsite staffing by knowledgeable service personnel to support Open Enrollment, from April through July? Anticipated need is 10 hours per week in April through June, and 40 hours per week in July.

Yes. We appreciate the need for active participation in the County's events. We currently participate in County Information Sessions that are held for two weeks in April and will supply 10 hours per week of support from April through June, as well as ongoing support as required during the month of July.

14. Do you agree to support annual enrollment meetings for retirees at a minimum of three locations designated by the County?

Yes.

15. How many clients do you have within Maricopa County?

We currently have 18 clients in Maricopa County.

16. Please complete Attachment C for three (3) clients who may be contacted with regard to your prescription plan. Also, please complete Attachment C for two (2) companies who have cancelled your services in the last two years.

A list of references can be found in Section 3.12.11.

Customer Service

17. Describe your customer service program including days and hours of operation, location, new employees and ongoing training plan, call recording and call tracking program, call quality program including scoring tool and quality standards, production expectations (number of calls per day, time spent in Available status, etc.), production and quality metrics, number of bilingual staff or phone line support available, and services to handle a diverse population. What types of issues do your customer service representatives handle? What is your call escalation process? What types of issues are referred to the employer? What is your service recovery plan?

We will continue to provide the County with a toll-free line and access to our complete pool of 500 Customer Care Professionals (CCPs). The Walgreens Customer Care Center (WCCC) provides the optimal combination of call technology and professional expertise, 24/7/365. These facilities are equipped to address any type of plan issue or member question – retail and mail – and are staffed by well-trained, highly motivated professionals who provide quick, efficient, and courteous service to all customers. WCCC facilities are located in Muscle Shoals, Alabama and Orlando, Florida. The centers are mirror images of each other and designed as business continuity backups with integrated Avaya software and infrastructure.

Call Escalation

The WCCC is equipped to handle all member issues. Complaints are typically addressed while the member is still on the phone. Depending on the nature of the issue, our CCPs can also escalate calls to the appropriate level. Typically issues received through the WCCC are routed to a Team Lead or Group Supervisor, as necessary, who in turn answers the caller's question. Issues that require additional research are forwarded to our Issue Resolvers or Corporate Customer Relations groups, depending on the issue type and research required. There, an Issue Resolver begins the investigation into a solution. We will document the date, the time, the parties involved, and other elements relevant to the issue. A follow-up phone call is provided, as necessary, to answer any remaining questions, or address any remaining issues. Once completed, the issue is closed and utilized for further performance enhancement.

The WCCC offers caller assistance in both English and Spanish 24/7/365. If a member calls in a language not already covered, we will escalate its status and review other departments that may support the language. If resources are exhausted, we will use the AT&T Language Line for translation as necessary. This service offers translation services in 150 languages. We also provide toll-free TDD/TTY and Internet services for members who are hearing impaired.

Training

All CCP candidates undergo rigorous training to prepare them to answer the most intricate calls. Our training pattern and methodology is designed to target the three types of adult learning styles (visual/seeing, auditory/hearing, and kinesthetic/doing). Lectures and power point presentations address the needs of the auditory and visual learner. Factual content and subject matter illustrations are posted in the classroom and represent an additional resource used to augment

the visual learner's style of learning. Computer Based Training Modules, Role Playing and actual phone time enhances the kinesthetic learner's ability to retain information. In order to graduate from the classroom setting, trainees must pass the final exam with a score of 80 percent or higher.

Every CCP receives coaching sessions that revisit training expectations and provides feedback regarding their performance (quality scores and learning assessments), attendance and break time adherence. In addition to scored exams, CCPs must also satisfy all attendance and performance expectations in order to be eligible for graduation.

CCPs receive scored quality monitoring during the training period; the expectation is a score 80 percent or better. Scores lower than 80 percent are evaluated and the trainee receives coaching and additional monitoring. If it is determined that the trainee would benefit from additional training, then the trainee may be partnered with a veteran representative to take or listen to calls. We do not establish expectations for call volume since every call is unique. Instead we encourage all CCPs to devote as much time as is needed to completely address a caller's question.

Re-Training

Ongoing training is required for all CCPs whose job is impacted by a new system, tool, product, service, or plan. Otherwise, ongoing training is scheduled at least three times per year, with over 24 hours of total new product training. On average, we provide approximately one to three hours of recurring training per week per CCP. Recurrent training is normally delivered in the traditional classroom format. However, informational content and Computer Based training can also be published to the Customer Care Professional's desktop. This resource places timely information in the hands of the Customer Care Professional and enables them to respond in much more precise and accurate manner.

Quality Assurance

The WCCC monitors Customer Care Professionals (CCPs) call center performance through:

- Side-by-side monitoring through Y-telephone cords at the CCP's station (during calls)
- Review of recorded calls through the NICE recording platform

Call monitoring and feedback sessions are key to maintaining and reinforcing our quality goals in an encouraging atmosphere. During these talks, we review virtually all areas of a CCP's performance through:

- Written documentation of calls
- Verbal discussion with the CCP of prior performance
- Review a recorded call (voice only or voice and screen)

Through the course of their career, CCPs are monitored two times per week for a total of eight times per month, and are graded against Quality Customer Experience (QCE) standards. The QCE is the overall quality experience a CCP provides to the member during the call, as measured by the QCE Monitoring Form (an internal scorecard). A CCP may earn a QCE score of up to 100 percent, as measured daily by Group Supervisors and the Quality Representatives.

Call Tracking

The WCCC uses the Avaya S8700/S8500 ACD/PBX switch system for Automatic Call Distribution (ACD). The ACD is used to queue calls to an available Customer Care Professional, and to track call center performance results. Our systems provide evaluation criteria, which includes the time and duration of each call, the average answering speed of all calls received and the number and percentage of calls abandoned. Performance results for the time and duration of each call, the average answering speed of all calls received and the number and percentage of calls abandoned are included in daily reports. These documents are distributed to senior management and used to evaluate areas in of enhancement.

The WCCC system can track calls by caller, by issue and by client. This tracking is done at the end of a call by a series of numbers, including values assigned to the following categories:

Call Categories		
Eligibility	Prior Authorization	Prescriber Calls
Copay	Benefits Office/Client	ID Card Request
Plan Use	Refill-Too-Soon	Direct Member Reimbursement
Mail Service	Locate Pharmacy	Drug Coverage
Drug/DUR Rejection	Prescription Incident	Miscellaneous

In all, our system is capable of tracking up to 46 individual reason codes as well as abandonment rate and average speed of answer. We can track calls on a book of business or individual client basis. Report frequency is typically on a quarterly basis, to coincide with client meetings.

Service Recovery Plan

The Walgreens Customer Care Center is structured with redundancy in mind. On a normal day-to-day basis, calls are virtually routed to appropriately skilled CCPs by one of three Avaya 8700 PBXs/ACDs within the WCCC location "footprint." When necessary, calls are routed seamlessly to another site by a Cisco router through a Sprint or AT&T Frame Relay Network. Excess volume flows naturally through our VoIP infrastructure through multiple "IP trunks."

In the unlikely event of an issue at one specific location, the WCCC's backup procedures would immediately reroute calls to alternate facilities. Additional Customer Care Professionals within the WCCC footprint can be assigned to assist with excess call volume; the process is virtually seamless, without the member noticing any change in the level of attention they receive. Internal procedures are regularly tested to ensure smooth performance.

18. List the top five member complaints related to each: retail, mail order and specialty pharmacies.

Code Description	Code Definition	% of Grand Total
Copay/Benefit Information	An inquiry where copay or benefit information was provided to the caller	23%
Eligibility	An inquiry about the effective date or termination date of a member plan	12%
Claim Status	This code is used whenever a pharmacy calls to check on a paid, denied, or rejected claim	12%

CCR Override	This code is used whenever an override is entered into Walgreens Information Systems by a Customer Care Representative	4.3%
CPA, Step Care, SPA	An inquiry to initiate a Step Care or Clinical Prior Authorization	4.3%

Please note: call tracking does not distinguish between retail, mail and specialty.

19. What corrective action has been put into place to resolve these complaints?

Corrective actions taken as a result of call center tracking can include follow up with client service teams and inclusion of issues in member satisfaction surveys. Issues that regularly show up on call center tracking reports are targeted for use in re-training of Customer Care Professionals.

In addition to focusing training on the above specific areas, we have implemented an enhanced call recording platform called NICE. The NICE system allows for detailed reporting and the ability to not only hear calls taken by the Customer Care Professional (CCP), but also see every step taken on the call. The system also allows the CCP to analyze personal stats, and supervisor or manager to review their team's stats and performance. Our recording platform also enables on-demand recording, if necessary.

We have also redesigned the monitor log used at the WCCC. The previous log focused on mechanical design and scripting. The redesigned form focuses on customer interaction and outcome of the call, to give a more personal and customer-focused experience.

20. Provide the following information for the customer service location proposed for Maricopa County during the past 12 months:

- **Percent of abandoned calls**

  During the last 12 months the Walgreens Customer Care Center reported an abandonment rate of 0.95 percent. This exceeds our historical abandonment rate standard of less than 3 percent.

- **Percent of calls handled by live representatives**

  All (100 percent) of calls that are routed to Customer Care Professionals are handled by a “live” person. During the last 12 months 82.7 percent of all calls were directed through our IVR system and handled by a representative.

- **Percent of calls handled by an IVR**

  During the last 12 months 17.3 percent of all callers resolved their issue through use of our automated menus without needing to speak with a Customer Care Professional.

- **Number of seconds to reach a live customer service representative**

  During the last 12 months the Walgreens Customer Care Center reported that 89.2 percent of all calls were answered within 20 seconds. This exceeds our historical standard for answering 80 percent of all calls within 20 seconds.

21. Do your customer service representatives have online access to real-time claim processing information?

Yes. Our Avaya Interaction Center is a "contact management" solution that is designed to integrate all channels of communication. Similar to Microsoft Windows in concept, it is a desktop through which our Customer Care Professionals (CCPs) access our various applications, including our online, real-time claims adjudication system, PBS, and our mail prescription order information system, Promise. In tandem with Avaya, our ANI database employs a logic protocol that helps tailor call center experience to members' needs. When a call passes through our Interactive Voice Response system, member information is updated within our database. Based on the results of successive calls, the system weighs the results of the member's response to the IVR's choices. Thus, if a member primarily utilizes the phone for prescription refills, prompts for mail order information are brought further up the IVR menu. This technology places us at the forefront of pharmacy call center capabilities.

22. Will your customer service representatives make outbound calls to a retail pharmacy to resolve a claims processing problem?

Yes. We offer all network pharmacies toll free phone access to a pharmacy help desk. This desk is staffed 24/7 by CCPs specially trained in issues facing retail pharmacies. If needed, the CCP will contact the pharmacy and work with the pharmacist to resolve issues like eligibility and copays.

23. Do you provide customer service for selecting and/or locating preferred and/or secondary network pharmacies?

Yes. All Customer Care Professionals have the ability to search plan-specific pharmacy networks to help callers locate convenient pharmacies. Each of our CCPs can provide the location of the pharmacy as well as useful information such as store hours.

24. Describe any web site self-service capabilities available for the employer, employees and pharmacies.

With 62,754 National Network locations throughout the United States, Guam, Puerto Rico, and the U.S. Virgin Islands, WHI provides comprehensive network coverage information. Using the Pharmacy Locator function on *WalgreensHealth.com*, members and employers can identify the nearest, most convenient pharmacies to the zip code or city/state they enter. In addition to the store name and address, searches can be filtered to return participating 24-hour, specialty and Walgreens90™ pharmacies.

WHI's Pharmacy Locator function also has a mapping feature that allows members to select a network pharmacy and view or print directions and maps from any location to that pharmacy. Members can also price a drug directly from the Pharmacy Locator at the pharmacy of their choice.

25. Are the pharmacy networks available online through your member portal?

Yes. Pharmacy network information is available online through our member portal.

26. Will the member be able to produce a temporary ID card through your member portal?

Yes. *WalgreensHealth.com* includes a tool that lets members print temporary ID cards in real-time. For their protection against fraud, members may choose to omit their prescription ID number from this card.

27. Can members request a replacement or additional ID card through your member portal?

Yes. Members may submit a request online for a replacement or additional ID card or may contact the Walgreens Customer Care Center toll free, 24/7/365.

28. How are members notified of new drug additions, formulary changes, significant changes in the pharmacy network, new and significant drug warnings, and drug recalls?

Formulary changes are reflected in our adjudication system and on our web site; when a drug is removed from our formulary (usually in January) letters are mailed to members at no additional charge. We also provide Industry Events letters that notify members when significant developments occur. We can also provide members with letters notifying them of program changes at least 60 days prior to the effective date. Other custom formulary letters and communication campaigns can also be developed both through PBM services and your onsite pharmacy.

Further, the Formulary Search function at our web site, *WalgreensHealth.com*, prompts the member (and prescriber, non-member or member who is not logged in or registered) with generic, preferred and non-preferred brand drug information. All users are able to browse the WHI Preferred Medication List (PML) by drug category or keyword. After selecting a formulary drug, the web page will provide the member with the formulary status and drug category. Subsequently, if the user is logged in, members will have the option to view coverages and copays for the applicable formulary drug.

Significant changes to your retail pharmacy network would be communicated to the County and its members by your account team. Members can easily access network pharmacy information through the Pharmacy Locator tool within *WalgreensHealth.com.* Our web site is updated on a nightly basis. Because of the network stability demonstrated by our pharmacy over the last 15 years, it is highly unlikely that the composition of our network would significantly change, prompting member notification.

As part of normal plan administration, our clients receive information on important industry developments and formulary changes via email or during quarterly on-site meetings. One-page newsletters provide a snapshot of products that have generic alternatives and of new products entering the market.

WHI will provide the County with more detailed information through our Mortar & Pestle (M&P) communication. This newsletter is emailed to clients and contains recent P&T Committee decisions, changes to our drug file, pipeline news, new drugs on the drug file, findings on investigational drugs, safety information and other useful recommendations. Drug information provided includes classification, pharmacology, dosage/administration, general precautions, side effects and interaction, as well as patient education and cost of therapy. The M&P also discusses the anticipated impact of each new drug approval. M&P services are provided at no additional cost. An abbreviated M&P can be found in *Attachment D.*

Our account teams are also equipped with a series of modeling tools they can use to help the County anticipate coverage ramifications. These tools use your plan data and forecast the impact of significant industry events, based on medication class-specific scenarios. For example, prior to generic pravastatin (Pravachol®) and simvastatin (Zocor®) coming to the market, WHI developed different scenarios from which our clients might choose to manage this cholesterol-lowering class (statins), once multiple generic products became available.

29. Will you agree to perform and report out a Maricopa County-specific member satisfaction survey at least annually? If yes, please explain how the survey will be administered to ensure sufficient member participation. Will you guarantee a statistically significant response rate?

To measure member satisfaction, WHI utilizes the services of an independent market research company to assure that the study is conducted objectively and professionally. As an example, we currently mail questionnaires to 6,000 randomly selected members who are asked to rate different aspects of their plan. While the questions are concise, they cover a variety of topics, including the performance of our call centers, mail service and the usefulness of member communication materials. There is a range of options and methods to "rate" satisfaction, most are scale, i.e. 1 to 9, N/A or D/K. This can be modified to meet your needs. We work diligently with our research partners to achieve response return rates, and confidence levels at 95 percent +/- 2 to 3 to 5 percent.

We also conduct surveys that measure patient satisfaction with Take Care Health services. Using an independent organization, the satisfaction survey asks the employee to rate services on a 1-5 scale (1=Poor; 5= Excellent). There are also several open-ended questions to allow for comments. In order for Take Care Health's services to be benchmarked nationally, the annual survey has been standardized to collect the exact same information from all sites.

Patient satisfaction survey collection and reporting is performed annually using a standard survey tool. In order to assure the reliability of the survey sample, the survey team/office staff offers a survey to *every* patient as he/she arrives for an appointment. The survey team/office staff directs and encourages survey completion by using positive statements informing the patient of the survey collection efforts, i.e., "We're conducting a patient survey as part of our commitment to quality and we're interested in your opinion. A few minutes of your time to complete the survey will be helpful and very much appreciated."

Rather than a County-specific survey, we propose including a mutually agreed upon number of Maricopa members in our annual survey. This would be enough to ensure a representative sample and sufficient to obtain a result that reflects your members' attitudes toward their pharmacy benefit.

30. Will Maricopa County's outsourced benefit administration vendor have access to update eligibility in your system in emergency situations? If not, please explain how a haste enrollment can be accomplished the same day that it is identified.

Although we are familiar with ADP's processes and procedures we do not presently grant them access to our system. Instead we will continue to provide the County with online access so that updates can be made from within your office at any time. Online updates are reflected in the system immediately upon entry.

31. Will you provide Maricopa County update and inquiry capabilities to your claims system? If yes, please describe any limits for updates and inquiry of the system by Maricopa County. Will you provide up to nine access codes to the County at no additional fees? Will you provide onsite training for the nine users?

Yes. In fact, we strongly recommend the County continue to utilize our online tool for complete control of member eligibility and elimination of paper eligibility changes. The County will have immediate online access to view/add/change/terminate eligibility, view adjudicated claims and enter plan prior authorizations. Further, the County will have online, real-time authorization of

designated drugs, access to member claim history and drug profiles, and the ability to review and download standard reports. We presently provide you with seven logins and passwords and are willing to increase the number to nine. Since we are locally based, onsite training is not a problem.

32. Will Maricopa County have access to run test claims and to process direct member reimbursement claims through your claims system?

WHI will provide the County with the ability to run a test claim through our web site *WalgreensHealth.com*.

33. Do you agree to communicate with Maricopa County's Employee Benefits Division using Maricopa County's case tracking system within 5 business days to resolve member issues? Will you agree to purchase at least one license for this purpose at the approximate cost of $25/month?

Yes. Client Service Manager Tammy Davis currently has a license and uses it as one means of communicating with the County's administrators.

Appeals/Grievances

34. Do you agree to provide the appeal/grievance process for Maricopa County's non-ERISA plan, in compliance with federal and state laws and regulations? Do you assume full fiduciary responsibility for this process? Please provide a copy of your appeals/grievance policy.

Yes. WHI provides members with the option of having advisers benefit determinations (denials) re-considered through its clinical appeal review program. The appeal process involves a full and fair review of the member's claim for benefit coverage and of the adverse benefit determination. The program provides at least one and no more than two levels of appeals for adverse benefit determinations. Appeal reviews may be conducted internally by WHI pharmacists or externally by an independent review organization. Depending on the client's appeal requirements, various review structures may be chosen.

The program is structured to be consistent with a client's obligations under the Department of Labor Employee Retirement Income Security Act (ERISA) and Patient Protection and Affordable Care Act (PPACA) appeal regulations. For those clients who are subject to these regulations, their members will receive a compliant denial notice information them of the benefit denial, their rights set forth by ERISA and/or PPACA regulations, and the information necessary for the member to initiate the clinical appeal review process, if desired. The program is also available to clients who may not be subject to ERISA or PPACA regulations.

WHI assumes no fiduciary responsibility when administering the appeals program. We refer ERISA-governed plans seeking fiduciary assignment to MCMC, LLC, WHI's subcontracted Independent Review Organization. MCMC, LLC is an industry leader in Clinical and IRO appeals. Further details on the appeals process can be found in *Attachment H*.

35. How are members notified about decisions that are appealable? Please provide a copy of the notice.

Members are notified in writing about decisions that are appealable. A sample letter can be found in *Attachment H.*

36. How are first-level member complaints received through your customer service department handled and/or escalated to an appeal?

Members that have questions regarding a prior authorization or other issue can contact the Walgreens Customer Care Center. Our representatives will address the issue and if necessary escalate it to a supervisor or our clinical call center for resolution. Members who receive a decision letter are provided with instruction on how to submit an appeal as well as an address and phone number to call if they have questions.

37. Please explain how your appeals process is anticipated to change due to Health Care Reform legislation.

WHI's appeals process is designed to be consistent with a client's obligations under the Department of Labor Employee Retirement Income Security Act (ERISA) and Patient Protection and Affordable Care Act (PPACA) appeal regulations. Updates include implementing denial notices that comply with the new notice requirements, updating standard operating procedures to complete urgent care coverage determinations within 24 hours and developing support for Federal external reviews.

38. What reports are available to Maricopa County regarding appeal activity? Please provide a copy of each report.

We provide quarterly reports that document useful metrics like the number of appeals, approval rate and average turnaround time. A sample can be found in *Attachment H.*

39. What is the cost of handling each level of complaint, appeal and grievance?

Medication management reviews are conducted at $40 per intervention. Internal clinical appeal reviews are available at $250 each. External Tier 1 clinical appeal reviews are also $250 each, while Tier 2 external clinical appeal reviews are $325 each. New for 2011, federal external reviews are $475 each.

Compliance

40. Do you agree that Maricopa County or its designee will have the right to audit, with an auditor of its choice, with full cooperation from the PBM, with at least 90-days advance notice, the services and pricing (including rebates) provided in order to verify compliance with all program requirements and contractual guarantees for up to three years after termination of the agreement?

We ask that audits comply with our audit policies and procedures. Subject to patient confidentiality and other applicable laws, we will provide the County with reasonable access to mutually agreed upon information for the purpose of auditing and/or inspection. We are amenable to audits, subject to the terms and conditions of our agreements with pharmacies, rebate aggregator and pharmaceutical manufacturers, so long as the selected auditor is not a competitor and we are provided a signed confidentiality agreement acceptable to Walgreens beforehand.

We ask that any audit of agreements with pharmaceutical manufacturers be conducted by (i) a big four public accounting firm whose audit department is a separate stand-alone function of its business; or (ii) a national CPA firm whose audit department is a separate stand-alone function of its business. Audits should be conducted no more frequently than annually.

41. Do you agree that Maricopa County will not be held responsible for time or miscellaneous costs incurred by the PBM in the audit process including all costs associated with provision of data, audit finding response reports, or system access, provided to Maricopa County or its designee during the life of the contract? This includes any data required to transfer the business to another vendor.

We agree in principle however additional charges may be involved should we be required to transfer data to another vendor in a custom format or one that is not presently in use.

42. Will you provide copies of your annual SAS70 type II audit including complete audit findings to Maricopa County during the length of the contract?

Yes.

43. Do you agree to adhere to all relevant federal and state laws and regulations?

Yes.

44. Do you agree that all systems and services are compliant with the HIPAA EDI, Privacy and Security regulations established by the Department of Health and Human Services and that you will execute the appropriate Business Associate Agreement as provided by Maricopa County?

Yes. WHI is required to comply with the privacy provisions as outlined in the American Recovery and Reinvestment Act of 2009 ("ARRA") and HITECH Act, Public Law 111-5, as it relates to Section 13401 with regard to the application of security provisions and penalties to business associates of covered entities, as applicable. Sections 164.308, 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations, shall apply to a business associate of a covered entity in the same manner that such sections apply to the covered entity.

45. Do you agree to abide by the provisions of the HITECH Act in the event of a privacy violation or data breach including notifying Maricopa County and the impacted members of a breach and provide any required remedies?

As part of Walgreens enterprise-wide privacy and security program, WHI will comply with any requirements under the HIPAA privacy and security rules, including HITECH amendments to the same, with regard to incident response, breach or data mitigation.

Data Sharing

46. Do you agree to provide monthly claims data in the required format to the vendor for Maricopa County's data warehouse and to the medical and behavioral health vendors at no cost to the County?

Yes. We will continue to provide monthly claims data to the County's data warehouse as well as your medical and behavioral health vendors at no additional charge.

47. Do you agree to provide the various vendors (e.g. medical, behavioral health) complete eligibility, prescriber (i.e., name, address, phone number, specialty, DEA and NPI numbers), and paid claims data on a monthly basis in a mutually agreed upon format?

Yes. We will continue to provide eligibility, prescriber and paid claims data to the County's data warehouse as well as your medical and behavioral health vendors on a monthly basis at no additional charge.

48. Do you agree to accept and process within 48 hours of receipt, weekly eligibility/enrollment/plan design data from the benefits administration vendor in HIPAA compliant format?

Yes.

49. Describe any programs that you offer to integrate medical (including lab data) and pharmacy data in order to improve member outcomes and cost savings opportunities.

Walgreens Optimal Wellness™

As a trusted source of health information, Walgreens leverages its presence in Arizona to give the County a unique opportunity to positively influence member well-being. Walgreens Optimal Wellness focuses on Type 2 diabetes and integrates capabilities across all of our platforms: pharmacies, retail clinics, worksite centers, call centers and mail service to enable patients to better control their condition through education and face-to-face engagement.

The average diabetes patient sees a doctor twice a year for roughly 20 minutes, and only 28 percent ever see a Certified Diabetes Educator. Using information provided by you, we flag the diabetes portion of your population for this program. When diabetes patients visit a Walgreen community pharmacy, they are provided with helpful tips about diabetes and an invitation to participate in further consultations.

During the months following enrollment, these individuals meet up to four times with a certified diabetes counselor dedicated specifically to this initiative. These one-on-one sessions create an open environment for learning about diabetes and lifestyle changes that bring about positive outcomes. We are also able to bill the County's medical provider directly for these services.

The program also offers enrolled members Point of Care (POC) testing that includes a Cholestech Full Lipid Profile(TC, HDL, TG, LDL) as well as Bayer A1C Now testing. POC testing is conducted by trained health coaches in the 19 centralized locations throughout Arizona. Members are encouraged to have POC testing done at each appointment however it is not mandatory.

With nearly 18 million Americans diagnosed with diabetes, Walgreens Optimal Wellness is one of the many ways Walgreens helps groups like the County create cost-savings opportunities, while giving your members the tools they need to live healthier and more productive lives. For additional information please see the program outline within *Attachment J.*

MedMonitor24

MedMonitor24 utilizes a state-of-the-art operating system that integrates medical data with

prescription claims to identify members at risk for dangerous and expensive drug-related problems and medical outcomes. The MedMonitor24 database contains over 1,500 conflict edits and over 100,000 subcategories designed to detect patterns of over-utilization and/or abuse, under-utilization and/or non-compliance, therapeutic duplication, drug-drug interactions, drug-disease interactions and appropriateness of therapy.

Member information is processed through our proprietary Patient Matching process, which captures and reconciles fragmented member data to provide a single member view over a lifetime of interactions with WHI. Members can have multiple insurance carriers or significant changes in coverage over their lifetime, on both the pharmaceutical and medical sides of their benefit. These fragments are joined into a single therapeutic view of all healthcare treatments received. Our Patient Matching process reduces and manages erroneous duplication of members in our central database repository, providing a clinically sound healthcare history.

MedMonitorXR

Working in tandem with the enhanced RDUR program, our MedMonitorXR (MTM) program focuses on managing patients who are at high risk for drug-related problems, resulting from taking multiple medications for several chronic conditions. By combining pharmacy information with medical data, MedMonitorXR pharmacists are able to view a patient's complete health profile. This leads to face-to-face consultations on issues like appropriateness of therapy, polypharmacy, compliance and persistency and the proper use of medications by the elderly.

Ingenix Data Sharing Arrangement

Beginning in October 2010 Walgreens worked with the County to establish a data sharing arrangement with Ingenix. As a result, we now share lab data with Ingenix and use it to enhance the analytic capabilities currently in place. This gives us a more complete overall view into a member's health profile, which lets us reduce existing gaps in care and identify opportunities to promote healthy outcomes.

Financials

50. Provide a listing of all administrative fees.

Service	**Fee**	
Claims submitted for Direct Member Reimbursement or other post-service adjudication (e.g. subrogation claims)	$1.50	Per "clean" claim
ID Card Re-issuance	$0.80	Per package (includes 2 cards)
Coordination of Benefits	$2.00	Per "clean" claim
Plan Prior Authorization	$0.00	Per entry when entered by the County (if applicable)
Plan Prior Authorization	$1.00	Per entry when entered by WHI
Internal Clinical Appeal Review	$250	Per appeal review
External Tier 1 Clinical Appeal Review	$250	Per appeal review
External Tier 2 Clinical Appeal Review	$350	Per appeal review
Federal External Reviews for 2011	$475	Per appeal review
Manual Paper Eligibility Submission	$0.75	Per record

Individual Mailings*	$1.50	Postage per mailing
Deductibles	$0.00	Fee is waived
Benefit Maximums	$0.00	Fee is waived
Claim Billing Tape (standard)	$100	Per tape
Claim Billing Tape (non-standard)	TBD	Per tape
Claim Billing Data	$0.00	Via FTP
Non-Return of Tape	$175	Per tape
Online Client Access to *PBS*	$0.00	Includes 9 Logon IDs
Online Reports via *RxVision*	$0.00	Provided via 3 Logon IDs
Complex Ad Hoc Report programming	$125/hr.	Minimum of 4 hours, *if programming required*
Additional Logon ID for *PBS* or *RxVision*	$50	Per user per month
Adjustment to previous paid Rx	$0.75	Per claim
Add/Return Management Report	$100	Per report, plus $0.05 per page
Member Detail Report	$0.02	Per claim

Clinical Services

Clinical Program	Fee for Service Pricing
Concurrent DUR	Included
Prospective DUR *Informed Prescribing*	Included
Retrospective Drug Utilization Review	Included
MedMonitor®24	$0.30 per claim
Clinical Prior Authorizations	$40 per review request
Step Care Therapy	$40 per review request
Formulary Copay Override	$40 per intervention
Cost Ceiling Prior Authorization Program	$40 per intervention
Formulary Delete Letter	No Charge
MedMonitor®XR MTM (*per intervention)* *Accompanied by a guaranteed 1.5 to 1 ROI, when combined with MedMonitor24.*	$70 Polypharmacy $25 Inappropriate Medication in the Elderly $25 Appropriateness of Therapy $17 Compliance & Persistency Plus $0.03 per claim.
Blueprint for Wellness™ Comprehensive	$96 per participant
Other Blueprint for Wellness™ Services - PSA - Waist Circumference - Cotinine Serum - Fecal Occult	 $8.90 per participant $1.20 per participant $18.00 per participant $40.80 per distributed kit, w/$6.00 fee per kit tested and returned
Flu and Pneumonia Immunizations	$28.50 per shot $34.99 per nasal vaccine $54.99 per pneumonia vaccine
Walgreens Optimal Wellness™	$500 per participant/year
Voluntary Tablet Splitting	$1.90 per intervention
Free and Clear™ Quit for Life	$409 per participant (includes medication costs for nicotine replacement)

51. Will there be any additional charges if the benefit plan design is changed? If yes, please explain.

We do not anticipate any additional charges if new members are added. Changes in the benefit structure (i.e. number of tiers) could affect rebate allocations. Revisions, if any, can be reviewed on a case-by-case basis.

52. Do you agree to produce ID cards and mail the cards to the member's home address within seven calendar days from receipt of enrollment information?

Yes. WHI is able to comply with this delivery timeframe.

53. Will postage be included in the administrative fees for ID card generation, duplicate ID cards, mail order prescriptions and any other notices or mailings?

WHI typically bulk ships materials to a central location designated by the County at no additional charge. ID cards and other mailings delivered to a member's home will incur additional fees in order to cover the cost of postage. Mail order prescriptions include the cost of postage.

54. Is multi-lingual phone support included in the administrative fees?

Yes.

55. What is the data source used for AWP?

We utilize First DataBank as our AWP pricing source.

56. How often are AWP prices updated in your claims system and member portal?

Prices within First DataBank are updated daily, with new drugs and clinical updates revised weekly.

57. Do all of your network pharmacy contracts include the lesser of retail, U&C, MAC price or discounted price provision? Can you guarantee that members always will receive the lowest price in the selected delivery channel?

All of our network pharmacy contracts include "lowest of "pricing logic when comparing retail, U&C and MAC price.

58. What will a member pay for a drug from a retail store's $4 list (such as Wal-Mart's list) if the ingredient cost plus dispensing fee totaled $3 and the member copay is $5?

Under WHI's adjudication logic, the member pays the lower of the Usual & Customary (U&C) price or copay. In situations like Wal-Mart's $4 generic program, the discounted cost would adjudicate as the pharmacy's Usual & Customary ($4 cash) price. This would ensure the member receives the benefits of the retail generic program.

59. Do you guarantee that Maricopa County and the member will be charged the generic cost, if a generic is out of stock and a brand is substituted?

Yes.

60. Describe the minimum, individual and overall discount rate guarantees (including U&C and MAC) in detail for each delivery channel and each drug type (i.e., generic, single-source brand, multi-source brand, specialty, bio-similar and bio-similar interchangeable products).

The proposed pricing does not differentiate between single- and multi-source brands. WHI is offering a retail 30 brand discount of AWP minus 18 percent through the Preferred Network and AWP minus 17.75 percent through the Non-Preferred Network. Advantage90 discounts for preferred and non-preferred are AWP minus 21.5 percent and AWP minus 21 percent respectively. Brand drugs are not MACd. The above discounts do not include the impact of U&C. When U&C is included an additional 0.15 percent is added to the above discounts, but is not guaranteed.

The Overall Effective Rate discounts for generics are AWP minus 67 percent for retail 30, AWP minus 71.5 percent for Advantage90 and AWP minus 71.5 percent for mail. The above discounts do not include the impact of U&C and MAC.

61. If some network pharmacies provide greater discounts than the minimum discount rate guarantees, are the discounts passed to Maricopa County?

We are proposing a traditional pricing model, which shields the County from fluctuating provider discounts. The discounts we propose represent the aggregated value of our pharmacy network. We conduct an annual "true ups" to ensure you receive the full benefit of what we propose.

62. Describe the retail network pharmacy reimbursement process in detail.

Under normal circumstances, invoicing of pharmacy claims occurs twice each month. Invoices include summary pages that list Claim, Fee and total amount by Group. We also provide detailed prescription claim information with categories including: Cardholder ID, CD Patient, Pharmacy ID, Fill Date, Rx Number, Drug, Qty, Total Cost, Patient Cost and Plan Cost. We prefer payment be made via wire transfer to enable timely payment to participating pharmacies. WHI pays network pharmacies every two weeks from client remittances.

63. Describe the mail order pharmacy reimbursement process in detail.

Under normal circumstances, invoicing of pharmacy claims occurs twice each month. Like in retail, for wire or ACH payment, a fax or email containing invoice numbers and amounts should be sent at the same time as the transfer to WHI. The County may also select a withdrawal on demand option. As a current client we do not anticipate any difficulty establishing reimbursement procedures for retail or mail service claims.

64. Describe the specialty pharmacy reimbursement process in detail.

Specialty pharmacy follows the same procedures as retail and mail. However, instead of an aggregate discount across an entire network, specialty is priced on a drug-specific basis. Our proposed pricing is reflected in Attachment A-3 Specialty Drug Acquisition Pricing found within Section 3.12.9.

65.

Explain your MAC pricing strategy for each delivery channel.

WHI is proposing MAC pricing at retail, mail and Walgreens90™. Generics are priced at the lower of discounted AWP or applicable MAC versus pharmacy's submitted U&C.

66. How many distinct MAC prices can exist for a specific medication and how are the prices for Maricopa County determined? How often do they change?

We propose our proprietary MAC list – WHI MAC. This list contains a single price for each medication. We also maintain a CMS MAC list for those public sector entities that must adhere to CMS MAC, but we feel the WHI MAC offers a much more aggressive baseline.

The WHI MAC list is a product of competitive market price research for generic drugs. Only clinically appropriate generics are currently included on our list. The MAC list is developed to maximize savings for WHI clients. Its pricing maintains fairness for network pharmacies and thereby maximizing the overall value of WHI's network for its clients. Our MAC list is updated monthly with occasional mid-month updates that occur to maximize opportunity when drugs become available as generics.

67. Do you set the MAC price?

Yes.

68. What percentage of generic prescriptions has a MAC price?

Of all generics, 89.8 percent are MACd.

69. Does your MAC list include multi-source brand drugs? If yes, what percentage of multi-source brand drugs has a MAC price?

Our MAC list does not contain multi-source brands.

70. Will MAC savings increase if certain pharmacies were removed from the preferred and/or secondary network? If yes, quantify the additional savings.

MAC savings would not be increased by limiting network pharmacy options for your members. This being said, we are willing to discuss potential improved non-MAC discounts if the County is interested in restricted network options.

71. Do MAC price lists vary between network pharmacies? If yes, please explain.

No. The WHI MAC list is applied uniformly among network pharmacies.

72. Describe the available tools for members to determine the delivery channel to purchase all of their medication (except specialty medication) at the lowest member cost.

Using the Drug Cost function at *WalgreensHealth.com*, members can query the WHI Preferred Medication List (PML). By entering the first three letters of a drug, our search engine returns the matching drug (and generic equivalent, if available) and plan-specific information, including coverage, applicable cost and days supply maximum. Any potential generic savings are prominently highlighted in red. The drug cost feature is also capable of distinguishing between

preferred and non-preferred brands and subsequently displaying the appropriate alternatives. The member can then choose an alternative to compare its cost and any potential savings.

Through consultation with the County we have also designed a custom guide to low cost generics. This list can be used by members in your Consumer Choice Pharmacy benefit who want to maximize savings. The list can be used as a guide for the member and provided to prescribers to encourage use of lower cost medications. A sample of this list can be found in *Attachment D.*

73. Do you agree to provide our members with the Maricopa County discounted cost for excluded medications (e.g. infertility medication, oral non-sedating antihistamines, etc.)?

Yes. We presently provide members with discounts today and will continue doing so in the coming years.

74. Will your organization send recovery letters to members who continue to receive services after their termination due to the timing of the data exchange? If yes, please explain your process.

As a general practice, our adjudication system alerts pharmacists to not fill prescriptions for an ineligible member. The pharmacist would then use his or her best judgment when deciding on how to proceed. For this reason, letters are not typically needed.

75. Describe any special banking arrangements you require under the ASO contract, including the method by which funds are transferred, the frequency, and any initial deposit or minimum balance required.

We prefer payment be made via wire transfer to enable timely payment to participating pharmacies. For wire or ACH payment, a fax containing invoice numbers and amounts should be sent to us simultaneously with the transfer. Alternatively, a withdraw upon demand option is available. An initial deposit or minimum balance is not required. We are always willing to revisit banking arrangements, but since the County is a longstanding client we foresee no difficulty following the procedures already in place.

76. Do you agree to provide advance notice of each fund transfer including date and amounts?

Yes. We will continue to work with the County to provide the information it requests.

77. Describe your invoicing/billing process, frequency and payment requirements.

Under normal circumstances, invoicing of pharmacy claims and administrative fees occur twice each month. As previously stated, we prefer payment be made via wire transfer to enable timely payment to participating pharmacies. Terms are fifteen days net from the end of the billing cycle.

Mail Order

78. Where will the mail order facility be located?

The County will continue to use the Walgreens Mail Service facility located in Tempe, Arizona.

79. What are the days and hours of operation for this facility?

The Tempe, Arizona mail service pharmacy operates Monday through Friday, 6:00 a.m. through midnight and 6:00 a.m. through 3:30 p.m. Saturday, Mountain Time.

80. What is the number of registered pharmacists on staff at the mail order facility? How many are full-time versus part-time?

There are 62 registered pharmacists on staff, one of whom is part-time.

81. What is the number of pharmacy technicians on staff at the mail order facility? How many are full-time versus part-time?

There are 200 pharmacy technicians on staff, all of whom are full-time.

82. What is the number of other clinicians on staff at the mail order facility? How many are full-time versus part-time?

The staff in the previous two questions accounts for all clinical professionals at the Tempe facility.

83. What was the total number of prescriptions filled in the most recent 12 months?

During the last 12 months approximately 3.3 million prescriptions were filled.

84. How much capacity does the most recent 12 months of prescriptions filled represent?

The 3.3 million prescriptions filled represents 31 percent of the facility's total capacity.

85. How many total prescriptions can be accurately filled on a daily basis?

The mail service facility is capable of dispensing approximately 35,000 per day.

86. Are any prescriptions being filled at the mail order facility which are being purchased through a retail pharmacy store?

Both mail service facilities serve as central fill sites for retail prescriptions, however our retail stores do not sell prescriptions that are shipped to them via mail.

87. Do you have a separate customer service department/unit that handles mail order issues only? If yes, please provide details.

We have an integrated customer service strategy. Walgreens Customer Care Professionals are trained to assist callers with most every aspect of their benefit including retail, mail and specialty.

88. What organizations are used for delivery service?

Packages are shipped via FedEx, United Parcel Service (UPS), or First Class U.S. Mail based on a combination of factors, including destination, special handling, drug type, value of the order, package weight and preference of the plan member. First Class U.S. Mail will be the predominant method, based on the design of our process.

89. Does your organization own the mail service facility? If this is a subcontractor, who do you contract with?

No. We provide mail pharmacy service through Walgreens Mail Service, Inc., a subsidiary of Walgreen Co.

90. Describe your process for ordering initial prescriptions through mail order.

Members submit new orders with the original prescription and applicable copay in a pre-addressed envelope. Once the order information is entered into our mail service database, the member has the option of ordering refill prescriptions by mail, phone, fax or online.

91. Describe your process for ordering refills by mail, phone, fax, and the Internet.

Once the initial order information is entered into our mail service database, members have the option of ordering refill prescriptions by mail, phone, fax, or online.

Mail

Members fill out a mail order form and submit it, along with applicable copayment to the mail facility in a pre-addressed envelope.

Phone

Members who choose phone refills can call a dedicated toll-free number and order refills using a touch-tone phone. The touch-tone refill service prompts participants through a series of simple order steps. The touch-tone refill service is provided in English and Spanish. Touch-tone refills are available 24/7/365.

Physician Fax

Members may refill their prescription by asking their prescriber to complete and fax a form. This form is provided as a part of the original prescription, and would be available via our website or through the benefit administrator.

Online

Members may choose to refill their Walgreen prescription over the Internet 24/7/365. By visiting our website, members need only fill in the prescription number provided on the Walgreen prescription label, zip code, and credit card information.

92. How far in advance may members order a refill of an 84-91 days' supply of medication?

Early refill status is a plan design parameter that can be set to your wishes. If a Maricopa County member submits an order within 63 days of the next scheduled refill date, we will hold the request on file and process it when the date arrives.

93. Can you accommodate the mail order plan design with pricing for a retail pharmacy at the onsite retail pharmacy for an 84-91 days' supply?

Yes.

94. Provide the results of your most recent State Board of Pharmacy inspection of your mail order facility.

All mail facilities are subject to review by the local State Boards of Pharmacy and are in good standing. The Tempe pharmacy's NABP number is 0320793; the Tempe pharmacy's Arizona license number is Y003788. We would be happy to discuss this issue further. Should you wish to confirm our standing, our status is listed on the following website: az.gov/app/pharmacy/search.xhtml

95. Describe what physician outreach services you provide at the mail order facility.

The mail service facility is staffed by numerous pharmacists, technicians and support professionals who understand the complexities of mail order fulfillment and proactively contact prescribers to see that members receive the medication they need.

Exception handlers within the mail service facility work in a dedicated area research orders that require additional information in order to be dispensed. We will call both the member and the prescriber about a problem with the prescription to resolve the issue. Delays may also be communicated via email, if the member provides us with a correct email address.

Our *Informed Prescribing*® system also checks for opportunities for therapeutic intervention. In these cases we call the prescriber and member to see if a preferred or generic alternative is appropriate. We do not typically hold prescriptions that are eligible for therapeutic intervention longer than 48 hours, so as not to interfere with the timely delivery of medication to the member. In the unlikely event that a delay does occur, our phone center would contact the member to explain the situation and offer solutions. If the member's email address is on file, we will also notify them via email.

If the mail facility only has partial stock, a system edit will notify us and a member of our staff will make an outbound call to the prescriber to determine if an alternate prescription is suitable under the benefit, or hold the script until inventory is received. If there is an immediate need, we will arrange for a small supply to be dispensed at a Walgreen community pharmacy at no cost to the member.

96. How many calendar days advance notice must a member provide in order to guarantee that their medication is received before their existing supply is depleted?

As a precautionary measure, we recommend claimants maintain at least a 14-day supply and provide for 10 business days when ordering, to account for any in-transit delivery/carrier lag. This being said, our internal turnaround time for clean mail orders is less than one business day.

97. Will you deliver mail order prescriptions to retail pharmacies, work or other locations other than the member's home/mailing address?

Yes. Our claims processing system is capable of storing multiple addresses so whether the member is away at college, on vacation or temporarily living away from home the prescription will arrive safely. Your members can also choose to pick up their prescriptions at your onsite pharmacy on Jefferson Street.

98. What is the average time in calendar days between receipt of a clean claim and delivery to member (including delivery time)?

We do not have data to support the total turnaround time from time of receipt of a claim to time of member delivery – too many variables exist in delivery times to our facility and in the delivery method to the member.

Instead, we track the time between the receipt of a claim and the time to medication shipping. Our goal is to ship all orders not requiring intervention within two business days. This provides ample time for delivery to the patient. *Our current turnaround time for clean claims from processing to ship averages 0.76 days.*

99. Outline your process for prescriptions which are ordered prior to the first available refill date.

Early refill status is a plan design parameter that can be set to your wishes. Our default value is 60 days; if a refill request is within 60 days, the mail service facility will keep the request on file and process it when this date arrives. A letter is sent to the member communicating this new date. If the next fill date is more than 60 days away, the order would be returned to the member with a letter stating the reason for return. All member communications are sent within two business days. At the County's request your members are required to use 70 percent of the medication or be within 63 days of the stated refill date. This approach is suitable for the County's members and can easily be continued.

100. What is your average generic dispensing rate for all clients utilizing this mail order facility?

The average generic dispensing rate for all clients using the Tempe facility is 63.89 percent.

101. What is your average generic substitution rate for all clients utilizing this mail order facility?

The average generic substitution rate for all clients using the Tempe facility is 96.34 percent.

102. Explain the process and criteria for providing members with a short-term retail prescription supply in case of delayed delivery of their mail order prescription. Is the member's contribution waived for the short-supply?

Our mail service professionals carefully monitor inventory levels and intervention practices to minimize delay. In the rare situation where an order is delayed, a mail service representative will make a personal call to the member and arrange for a short-term supply to be available for pickup by the member at any Walgreen community pharmacy nationwide. If a short-term supply is authorized, the member contribution for that temporary supply is waived.

103. How are members notified when mail order prescriptions have been mailed?

Members are able to track the status of their prescription via *Walgreens Health.com.* Using the Prescription Status feature on our web site members can see the dates we both received and shipped their medication. Members can also contact the WCCC 24/7 and receive a status update on their order.

104. How are members notified when a mail order prescription is delayed?

Notification procedures depend on the reason for the delay. Exception handlers within the mail service facility work in a dedicated area to ensure the most streamlined intervention process available. We will call both the member and the prescriber about a problem with the prescription to resolve the issue. Delays may also be communicated via email, if the member provides us with a correct email address.

Should a delay occur as a result of operational capacity or drug supply issues, WHI's phone center would contact the member to explain the situation and offer solutions. Should there be a mail delay of over seven days, members would be contacted via outbound call, alerting them of the issue.

We do not typically hold prescriptions that are eligible for therapeutic intervention longer than 48 hours, so as not to interfere with the timely delivery of medication to the member. In the unlikely event that a delay does occur, our phone center would contact the member to explain the situation and offer solutions. If the member's email address is
on file, we will also notify them via email.

105. What is your process for notifying customers of the expiration date, next refill date and number of refills remaining for their mail order prescriptions?

WHI offers several methods of encouraging refill adherence. Each mail pharmacy order includes an invoice that advises the member when the prescription should be refilled and the number of refills remaining. Comprehensive drug education materials and refill order instructions and forms are also provided.

We can also forward an email reminder, if the member registers information (a valid email address) with us and selects a refill reminder option. Additionally, the member may track order fulfillment through the Prescription Status feature on our web site. This program notifies members when we have both received and shipped their medication.

106. Please describe your mail order program including when notifications will be made to the County, the members and the prescribing physician when a medication's tier is changed from preferred to non-preferred or if significant cost changes in a medication occur.

Your dedicated account team will work closely with the County to ensure that your members and the prescribing community are notified of any significant changes. Due to recent healthcare reforms, we will provide the County and its membership with notification 60 days before our formulary is updated. WHI Formulary Alert Letters are provided at no additional charge.

107. Will you provide Maricopa County with a detailed disruption and financial impact analysis at the same time?

Yes. The members of your account team will model the impact recommended changes will have on your plan and review the data with you so that you can make an informed decision.

108. What is your process for notifying members when they are ordering excluded or very expensive medication?

Excluded medications will be adjudicated according to the County's plan design. This may involve a prior authorization or step care review. If the order amount simply exceeds $125 or another threshold set by the County, we will contact the member before billing. High dollar amount copays or order totals (i.e., amounts exceeding $125) are monitored by our registration, order entry and order production departments. If a high copay is encountered in either the registration or order entry departments, the member's history is checked to determine whether the high copay amount was encountered previously. If the issue was not previously addressed, then the member will be contacted and informed of the costs associated with the filling of the prescription or order.

109. What is your process for notifying members about new and significant drug warnings or product recalls?

We are notified of recalled products through emails from corporate contacts, letters from manufacturers, letters from wholesalers, or recall information on our internal web resources. If a product is recalled, it is immediately checked for affected lots. Affected lot numbers are pulled from the shelves and quarantined in the facility returns department. Affected product is held in this area until return information is acquired from the manufacturer or from corporate headquarters.

The FDA ranks the drug recalls by recall class and market level. Not all requests to remove products are recalls and the drug may not fall into the recall classes. Recalls are classified by a drug's danger to public health. When a recall is a consumer level recall, we send letters to contact the member about the recall, with instructions on how to return the medication. WHI will also contact the County to notify you in the event a recall has a material impact on your account.

110. What are your contingency plans for providing back-up mail order service in the event of a strike, natural disaster, or backlog?

Walgreens Mail Service has positive relationships with its employees and the clients it serves. As such, WMS has never had a work stoppage or strike.

Should a period of extended downtime occur at the Tempe facility, all prescriptions and customer calls would be immediately routed to the Orlando mail center. Any "overflow" beyond a facilities' capabilities would be routed to an appropriate Walgreens retail facility via *Intercom Plus*, Walgreens proprietary electronic patient database system. Retail locations are similarly integrated; workflow can be routed to any alternate Walgreen community pharmacy. With 7,650 community pharmacies nationwide and a staff of more than 25,000 registered pharmacists, Walgreens offers a comprehensive health and wellness presence.

This strategy has been tested in a real crisis. Following Hurricanes Katrina and Rita and with permission from State Boards of Pharmacy, Walgreens activated its proprietary system *VISION* and sent prescription background work from overwhelmed stores in Louisiana, Mississippi, and Texas to Walgreen stores in non-Katrina states. This allowed us to meet two to four times the usual prescription demand in affected areas.

111. Explain your packaging and shipping of prescriptions that require special handling.

Our shipping system flags temperature sensitive medications for special handling. The software automatically provides the technician with information on the medication's package requirements. This includes the number of cold packs required to maintain product integrity during shipping. Cold-packed products are shipped according to seasonal variations and as per the manufacturer's requirements. Insulin is shipped overnight delivery in cold packs, year round.

112. Do you require payment of mail order prescriptions before the prescription is filled and shipped or after?

Patients are asked to send in the applicable copayment with their order or have a credit card on file for ease of payment. This happens before a prescription is filled. While not typical, we will extend credit to a customer, as our primary concern is the well being of the patient.

Formulary Management and Rebates

113. Describe how your formulary is established. Include how specific drugs are selected and how often your P&T committee meets.

WHI typically utilizes an open, actively managed formulary. Our Preferred Medication List (PML) is an evolving list of medications that is developed by the WHI Pharmacy and Therapeutics (P&T) Committee. The Committee meets on a bi-monthly basis to discuss industry developments and evaluate medications for our formulary. The P&T Committee takes into consideration the clinical attributes and cost potential of medications and decides which products in a class to designate as formulary. The Committee's evaluation is based solely on clinical criteria. It is only after the Committee's clinical assessment is made that the economics of the drug are considered. For clients with a three-tier formulary design, the P&T Committee recommends medications be placed on the formulary's preferred (2nd tier) list if they have demonstrated significant clinical and economic value.

Medications are generally placed on our Preferred Medication List in the following manner:

- New brand medications are initially non-preferred (3rd tier) until the P&T Committee can conduct its evaluation process. This can occur very quickly for high impact medications on a priority basis. New drugs and new indications are reviewed no more than 90 days post-approval and all formulary decisions are made within 180 days of marketing launch. For expedited new drugs, all decisions are made no more than 90 days from market launch.

- During the time a medication is set to arrive on the market, the P&T Committee applies a safety check on the medication. It may have been deemed safe and effective by the FDA, but placed under special distribution restrictions to ensure a safety check happens. Other medications may remain on the market after significant safety issues have been identified, because they are used in special populations that need it. These medications remain non-preferred (3rd tier).

- Generic medications are always preferred and are recommended to be placed on the lowest copay tier (1st tier).

With the exception of Narrow Therapeutic Index (NTI) medications, multi-source brands with generics available are recommended to be non-preferred and are placed on the highest brand copay tier (3rd tier).

Remaining brands are evaluated thoroughly using the following components of clinical merit and are placed on an appropriate tier.

Criteria	Rationale
Therapeutic Value	The agent has shown to have a favorable effect on clinical outcomes. As demonstrated by the drug's efficacy, effectiveness and/or reduction of harm to patients.
Therapeutic Advantage	The agent exhibits benefits not seen in other drugs used for the same condition(s).
Economic Value	The cost of the agent is favorable compared to other drugs used for the same condition(s). Lowest net cost is a primary goal.

114. Are any P&T committee members employed by or under contract with any drug manufacturers?

It is important to note that WHI has neither a financial interest in a drug manufacturer nor are any Pharmacy and Therapeutic (P&T) Committee members employed by one. WHI has policies and procedures in place that maintain the privacy of voting members and document any conflict of interest to assure unbiased decision making. Every year all voting members are required to file a statement with the Secretary of the Committee listing any financial holdings the member has with a pharmaceutical company, participation in any research, educational or advisory programs funded by drug manufacturers, and receipt of any gift or hospitality (over $100) from a manufacturer.

115. Are any P&T committee members directly employed by your organization?

Yes. The Committee currently has 14 members, all of whom have voting authority. Of these professionals, nine are physician experts in the areas of internal medicine, cardiology, geriatrics, pulmonology, nephrology, women's health, and psychiatry. An additional member is a PharmD expert in geriatric medicine. The remaining four voting members are internal director or vice president level experts in formulary management, clinical therapeutics, pharmacy practice, formulary implementation and customer service.

116. Will you be able to customize and support a specific formulary for Maricopa County?

Yes. We look forward to discussing any formulary changes you would like to see. If customization will significantly impact the financial aspect of your plan, your account team will model the potential impact for you and outline their projections in advance of your decision.

117. How are maintenance medications for the mandatory 90-day prescription fill/refill program defined? Please provide a list of your maintenance medication list.

Maintenance medications are determined using the maintenance indicator on the First DataBank drug file. There are certain maintenance drugs such as narrow therapeutic index drugs and controlled substances, which are exempted from the mandatory 90-day prescription program due

to special circumstances. This list of exempted drugs, which are still allowed to be filled for a 90-day supply, but are not required to be, is called our "mandatory 90-day exclusion list." Using the maintenance indicator from the drug file and the mandatory 90-day exclusion list, the resulting drugs are what comprise our mandatory 90-day maintenance medication list. We have created a member guide of these drugs specific to Maricopa County, the most recent of which can be found in *Attachment D*.

118. How are preventive medications defined? Please provide a list of your maintenance medication list.

Our Preventive Drug List was created following IRS guidelines for HSA/High Deductible health plans and preventative medications. We then customized the list for the County to apply only to generics on the Preventive Drug List according to the County's plan design requirements. A sample of the list created for the County can be found in *Attachment D.*

119. Provide a list of your tier 3 non-preferred brand drugs. How was this list developed? What percentages of prescriptions typically fall in tier 3?

A list of WHI's tier 3 non-preferred brand drugs can be found on the CD-ROM that accompanies this proposal. In compiling this list the following logic was used:

- Obsolete NDCs were removed
- OTC products were removed since they are not covered on our formulary
- Repackaged NDCs were removed
- The following drugs were removed from the list because as of 1/1/2011 they are moving from Tier 3 to Tier 2
    - Jalyn
    - Tribenzor
    - Effient
    - Activella 0.1-0.1mg Tablet
    - Zylet
- The following drugs were added to the list because as of 1/1/2011, they are moving from Tier 2 to Tier 3:
    - Dexilant
    - Kapidex
    - Azmacort
    - Pulmicort Flexhaler
    - Pulmicort Turbuhaler
    - Proventil HFA
    - Cenestin
- Femtrace
- Tobradex Eye Ointment
- Femhrt
- Prefest

Using this methodology 34 percent of the medications on our drug file are on the third tier.

120. Will you guarantee that any formulary switches which are not economically advantageous to Maricopa County on an ingredient cost basis be reported and reimbursed to the County on a dollar-for-dollar basis using the least expensive, therapeutically equivalent alternative drug as the basis for reimbursement?

We select medications for our Preferred Medication List, using a lowest net cost methodology, where preferred medications result in safe, effective treatment and/or overall net plan cost after rebates. We will continue to work with the County to identify those instances where the ingredient cost may be higher and ensure you understand why this is taking place. If desired, the County can opt-out of *Informed Prescribing*® on select categories where the medication cost of the intervened drug is lower than our preferred product. As this may impact rebates, we will model the implications and provide you with the data you need to make an informed decision.

121. Please describe when and how notifications will be made to the County, the members and the prescribing physicians when a medication's tier is changed from preferred to non-preferred or if the cost of a medication significantly changes. Will you provide Maricopa County with a detailed disruption and financial impact analysis at the same time?

Your dedicated account team will work closely with the County to ensure that your members and the prescribing community are notified of any significant changes. Before our formulary is updated, we can provide the County and its membership with notification (when requested) 60 days prior to implementing the formulary changes. WHI Formulary Alert Letters are provided at no additional charge. Your account team will model the impact recommended changes will have on your plan and review the data with you so that you can make an informed decision.

122. What tools are available to promote formulary compliance and member education?

Our *Informed Prescribing* program employs dedicated, specially trained pharmacy professionals who, according to client-specific plan designs and established clinical criteria, identify those retail and mail service prescriptions appropriate for intervention activities. Intervention activities can include contacting prescribers and members regarding "Dispense As Written" (DAW) prescriptions at mail, activities directed toward formulary adherence, member adherence with medication regimes and other related clinical issues determined by the plan. All of our programs are developed with our patient-first philosophy in mind and include: Brand-to-Generic Intervention; Brand-to-Brand Interchange; and Formulary Management Support. *Informed Prescribing* is provided to the County at no additional cost.

Members with formulary questions may also call the Walgreens Customer Care Center. There a trained Customer Care Professional can answer questions on alternative medications, coverage issues and options for filling a prescription.

Further, the Formulary Search function at our web site, *WalgreensHealth*.com prompts the member (and prescriber, non-member, or member who is not logged in or registered) with generic, preferred and non-preferred brand drug information. All users are able to browse the Preferred Medication List (PML) by drug category or keyword. Pursuant to selection of a formulary drug, the web page will provide the member with the formulary status and drug category. If members are logged in they also have the option to view coverages and copays for the applicable formulary drug.

The WHI PML is also available as a PDF file, available for download and printing, if desired. This convenience will enable the member to print selected formulary information and present it to the prescriber at the point of prescribing. The formulary is printable in Spanish and English.

Walgreens Optimal Wellness

This program provides those with diabetes with face-to-face educational discussions about useful

tips for living with Type 2 diabetes. When members visit a Walgreen community pharmacy, they are provided with helpful tips about diabetes and an invitation to participate in further consultations. Through a series of consultations we work with diabetics and their physicians to improve wellness and reduce medical costs associated with diabetes.

Since Maricopa first implemented WOW, member awareness has steadily risen. For example, during the first six months nearly half of new Maricopa program participants said that they had never before received diabetes education.

The program also offers enrolled members Point of Care (POC) testing that includes a Cholestech Full Lipid Profile(TC, HDL, TG, LDL) as well as Bayer A1C Now testing. POC testing is conducted by trained health coaches in the 19 centralized locations throughout Arizona. Members are encouraged to have POC testing done at each appointment however it is not mandatory. We appreciate the County's commitment to WOW and share your belief that fills a gap in care for your employees and family members with diabetes. This will translate into enhanced quality of life for your employees and financial savings for the County.

MedMonitor XR

Walgreens MedMonitor®XR represents the next generation of medication therapy management. MedMonitorXR targets the most at-risk patients within a payer population for intense, concentrated clinical management. Through the various MedMonitorXR services, members medication therapy is reviewed for areas of drug therapy optimization, such as addressing gaps in therapy for those with certain chronic conditions not prescribed appropriate therapy, changing therapy for older adults on potentially inappropriate medications, addressing medication adherence, and working to reduce drug spend and pill burden for those with costly and complex drug regimens.

MedMonitorXR operates on its own platform via the Utilization and Therapeutic Management (UTM) system and is supported by an MTM Care Center that is staffed by registered pharmacists and pharmacy technicians. Members qualifying for the MedMonitorXR program receive one-on-one counseling, either by their local community pharmacist or one of our clinical care center pharmacists. This consultation lets the pharmacist provide valuable medication-related information to the member and gives the member an opportunity to ask the pharmacist any questions about drug therapy.

MedMonitorXR's Compliance and Persistency (C&P) interventions identify patients who are not following a prescriber's instructions regarding medications (compliance) or are not staying on the prescribed therapy as long as they should (persistency). The program seeks to identify and resolve barriers to compliance and persistency, and educate patients about the benefits and consequences of their medication-related behaviors. Taking medication exactly as prescribed is important, because inappropriate medication use can lead to increased healthcare costs, morbidity and mortality. Optimizing both compliance and persistency helps maximize medication benefits while helping to control overall healthcare costs.

Compliance and Persistency Case Study

A MedMonitorXR network pharmacist in Chandler, Arizona identified a Compliance and Persistency intervention opportunity for a patient who was potentially underutilizing cholesterol-lowering medication. The pharmacist consulted with the patient, who acknowledged that he had missed more than four doses of his medication due to cost concerns. The pharmacist educated the patient about the importance of compliance and offered to refill the medication for the patient. The

patient agreed to have the medication refilled and records indicate the cholesterol-lowering medication was filled on time a month later. This pharmacist helped his patient maintain adherence with their cholesterol-lowering medication, thereby lowering the patient's risk for an adverse cardiovascular event and/or healthcare utilization.

Our Polypharmacy program focuses on managing patients who are at risk for drug-related problems as a result of taking multiple medications for multiple chronic conditions. Approximately one-third of the elderly population in the United States is at risk for polypharmacy and associated complications. More than 20 percent of seniors are prescribed medications inappropriate for their age; one in four are under the care of four or more physicians; and one-third fills prescriptions at four or more pharmacies. As a result, seniors taking five or more medications a day are twice as likely to experience preventable, adverse drug reactions. The occurrence of polypharmacy and associated direct and indirect healthcare costs are largely underestimated, since the use of over-the-counter drugs and dietary supplements is generally not taken into consideration.

Polypharmacy Case Study
A MedMonitorXR network pharmacist in Davie, Florida identified a Polypharmacy consultation opportunity for a therapeutic interchange involving a patient's blood pressure medication. The patient had been taking a brand blood pressure lowering medication as ordered by her physician even though a generic alternative was available. The pharmacist consulted the physician who agreed to allow the brand to generic conversion. During the patient consultation, the patient informed the pharmacist that she was pleased with the change as she was now lowering her copay by 80 percent. This pharmacist's intervention helped her patient maintain therapy with blood pressure medication at a lower cost, thereby potentially improving long-term adherence.

A MedMonitorXR clinical pharmacist performs an extensive medication review to determine ways to optimize therapy and reduce overall healthcare costs. When conducting a profile review, a pharmacist answers the following questions for each medication. Pharmacists also examine the profile for dose optimization opportunities and other drug-related conflicts.

- Is there an indication for the medication?
- Is the medication effective for the condition?
- Is the dosage correct?
- Is the duration of therapy acceptable?
- Does the member's prescription benefit plan offer a preferred option for this medication?
- Are there clinically significant medication interactions?

Appropriateness of Therapy (AOT) interventions identify patients with certain chronic disease states, such as diabetes, asthma and heart failure, who are not receiving certain medications for their particular condition. AOT medication recommendations reflect clinical practice standards, evidence-based medicine and published national guidelines, including HEDIS and NCQA.

Appropriateness of Therapy Case Study
A MedMonitorXR network pharmacist in Holmes Beach, Florida identified an Appropriateness of Therapy intervention opportunity for a diabetic patient who was not on a lipid-lowering medication. During consultation with the prescriber, the prescriber informed the pharmacist that the patient was already taking a statin medication. There were no records of statin therapy on the patient's prescription profile prior to the consultation. Nine days after the consultation, a prescription was written for statin therapy for the patient by the same physician. It is unclear whether the patient may have forgotten to fill a written prescription by the physician or if the physician had forgotten to write a prescription for the intended therapy. Nonetheless, the communication between the pharmacist and the patient's prescriber may have facilitated the initiation of statin therapy in this patient, thereby potentially avoiding a costly adverse event.

Inappropriate Medications in the Elderly (IMIE) interventions seek to prevent further dispensing of medications that have been identified as inappropriate for persons 65 and older, based on consensus criteria for safe medication use in elderly patients. This program identifies elderly patients receiving potentially harmful, high-risk medications that may cause adverse drug events or unintended consequences.

During the three years the County has utilized our Polypharmacy program you have seen savings of $931,182. Other components of the program have generated savings totaling $1.14 million; a 4 to 1 return on investment.

If the County adopts our MedMonitorXR program in combination with MedMonitor24, we will guarantee an improved 1.5 to 1 Return on Investment.

For additional information on the MedMonitorXR program please see *Attachment G*.

123. Please describe the rebate program you are proposing for Maricopa County for all medications through all dispensing channels. Include whether the program is a pass-through, per prescription dispensed, or on brand or formulary prescriptions.

WHI is proposing rebates on a per net paid prescription dispensed basis. This applies to retail, mail and 90-day retail channels.

124. How often will you make rebate payments to Maricopa County?

WHI accumulates rebate dollars and then disburses them to our clients on a quarterly basis, based upon the contractual terms. Payments usually run 270 days in arrears, based upon when payments are received from manufacturers.

Specialty Pharmacy

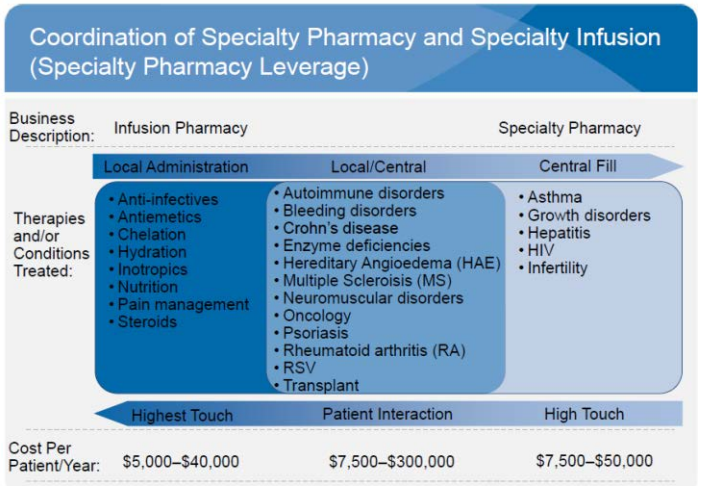
125. Describe your specialty pharmacy program including developed services to meet the unique challenges of dispensing and monitoring these medications, provision of cost-effective care and positive patient outcomes through increased adherence, convenience of scheduled delivery, disease management programs and compliance monitoring.

Over the last seven years, Walgreens has gained invaluable knowledge and experience related to the County's membership and your specialty pharmacy expectations. Along with experience, we have the distribution systems, disease-focused clinicians and financial stability to meet your requirements and any future growth. We appreciate the relationship that exists between the County and Walgreens, and we welcome this opportunity to continue collaborating on industry-advanced pharmacy solutions.

We offer the County program options and synergies unparalleled in the industry; we believe you will benefit from Walgreens global approach – a unique, continuous model that connects specialty pharmacy injectables, infused medications and clinical services. Walgreens suite of services provides detailed account management; compassionate patient care; patient education, consultation, and support; prescriber/care giver/case manager communications; enrollment,

reimbursement, and patient assistance programs; delivery coordination; clinical monitoring; proven therapy management programs, compliance tracking, and patient follow-up.

County members will continue receiving specialized, in-depth care from dedicated care teams with specific knowledge and understanding of specialty management. Walgreens proven clinical management programs create a unique offering to ensure competitive drug acquisition costs, appropriate utilization and carefully coordinated treatment. Our programs were established to treat complex conditions that may have a greater propensity to discontinue and/or adjust therapy based on multiple indicators such as patient's response, patient status or weight change. These programs have been developed with input from physicians and clinicians who are thought leaders with extensive expertise in the related condition.



The Future of Specialty Pharmacy

Growth in specialty pharmacy will outpace the traditional pharmacy growth over the next five years. By 2016, it is anticipated that approximately 50 percent of the top 100 drugs worldwide will be specialty products. More than half of all research and development dollars are being spent on specialty drugs. Many of these new medications will require administration by a healthcare provider. Physicians, payers and patients will have access to advanced medications and will need assistance to manage their administration, delivery, clinical monitoring and cost control.

Based on this trend, we have made it our mission to become the industry leader in both specialty pharmacy and infusion services in the next three to five years. We offer the County a customized, convenient and consistent solution. Our specialty infusion model is designed to generate positive, measurable patient outcomes and cost-effective care. We are the only provider with resources in place to offer full-service pharmacy alternatives in patients' homes, in physicians' offices, in Alternate Treatment Sites, and through our community pharmacies. Our business model utilizes Walgreens national points of care to create a pharmacy solution that optimizes care and maximizes value for clients. We will:

- Leverage community healthcare professionals (RPhs, RNs, NPs, RDs LVNs, CPhTs) and centralized therapy specialists to drive adherence and outcomes by providing enhanced care;
- Evolve specialty service center hubs to support complex needs of all specialty patients;
- Drive access, adherence, maximized outcomes and patient-centric care through integration with Walgreens points of care; and
- Expand access for County members through Alternate Treatment Sites.

Our unique model has made Walgreens a leading national provider of pharmacy services and allows for a more strategic partnership with the County. This is an opportunity to further expand our broad range of services through a consolidated agreement. Walgreens is offering the County a combination of home infusion and specialty infusion services unmatched in the industry.

We can provide the County with unprecedented access to specialty and infusion services in manners consistent with industry practices and member needs. All this, coordinated through a series of Walgreens facilities strategically located to offer convenient service. Our footprint includes:

- Over 7,650 Walgreens Community Pharmacies
- Over 90 Home Infusion Pharmacies
- Over 70 Alternate Treatment Sites
- Over 73,000 Healthcare Providers
- Over 1,000 Registered Nurses and 60 Dietitians directly employed by Walgreens
- Six Specialty Pharmacy Facilities

These options facilitate cost-effective care in the most appropriate setting. At every site, we emphasize consistent clinical support and therapy management to raise medication adherence levels, reduce costs through clinical interventions and improve overall patient and physician satisfaction and clinical outcomes.

126. Does your program use a care coordination model? If yes, please explain.

Yes. All medications we dispense are accompanied by varying levels of care coordination that educate, promote adherence and provide support to patients. Walgreens covers a wide range of chronic, complex disease states. These include, but are not limited to:

Anemia/Neutropenia	Oncology
Asthma	Osteoarthritis
Crohn's Disease	Pulmonary Arterial Hypertension
Growth hormone Deficiency	Psoriasis
Hemophilia	Psoriatric Arthritis
HIV/AIDS	Rheumatoid Arthritis
Immune Deficiency/IVIG	Respiratory Syncytial Virus
Fertility	Transplant
Multiple Sclerosis	Urology

On an exclusive basis, we actively reach out to patients, based on contact data provided by our clients. Following an initial mailing, our clinical staff calls patients to explain our programs and services, and enrolls them into our various adherence, persistency, refill reminder, educational, and clinical programs. During this call, we perform a host of welcoming activities, including – but not limited to:

- Review and verify the patient's disease state and physician information
- Notify patients on applicable HIPAA rights and responsibilities
- Describe and confirm, as applicable, services, delivery information, benefit coverage, and co-pay responsibilities

- Set-up patient ordering and confirm product receipt
- Provide pharmacist counseling and review of the order
- Monitor, identify, and triage adherence challenges and track compliance levels
- Secure patient confidentiality and maintain the highest pharmacy standards of care and service

Enrolled patients receive refill contacts after a set percentage of the medication has been utilized (as applicable to the therapeutic category) to ensure adherence and persistency. Our pharmacy staff contacts the patient by phone at a set time after a portion of the previous prescription has been utilized. This contact window allows for a care specialist to check the number of units or doses remaining; confirm the delivery schedule; ensure all patient information remains current; and perform ongoing phone surveys that focus on the patient's health, state of mind, side effects issues, and other data used to tabulate outcomes reporting.

On an ongoing basis, our clinical staff monitors medication adherence, provide enrolled patients with information to improve their understanding of their condition, and support them as they take a central and active role in managing their chronic illness. Through our adherence efforts, we assist enrolled patients in:

- Remaining adherent with their medication regimens;
- Managing medication side effects;
- Proactively preventing complications or managing existing complications;
- Reducing the impact of their symptoms (e.g., managing pain); and
- Becoming active partners in managing their own health (e.g., diet and exercise management).

If we are unable to reach the enrolled patient by phone after three attempts, we will attempt to contact the prescriber in order to determine the status of the patient's current therapy and discuss any potential issues. We are very proactive in managing our enrolled patient's health, averaging a 3 to 1 outbound to inbound call ratio.

We perform many other clinical activities, each appropriate and specific to the treated disease state. For example, when medication stability allows, our ACHC- and URAC-accredited facilities will pre-fill syringes upon request to help ensure patient safety; promote patient adherence; and provide patient convenience. Weight-based dosing is also performed to preserve patient safety. In the case of hepatitis therapies, our specialty pharmacy staff will work with the prescriber to obtain labs and prepare doses appropriately. Our pharmacists will ensure the medication dose is accurate, based upon the patient's weight, before filling the first prescription. Our pharmacists will also work with prescribers to round the product dose to the nearest package size when appropriate.

Trigger Reports

Our specialty pharmacies work closely with patients and the healthcare providers to proactively identify care management opportunities. Through the use of our advanced technology we are able to link patient responses to client initiatives. We can work collaboratively with your care

management team to identify key disease-based patient events and build custom trigger reports. These triggers prompt early intervention and allow care managers to proactively prevent complications.

Custom pivot tables allow the user to view, reorganize and summarize relevant clinical assessment data. We can easily build custom pivot tables for the County and train our professionals on how to use them to obtain the summarized data of their choice.

For example, we currently provide weekly trigger reports to the County for multiple sclerosis and rheumatoid arthritis patients who may have fallen, missed a dose or experienced a flare up. This data is then shared with your case management team for follow up and care coordination. Through these types of interventions we seek to prevent potentially harmful and costly complications.

127. Is a care plan developed? If yes, please provide details of what the plan addresses.

Yes. In addition to our therapy management, our clinicians are dedicated to specific disease states, identified as those that would benefit from additional support. They are:

- Multiple Sclerosis
- Rheumatoid Arthritis
- Respiratory Syncytial Virus
- Viral Hepatitis C
- Oral Oncology
- Fertility
- Hemophilia
- Heart Failure
- Nutrition
- Immune Deficiency/IVIG

Pharmacists, nurses and patient care coordinators in these teams work with patients upon enrollment to develop a Care Plan. This Care Plan will help guide the patient's therapy, and help our team proactively work with the patient to overcome barriers to effective treatment. This, in turn, reflects best practice in care management. For example, we enhance medication adherence by providing:

- Education related to injection training support;
- Diet needs counseling;
- Financial assistance counseling;
- Referrals to community and emotional support services;
- Lab and doctor reminders;
- Tools to track side effects, and ensure appropriate dosing;
- Confidentiality through unmarked packaging;
- Proactive refill reminders;

- Insurance paperwork support (as applicable); and
- Referral to pharmaceutical educational and patient assistance programs (as applicable).

Through the Care Plan and these dedicated programs, our pharmacists, patient care coordinators, and nurses monitor patient medication adherence; provide the information to improve understanding of the condition; and offer support as the patient takes a central and active role in managing the chronic illness.

Through our adherence efforts, we can assist enrolled patients in:

- ✓ Remaining adherent with their medication regimens;
- ✓ Managing medication side effects;
- ✓ Proactively preventing complications or managing existing complications;
- ✓ Reducing the impact of their symptoms (e.g., managing pain); and
- ✓ Becoming active partners in managing their own health (e.g., diet and exercise management).

Enrolled patients receive refill contacts prior to each refill date (as applicable to the therapeutic category) to ensure adherence and persistency. Our pharmacy staff contacts the patient by phone, typically after a set amount of the medication has been utilized. This flexible contact window allows for a care specialist to check the number of units or doses remaining; confirm the delivery schedule; ensure all patient information remains current; and perform ongoing phone surveys that focus on the patient's health, state of mind, side effects issues, and other data used to tabulate outcomes reporting.

We are very proactive in reaching out to our patients, with a 3 to 1 outbound to inbound call ratio. If we are unable to reach the enrolled patient by phone after three attempts, we will attempt to contact the prescriber in order to determine the status of the patient's current therapy and discuss any potential issues.

128. Can you manage separate plan designs for specialty medication? Please provide examples of your capabilities.

Yes. Plan designs are specific to each client. The pharmacy benefit design we have seen preferred among many of our clients is a flat dollar copay as part of a three-tier preferred medication list. The ultimate goal of many plan designs is to encourage use of the most cost-effective medication; in the case of specialty medications, a flat dollar copay encourages utilization and prevents medical costs due to hospitalization or disease progression.

The copay design aligned with the three-tier list incorporates the preferred medications and non-preferred medications listings in certain specialty medication categories when appropriate. Finally, some clients prefer to create a separate copay tier or "fourth tier" where a distinct copay can be applied for all specialty drugs.

129. Do you have a specialty medication formulary containing preferred and non-preferred medication? If so, describe the formulary process and basis for classification as preferred versus non-preferred. Please provide a list of the preferred and non-preferred products.

We do not have a separate specialty medication formulary. The formulary currently used by the County contains both preferred and non-preferred specialty drugs. Specialty pharmacy medications subject to formulary review undergo the same rigorous review for clinical factors (such as efficacy and safety), and financial factors. Clinical factors precede financial considerations at all times. A list of preferred specialty medications that are part of the WHI formulary the County currently utilizes can be found in *Attachment I.*

130. Do you have a separate customer service department/unit that handles only specialty pharmacy inquires? If yes, what are the customer service hours of operation for your specialty pharmacy program?

Customer Care Professionals focused specifically on specialty pharmacy are available to provide assistance to enrolled patients and prescribers Monday through Friday 8 a.m. to 7 p.m. and Saturday 9 a.m. to 5 p.m., Eastern Time. In all there are 196 professionals at the specialty pharmacy facility, 147 of which are focused on patient support. A pharmacist is available for urgent medication issues 24/7/365. Our call center also has a TDD line for hearing impaired callers and is contracted with AT&T Language Line services for translation services in servicing non-English speaking callers, accommodating 170 languages.

131. Discuss your capabilities related to management programs for drugs with a greater propensity to discontinue or adjust therapy.

Walgreens therapy management programs create a unique offering for payers to ensure competitive drug acquisition costs, appropriate utilization and proactive clinical management. Our programs were established to treat complex conditions that may have a greater propensity to discontinue and/or adjust therapy based on multiple indicators such as patient's response, patient status or weight change. These programs have been developed with input from physicians and clinicians who are thought leaders with extensive expertise in the related conditions. Below are descriptions of three programs we offer, the detailed description of adherence outcomes resulting from these programs can be found in the response to question 133.

Oral Oncology Cycle Management Program

Walgreens Oral Chemotherapy Cycle Management Program provides optimized clinical management and support to patients who receive certain oral chemotherapy drugs. Patients are contacted at predetermined intervals during their first month of therapy to educate them about their medication and potential side effects, assess for side effects and confirm medication adherence. If an adverse event is noted, our team responds according to established protocols and contacts the physician as necessary.

Multiple Sclerosis

Multiple Sclerosis (MS) is a chronic progressive disease of the central nervous system affecting approximately half-million Americans. According to the National Multiple Sclerosis Society, annual treatment costs per patient are estimated at $34,000. Disease-modifying therapies, which include Avonex, Betaseron, Copaxone, Rebif and Tysabri, can modify the progress of multiple sclerosis and have shown to decrease the relapse rate of MS by 30 percent. Appropriate use of these medications can decrease the number and severity of exacerbations and delay progression of disability.

Walgreens has a fully developed and implemented MS In-Depth Clinical Program. Our MS team is staffed by pharmacists, patient care coordinators, and nurses specifically trained in the dispensing, handling and consulting required for MS specialty medications and the patients who rely on them. Prior to each refill, a MS patient care coordinator who has worked with the patient contacts the patient every month. This encourages the development of trust-based relationships.

Through our MS In-depth Clinical Program our clinicians work to:

- Promote MS medication adherence
- Manage MS medication side effects
- Recognize and respond to suboptimal responses to therapy
- Proactively prevent complications

Rheumatoid Arthritis

Rheumatoid arthritis (RA), a chronic inflammatory disease of the joints, affects more than 2.5 million Americans. Drugs used in the treatment of RA which include Enbrel, Kineret, Humira, Orencia, Rituxan and Remicade can actually stop RA disease progression and, in many cases initiate a long-lasting remission.

Walgreens has a fully developed and implemented RA In-Depth Clinical Program. Our RA Team is comprised of pharmacists and nurses who are specially trained and have in-depth knowledge of RA. During the enrollment phone call, the RA team conducts an initial health assessment. The assessment includes collecting the patient's condition and medication history to create a comprehensive profile of the patient. Our RA clinicians provide counseling and support for issues specific to the RA condition, such as medication side-effect management, joint flare-ups, injection site reactions, and RA symptom management.

132. Describe how you coordinate with other vendors when opportunities are identified by your specialty pharmacy staff for engaging specialty members in applicable Care Management programs.

Our specialty pharmacies work closely with patients and the healthcare providers to proactively identify care management opportunities. Through our advanced technology we are able to link patient responses to client initiatives. We can work collaboratively with your care management team to identify key disease-based patient events and build custom trigger reports. These triggers prompt early intervention and allow care managers to proactively prevent complications.

Custom pivot tables allow a user to view all clinical data and then reorganize and summarize that clinical assessment data. We can easily build custom pivot tables for the County and train our professionals on how to use them to obtain the summarized data of their choice.

For example, we currently provide weekly trigger reports to the County for multiple sclerosis and rheumatoid arthritis patients who may have fallen, missed a dose or experienced a flare up. This data is then shared with your case management team for follow up and care coordination. Through these types of interventions we hope to prevent complications like hip fractures and achieve a savings of $20,000 to $50,000 per patient.

133. Provide results from your adherence programs specific to individual disease states.

Walgreens recognizes that maintaining patient adherence to appropriate specialty therapy is a key factor to obtaining the desired specialty pharmacy objectives of decreased hospitalizations, decreased emergency room (ER) visits, decreased complications and decreased use of adjuvant medications. Through the various levels of care we provide, Walgreens assures patient adherence to therapy by assessing and managing adverse effects; providing patient education; and recognizing and responding to suboptimal responses to therapy. By working collaboratively with all key players in the patient's care – whether it is the primary care provider, care givers, the payer and the patient herself – we work to help ensure that patient outcomes are improved.

Oral Oncology Program

One month's supply of oral chemotherapy drugs typically costs thousands of dollars. Often, a portion of these expensive cancer medications may go to waste because a patient who is struggling to cope with medication side effects, among other challenges, doesn't complete a full month of therapy. Because there is less physician oversight of self-administered oral chemotherapies as compared with intravenous chemotherapies, there may be a delay before a physician is made aware of a patient experiencing medication side effects and the resultant medication non-adherence. For these reasons, clients are increasingly seeking strategies to help increase patient adherence to oral chemotherapies and reduce medication waste associated with early therapy discontinuation or dose reductions.

Because physicians often have concerns about relying on patients to take these medications as prescribed, the program provides support and communication throughout the patient's medication cycle. At the conclusion of the first month of therapy, the physician receives a report that details the date the patient started therapy, the stop date and cycle (if applicable), adverse reactions or side effects and interventions performed on the patient's behalf. All program services are based on drug-specific clinical protocols recommended by our Oncology Advisory Board, composed of nationally recognized oncologists.

Our cycle management program includes an optional monitored dispensing component that helps reduce expenses resulting from the medication waste associated with early therapy discontinuation or dose reductions due to side effects. With this option, a partial supply of the month's medication is initially shipped. A mid-cycle assessment is performed and once it is determined that the patient is tolerating therapy, the remainder of the month's supply is shipped.

If serious side effects or problems are identified during the mid-cycle assessment, the remainder of the month's supply is held, thus preventing medication waste and saving payers between $2,000 and $4,000 per monthly dispense. This option offers payers direct cost savings by significantly reducing the expense resulting from medications that go unused. In addition, increased therapy monitoring may help avert incremental healthcare costs associated with adverse events.

Outcomes

Nineteen months after program inception, a retrospective claims analysis was performed to identify discontinuations, and potential savings tied to monitored dispensing. A total of 1,178 patients of Nexavar®, Sutent® and Tarceva® between June 1, 2008 and December 31, 2009 were analyzed.

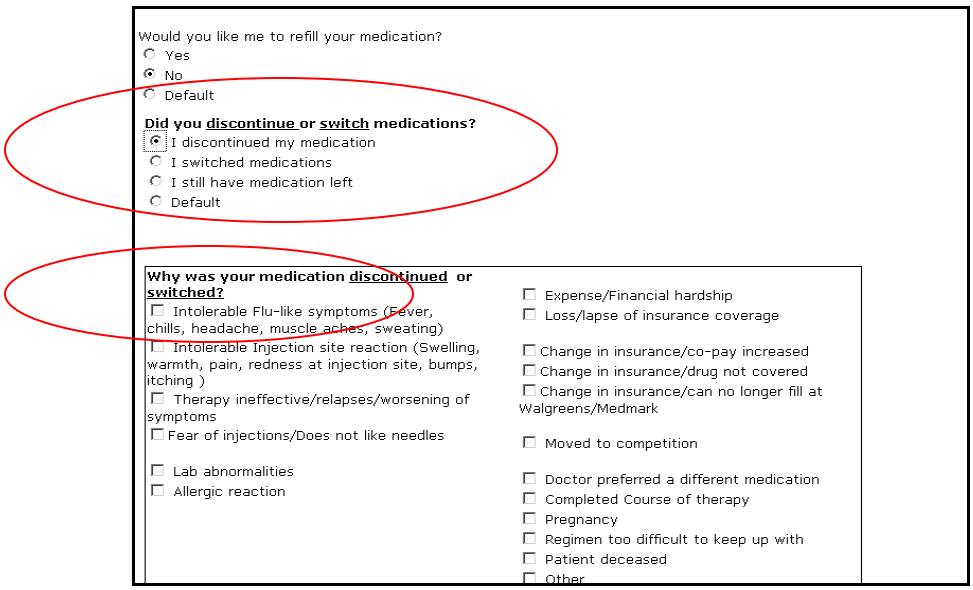
After one month in the program, 69 percent of all participants were persistent with their therapy—that is, they were still taking their medications. Of those who were persistent after the first month,

71 percent were also persistent after the second month. Of these, 77 percent were persistent after the third month. The increase in persistency reflects the benefits of access to clinical support between physician office visits. In the first month alone, the total cost of the three drugs for all program participants would have been $7,617,907 without the monitored dispensing option. If all patients had participated in the monitored dispensing option during the first month, the total medication cost would have been $6,521,101. In this example, the monitored dispensing option would yield a savings of $1,096,806, or 14.4 percent of total medication costs. Potential savings continue into the second and third months with medication cost savings of $706,914, or 13.5 percent of total costs and $379,078, or 10.2 percent of total costs, respectively.

Multiple Sclerosis Therapy

The major impact that specialty pharmacy can have on MS involves educating patients about the benefits of disease modifying therapy, and helping them adhere to therapy so that they do not join the 20 percent of patients who quit treatment. Patients sometimes have unrealistic expectations of their MS therapy, and are susceptible to discontinuing their interferon injections because they don't feel like they're getting better. Our team focuses on educating the patient on disease-modifying medications, educating them as to potential side-effects and the benefit of the medication. We are honest with our patients, letting them know that they may not feel an immediate benefit, but reinforcing that the medication will reduce the number of MS relapses and slow the progression of MS.

During the patient's compliance call, an MS Clinical Management Ongoing Survey is used to collect data and to guide the team member through the appropriate questions to ask. Utilizing this technology allows us to have a structured, consistent approach to our interactions with patients and to the interventions done on their behalf. All data collected via the Clinical Management Survey is stored in our database and is reportable. If a patient expresses to us that he or she does not want a refill of MS medication, our built-in systems would direct the team member to question the patient, determine the reason for discontinuation and perform intervention if possible.



In addition, we have a built-in consistent process that would direct us to advise the physician when a patient is non-adherent.

Did you discontinue or switch medications?
- ○ I discontinued my medication
- ○ I switched medications
- ◉ I still have medication left
- ○ Default

Why do you have medication left?
- ☐ Doctor changed directions and/or strength
- ☑ Held doses due to infection/illness
- ☐ Held doses due to surgery
- ☐ Missed some doses
- ☐ Other

Discuss with patient when in the future you should contact them for a refill and schedule activity for CP call

Is your MS medication currently on-hold?
- ◉ Yes
- ○ No, I have restarted taking my medication
- ○ Default

Is your MS doctor aware that your MS medication is currently on-hold?
- ○ Yes
- ◉ No
- ○ Default

Refer to RPh to provide Medication Compliance education and notify doctor regarding noncompliance

By utilizing state-of-the-art technology and following our MS treatment plan, we are able to achieve adherence rates of 92 percent or above for MS patients on disease modifying drugs.

Managing MS Medication Side Effects

Through our MS Program and by utilizing advanced technology, our MS Team is able to proactively assess for and assist the patient to manage medication side effects which results in improved patient adherence.

Within the **PAST MONTH** which side effects, if any, have you experienced?
- ☐ No side effects at all
- ☑ Flu-like symptoms (Fever, chills, headache, muscle aches, sweating)
- ☐ Injection site reaction (Swelling, warmth, pain, redness at injection site, bumps, itching)
- ☐ Anxiety
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Other

Refer to RPh for Side Effect Management education

By utilizing advanced technology we have been able to standardize our patient education process. For example, if a patient requires MS Side Effect Management education, the key teaching points have been outlined within the MS Clinical Management Ongoing Survey as below, so that patient teaching is consistent across our system.

Teaching Points

Side Effect Management

Educate the patient with the following points about Side Effect Management:

- Several of the Disease-Modifying Drugs are **Interferon**-based treatments. The side effects of Interferon-based treatments may include flu-like symptoms. These may include fatigue, chills, fever, nausea, headache, muscle aches, and sweating. **It is very important to persist in taking the drugs. Most of these symptoms will disappear after the initial few weeks of treatment.**

- **Some strategies for managing the flu-like side effects include:**
  - Taking acetaminophen (Tylenol®) or ibuprofen (Advil®) immediately prior to each injection and during the 24 hours following the injection. *Always check with your doctor before taking additional medications.

  - Consider the side effects when scheduling the time for your injection. Some people find that bedtime works best. Some people find that Saturday afternoons which allow all of Sunday to recuperate works best. Determine what works best for you.

  - Eating a meal an hour before (but not immediately before), your injection may help to avoid nausea. Some patients report that taking one Alka-Seltzer tablet before their injection lessens both their nausea and their headache. *Always check with your doctor before taking additional medications.

  - Hang in there and stick with it! The side effects will lessen.

Recognizing and Responding to Possible Suboptimal Responses to Therapy

Proactively Preventing Complications

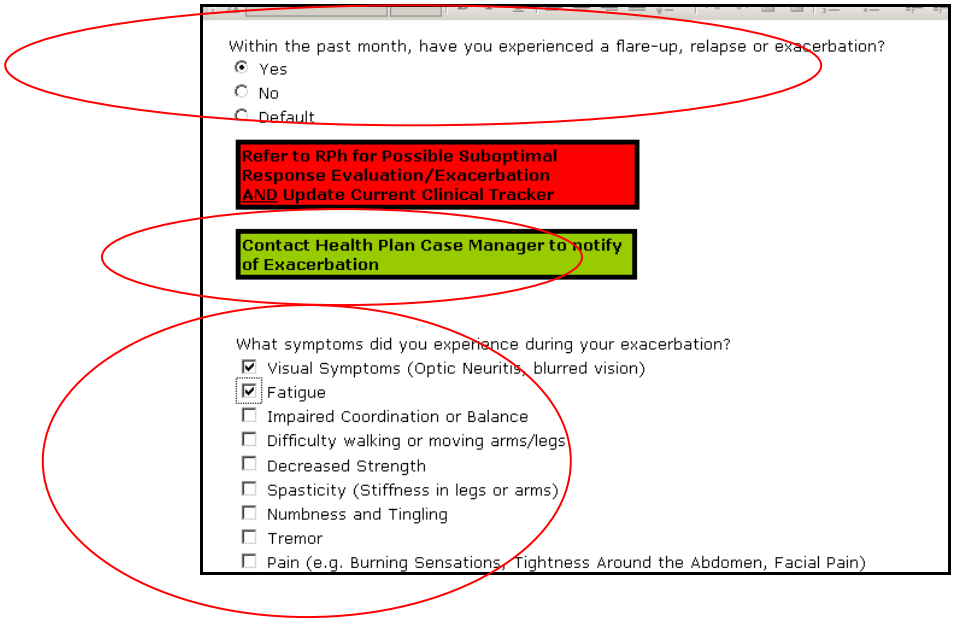
To ensure that care and outcomes of our MS patients are the best in the industry, we have implemented superior specialty pharmacy solutions. These solutions include recognizing and responding to possible suboptimal responses to therapy and proactively preventing complications.

On a monthly basis, our MS patients are asked if they have experienced an exacerbation within the past month. If they report that they did experience an exacerbation the patient is automatically referred to our MS pharmacist for a "Possible Suboptimal Response" evaluation. The MS pharmacist evaluates the case and determines if the physician should be contacted for possible medication dose change, medication switch, medication discontinuation etc. As a result, Walgreens can assist in achieving savings for the payer by helping to avoid the consequences of a high-intensity exacerbation, which can result in hospitalization and post-discharge rehabilitation with an average cost of $13,000.

In addition, each month our patients are asked if they experienced an MS-related fall. A response of yes would also trigger an automatic referral to our MS pharmacist for evaluation. By intervening, Walgreens hopes to prevent complications like hip fractures and achieve a savings for the payer of $20,000 to $50,000 per patient.

Working Collaboratively with Plans for Better Patient Care

Through our advanced technology we are able to work collaboratively to provide better MS patient care. By building triggers within our MS Clinical Management Ongoing Survey, we are able to notify your case managers or disease management team of patient issues such as exacerbations, falls and the use of new home medical equipment (HME).



Within the past month did you have any falls?
- (•) Yes
- ( ) No
- ( ) Default

Was the fall related to your MS or symptoms of your MS?
- (•) Yes
- ( ) No
- ( ) Uncertain
- ( ) Default

Refer to RPh for Possible Suboptimal Response Evaluation/Fall AND Update Current Clinical Tracker

Contact Health Plan Case Manager to notify of Fall/Proactively Prevent Complications

Are you experiencing more than one fall per month?
- ( ) Yes
- ( ) No
- (•) Default

Over the past month, have you BEGUN to use any NEW assistive equipment such as a cane, walker, wheelchair, urinary catheter or scooter?
- [ ] Cane
- [x] Walker
- [ ] Wheelchair
- [ ] Urinary Catheter
- [ ] Scooter
- [ ] None

Contact Health Plan Case Manager to notify of Use of New Assistive Equipment

Rheumatoid Arthritis RA

Our RA clinicians actively engage RA patients, providing the support they need to stay adherent to their prescribed treatment plans. The RA team contacts each patient on a monthly basis to conduct a RA Clinical Management Ongoing Survey. Medication adherence is assessed and appropriate counseling is provided to help remove barriers to adherence. The RA team provides counseling and support, helping patients to avoid medication interactions; effectively manage side-effects; address injection-related issues; and answer questions specific to the medication and the disease state. RA patients receive an RA Wellness Planner filled with disease-specific educational materials. In addition, the RA team has a library of written materials available to send to patients when a specific educational need is identified.

By utilizing state-of-art technology and following our RA treatment plan, we are able to achieve adherence rates of 89 percent or above for RA patients.

Recognizing and Responding to Suboptimal Responses to Therapy

To ensure that care and outcomes of our RA patients are the best in the industry, Walgreens has implemented a superior specialty pharmacy solution. The RA Team works to recognize and respond to suboptimal responses to RA therapy.

On a monthly basis our RA patients are asked if they have experienced a RA flare-up within the past month. If they report that they did experience a flare-up the patient is automatically referred to our RA pharmacist for a “Possible Suboptimal Response” evaluation. The RA pharmacist evaluates the case and determines if the physician should be contacted for possible medication

dose change, medication switch, medication discontinuation etc. As a result, Walgreens can assist in achieving savings for the payer by helping to avoid the consequences of RA flare-ups, which can indicate disease progression, and ultimately result in a hip replacement costing $20,000 - $50,000 or a knee replacement costing $30,000.

134. Provide the percentage of your prescriptions that are shipping to a physician's office, a member location, a pharmacy location, and any other location (please define).

Approximately 40 percent of all prescriptions are delivered to a prescriber, with the remaining 60 percent shipped to a patient location. Shipments to pharmacy locations are rare (less than 1 percent).

Please note: These statistics vary by season (as some drugs, like Synagis, that are administered at the prescriber's office are dispensed mostly in winter months).

135. What accreditations or certifications does your specialty pharmacy maintain?

All Walgreens specialty pharmacy centers are dually accredited through ACHC and URAC.

136. Discuss any additional unique capabilities, services or partnership opportunities you could provide to Maricopa County that would provide significant value to the performance of the specialty pharmacy program. Is there an additional fee?

Presence

Walgreens offers a global specialty infusion solution that is truly unique in the industry. We can the County with unprecedented access to specialty and infusion services in manners consistent with industry practices and member needs. All this, coordinated through a series of Walgreens facilities strategically located to offer convenient service. Our footprint includes:

- Over 7,650 Walgreens Community Pharmacies
- Over 90 Home Infusion Pharmacies
- Over 70 Alternate Treatment Sites
- Over 73,000 Healthcare Providers
- Over 1,000 Registered Nurses and 60 Dietitians directly employed by Walgreens
- Six Specialty Pharmacy Facilities

We work with patients and payers to identify the most appropriate delivery model for the patient and offer options that facilitate cost-effective care in the most appropriate setting. This channel agnostic philosophy emphasizes consistent clinical support and therapy management to raise medication adherence levels, reduce costs through clinical interventions and improve overall patient and physician satisfaction and clinical outcomes.

Comprehensive Therapy Management Programs

Our programs create a unique offering for payers to ensure competitive drug acquisition costs, appropriate utilization and proactive clinical management. Our programs focus on complex conditions with a greater incidence of discontinued/adjusted therapy based on indicators like patient response, status or weight change. Programs are developed with input from physicians and clinicians who are thought leaders with extensive expertise in the related conditions.

Walgreens Field Sales Presence

Walgreens employs over 200 Account Managers that are available to educate referral sources on services available through Walgreens, as well as strategic programs implemented between our organizations.

Pipeline Communications

Walgreens has tremendous resources to monitor the pipeline of new drugs coming to market. In evaluating the medication pipeline, we scrutinize the cost of the medication, the medication's clinical efficacy compared to current medications on the market, product guidelines as indicated by the manufacturer, the route of administration, administration times, dosing intervals, and the review of the drug profile. Walgreens provides pipeline reports to our clients on a quarterly basis. New medications are reviewed to discuss financial impact and strategy with the County.

Walgreens Pipeline Product Committee (PPC) continuously evaluates and assesses specialty pharmacy products in the FDA pipeline. The PPC conducts these activities to ensure proactive steps are taken to gain access to applicable new drug products and limited/exclusive specialty pharmacy networks. The PPC also helps ensure that healthcare resources focus on maintaining necessary manufacturer relationships.

Additionally, Walgreens can provide the County with a pipeline presentation up to four times per year. The presentation outlines new drug approvals and drugs in the pipeline that have the potential to impact your plan. Walgreens will also provide the County with a monthly list of all limited distribution drugs. We can work with your administrators on strategies related to pre-launch distribution, access and cost issues for potential limited distribution drugs.

Patient Assistance Programs

Walgreens also maintains a Patient Assistance Program (PAP) team for patients who may have exhausted their benefit and financially qualify. Once a patient has given our PAP team permission, our PAP team members will research and match the patient to the appropriate resource, completing all applicable paperwork on his or her behalf.

137. Discuss your current reporting capabilities and any enhancements and timeframes that you are making that will enable Maricopa County to understand the value, performance, and outcomes of the specialty criteria management, waste management, product conversion, adherence and other initiatives.

Our specialty pharmacy measures utilization, costs and savings. The utilization and cost report breaks down your top specialty drug utilization by cost and compares this to your overall specialty pharmacy drug spend and your overall drug spend. The utilization and cost report also breaks down costs according to plan, member, and total cost for specialty drugs and compare this to your overall drug spend. The savings report breaks down utilization and overall savings from using our Specialty Prior Authorization programs.

The County also receives our MERWIN report as well as a comprehensive utilization report. Both are provided on a quarterly basis. The MERWIN report is provided in "Dashboard Format," designed to provide greater utility and meaning to the data. The key components of MERWIN include:

- Streamlined high-level utilization data with analysis including:
  - Quarterly Trend of Spend by Benefit
  - Total Rx and Medical Spend Trend Year To Year (YTY)
  - Top Ten Drugs by Plan Cost

  - Top Five Therapeutic Categories by Plan Cost
  - Top 10 Prescribers
  - Top Therapeutic Categories benchmarked against the BOB
  - Top Drugs by Plan Costs benchmarked against the BOB

- Disease-State Specific (MS,RA, ONC, HCV) data including:
  - Utilization Data with analysis
  - MPR benchmarked against BOB
  - Clinical Programs data benchmarked against BOB with analysis

- Cost Savings data including:
  - Multiple Sclerosis Savings via the Serono MS Economic Model
  - Oral Oncology Cycle Management Savings or Potential Savings
  - Overall Specialty Clinical Savings based upon Interventions

Utilization reporting is necessary to understand today's spending and tomorrow's budget and to support decision-making. Comprehensive business reviews are provided to offer a detailed analysis of utilization trends. Our comprehensive utilization report, which supports our more streamlined MERWIN report, provides a break-down of utilization in the following ways:

By Plan Spend
- Spend by disease category
- Total specialty utilization by disease category (Ranked by plan cost)
- Total specialty utilization by disease state by benefit (Ranked by plan cost)
- Total pharmacy & medical spend YTY

By Benefit
- Quarterly trend of spend by benefit
- Total pharmacy & medical spend YTY

By Drug
- Total specialty utilization by drug (Ranked by plan cost)
- Total specialty utilization by drug within disease category (Ordered alphabetically)
- Top 10 prescribers by dollars

Demographics
- Demographics for all Specialty Patients

By Disease State Overall
- Spend by disease category
- Total specialty utilization by disease category (Ranked by plan cost)
- Total specialty utilization by disease state by benefit (Ranked by plan cost)
- Total specialty utilization by drug within disease category (Ordered alphabetically)

By Disease State Specific
- MS, RA, HCV, GH, Crohn's, Oncology trends & summary
- MS, RA, HCV patient demographics current quarter
- MS, RA, HCV patient count quarterly trend
- MS, RA, HCV medication adherence
- MS, RA, HCV medication adherence by drug

Contacts
- Contacted patients by program
- Completed contact method and contact party

To illustrate the level of detail available, some reports can be up to 48 pages long. In the interests of space, excerpts from one of our reports are provided in *Attachment I.* We can provide reports in

whatever media is most convenient to you: paper, electronic attachment, disk or web access vehicles are all available. Note that we are also able to provide access to our reporting tool, Cognos.

138. Discuss your strategy and plan for controlling costs for Maricopa County in regards to biosimilar products, biosimilar interchangeable products during and after the 12-month exclusivity period.

We are monitoring the biosimilar frontier very closely. At this point, while there has been significant speculation and discussion, the end state of biosimilars is still largely in question. Our research has led us to certain assumptions in this field. For example, we are fairly certain that biosimilars will not follow traditional generic substitution rules. As a result, we see ourselves in a consultative role, keeping our clients updated and current on any potential biosimilar approvals. Our clinical and trade team will work with the County to monitor the biosimilar pipeline and help evaluate products. In addition, we have enhanced our system to better facilitate formulary management in the dispensing process. Our changes will help identify potential formulary opportunities and track physician response and any reason for decline of formulary change. We can then report that information back to the County and improve biosimilar utilization.

Implementation, Ongoing Support and Termination

139. Do you agree to load all current prior authorizations, ongoing overrides, current mail order refills, and accumulator files that exist for current members from the existing PBM at no charge to Maricopa County no later than the effective date of the contract?

Should the County decide to retain WHI as its PBM, no additional implementation actions would be necessary. Conducted in late 2002, your transition to WHI addressed existing prior authorizations, eligibility, mail service refills, clinical programs, accumulator files and other issues critical to plan administration. Through regular discussions with County representatives, your account team established a schedule, outlined project needs and defined each organization's responsibilities. These issues were included in a transition work plan designed by your WHI implementation manager. As a result, on January 1, 2003, your program was in place and ready to serve the needs of your members. Since then we have worked with the County and its other vendors to provide your members integrated wellness solutions. Should your decision necessitate additional data loads, we will do so at no additional charge.

140. Do you agree to implement all future plan design changes at no cost to Maricopa County?

Yes.

141. Do you agree to provide an annual detailed implementation plan for Open Enrollment and other plan changes to include tasks and assignments for the PBM, Maricopa County and the benefit administration vendor?

Yes. Our commitment to the County goes far beyond traditional pharmacy benefit management. Lisa Cuellar will lead an expanded Maricopa account team that will address any issues. Lisa and other professionals will provide the County with an implementation plan outlining a timeline for open enrollment and the completion of any tasks that need to be performed in anticipation of desired revisions. The plan will also include any changes to the pharmacy and/or on-site health center as well as any optional services we may provide.

142. Describe your run-out process at the end of the contract.

Since the vast majority of claims are electronically adjudicated, run-out claims are rarely an issue. If such claims exist, we typically administer them for up to sixty days following contract termination. Should the County require a longer window, alternate terms may be accommodated.

143. Are any implementation, ongoing maintenance or other fees available to be paid to the County's consultant? If so, describe fully how they are determined and the County's rights to assign them to the consultant of its choice.

As an existing client, WHI is not offering any implementation or related allowance that could be allocated to the County's consultant.

144. Do you provide assistance in reviewing plan collateral produced by the County such as the Summary Plan Description on at least an annual basis?

Yes. Your dedicated account team will continue to review plan collateral and offer suggestions to the County.

145. Do you agree to attend a minimum of five initial rollout meetings with elected and appointed officials and department heads?

Yes. Tammy Davis and the rest of your team are well-versed in your plan and will attend at least five rollout meetings.

146. Do you agree to perform "Welcome Calls" to enrolled retirees (approximately 250) and COBRA (approximately 350) participants?

Yes. We welcome the opportunity to conduct Welcome Calls for retirees and COBRA participants.

147. Describe any communication support you are prepared to provide to introduce the new program and any associated fees. Provide copies of any generic communications available within the scope of the contract. Are all materials available in Spanish?

We recognize the important role member outreach can play in the success of any program. Our communication professionals will work with you to design a suite of materials that convey messages aligned with your goals. Throughout the years we have worked with the County to create brochures, letters, newsletters and other documents that provide your members with the information they need to make healthy choices. These materials, many of which in English and Spanish, have been mailed to your members, distributed through your onsite pharmacy and can easily be emailed or downloaded from your web site. For example, we recently created a communication piece specifically for the County's *Wellness Works* campaign that encouraged members to enroll in the Healthful Living™ Smoke-Free program. Copies of this and other communication support materials can be found in *Attachment A.*

148. Are you available to produce educational webinars and/or conduct live webcasts using County technology?

Yes. Client Service Manager Tammy Davis and her team can conduct or produce educational webinars and/or conduct live webcasts using County technology. She has visited your offices to

create slides and record dialog that the County has included in its online benefits audio webinar. Tammy is available to update information and has a hand held recorder for use at her office.

149. Which of the following can you provide (in English and Spanish) to assist the County with open enrollment and member education? Is there an additional fee or limitation?

a. Home mailing – plan summary, network listing, welcome letter, other (please describe)

Our member packets provide all of the information needed to effectively use and clearly understand the pharmacy benefit. We have found that members are more likely to retain the material – and subsequently refer to it – if all the benefit information is contained in a single package. WHI can prepare and ship the materials directly to the County or to member homes or to a central location for the County to distribute.

ID cards are included as standard and are physically part of the communication materials sent to the member as part of each member's plan information. Along with the ID cards, standard communication materials include a member introductory letter, description of the benefits to be provided and the procedures for utilizing the program.

b. Mail order material

Our communication materials include mail order forms and other documents designed to give members the answers they need to use mail service.

c. Web site – Describe content and functionality

The County currently has access to *WalgreensHealth.com.* Available in English, this online tool allows your members to search for network pharmacies, research health conditions, search and download their formulary, track prescription histories and much more. Your members can also track balances within the County's Consumer Choice Pharmacy Plan.

d. Newsletter articles

Every month your Walgreens worksite pharmacy provides members with *Pharmacy Times,* a custom newsletter containing helpful health tips and advice for leading a healthy life. The November 2010 edition, featured articles on how to get tested for diabetes and common myths about checking blood glucose levels. We will continue to work in conjunction with the County to develop newsletters aligned with your wellness strategies. A sample newsletter can be found in *Attachment A.*

e. Information to promote generic utilization

We will continue to provide the County with our *Go Generic* brochure and other custom materials designed to promote use of appropriate, low-cost generics.

f. Targeted educational communication

Our familiarity with your member population gives us a distinct advantage when creating targeted communication materials. The pharmacy and Take Care Health Center within the Maricopa County Administration Building only enhance this capability. Through joint collaboration with

the County, we can design letters, flyers, emails and other materials that contain useful health tips that help your members lead healthier lives. Many of these materials are included as part of your existing service offering and can be provided in Spanish. Samples of some of these materials can be found in *Attachment A.*

g. Other communication or tools you can provide to educate the member on plan design, etc.

WHI offers the County a superior communication vehicle that provides answers to many of the questions members ask. Materials may be customized specifically for the County, provided in Spanish and delivered at a frequency that meets your needs. To kick off new aspects of your plan, we suggest that announcement letters appear on the County's letterhead. We can provide sample drafts of transition announcement letters, payroll stuffer notices and other materials.

Our *Go Generic* brochure provides the member simple, easy-to-understand facts revealing the importance of substituting brand name drugs to generics, while our *Quality and Convenience* publication outlines the many benefits of mail order. We can also work with your administrators to sponsor Take Care Health Center lunch and learns or other events that education members. Please refer to *Attachment A* for samples of the member communication materials described above.

Network Management and Quality Assurance

150. Provide a list of all contracted pharmacies in Maricopa County. Which pharmacies will be in the preferred network and which will be in the secondary network?

We will provide the County with its choice of a Preferred Network composed exclusively of 6,250 Walgreen community pharmacies or a Non-Preferred Network that includes a majority of chain and independents without Walgreens participation. County members will also be able to receive a 90-day supply of maintenance medications through our Advantage90 program. A retail pharmacy directory based on all currently contracted locations can be found in Section 3.12.7.

151. Provide a geographic access report for each of the networks you are proposing (both preferred and secondary), using the census data provided. Please use the full five-digit zip code when preparing this report and include:

The following results are based on all pharmacies currently in our broadest network.

a. One network pharmacy within three miles of residence

Of all the members on your census file, 96.2 percent will have one network pharmacy within three miles of their residence. A GeoAccess report can be found in Section 3.12.7.

b. Three network pharmacies within eight miles of residence

Of all the members on your census file, 98.5 percent will have three network pharmacies within eight miles of their residence. A GeoAccess report can be found in Section 3.12.7.

152. List any pharmacy chains excluded from your proposed preferred and secondary networks.

Our Preferred Network only includes Walgreen community pharmacies. Our secondary or Non-Preferred Network includes all major chains except for Walgreens.

153. Describe your quality assurance activities and standards.

At WHI our commitment to qualitatively serving our clients is embedded in virtually every aspect of our audit and control policies and procedures. Internal quality controls include, but are not limited to:

- Client benefit design setups are tested for accuracy by the implementer and a peer reviewer, including effective date, formulary, rates and copays;
- Pharmacy reimbursement rate calculations are tested for accuracy by the implementer and a peer reviewer;
- Management performs an audit of manual pharmacy data changes to determine the changes are being performed completely and accurately;
- The MAC team performs a complete daily quality assurance reconciliation of MAC prices, ensuring the prices are complete and accurate;
- The weekly drug file from First DataBank is run against a macro for completeness, accuracy and effective dates;
- An Enrollment File Review, Program Design, and Quality Control document is completed for eligibility file loading into our claims processing system, *PBS*;
- Audits are performed on *PBS* plan setup configurations to ensure the accuracy of invoices;
- Peer audits on administrative fees are performed on *PBS* plan setups to ensure completeness and accuracy;
- A check run reconciliation of *PBS* to the check register is performed by the Accounting Manager and approved by the Director of Finance;
- Operating system configuration changes are implemented into a test environment prior to production.

Outside Auditors

Once a year, we engage the services of an independent audit firm, to assess our compliance with certain self-defined controls within our *PBS* system and our Prescription Benefit Management services. The assessment process is conducted according to standards established by Statement on Auditing Standards No. 70 (SAS 70). Successful completion of a SAS 70 audit represents that the *PBM* has been through an in-depth review of its control objectives and control activities for appropriateness and reliability.

154. Describe your network management processes employed to avoid fraud and abuse.

We monitor network pharmacies through an in-depth combination of both desk and onsite audits. These efforts, combined with the fact that all claims are reviewed concurrently at the point of service (via client or *PBS*-directed edits) drastically reduce the likelihood of fraudulent or abusive activity that could affect plan performance.

WHI's desk audit program is administered in conjunction with Prudent Rx, an independently owned company recognized for its auditing capabilities. A desk audit is a thorough process during which potentially erroneous claims are examined in order to validate billing and filling practices. Every month, WHI sends claims to Prudent Rx for review. This data is scrubbed prior to loading to remove reversed and denied claims. In addition, all data fields are validated and compared to standard NCPDP data fields.

Once cleared, the data is loaded and analyzed using Prudent Rx's Central Script Review procedures. This process runs WHI's data against approximately 90 proprietary edits designed to detect anomalies that may indicate fraudulent activity. These edits look at numerous facets of a prescription including DAW parameters, duplicate therapy /prescriptions, early refill and incorrect package size billed, among others. Once identified, Prudent Rx researches outliers and notifies WHI of specific claims that should be addressed. Following internal review of these recommendations, WHI recoups funds from pharmacies and credits affected clients in accordance with contract terms.

Onsite audits are conducted on a random and ongoing basis. Conducted by Pharm/DUR, Inc., these audits serve as an opportunity to observe network pharmacies in action and ensure adherence with contractual requirements. Through a number of proprietary and customized rule sets, Pharm/DUR's AudiTrack® application identifies and reports claims discrepancies that may be indicative of abusive practices. Selection criteria can consist of a number of factors including but not limited to, gross claim volume, brand/generic utilization, controlled substance utilization and incorrect prescriber submissions.

With the exception of suspected fraud, waste or abuse, the pharmacy is typically given two-week notification of a scheduled onsite audit. Pharm/DUR investigators visit the pharmacy and perform an onsite review of procedures. Investigators capture claim data with laptops and portable scanners. Each individual claim is reviewed and checked for completion before the auditor can sign-off and move on to the next prescription. At the conclusion of the audit the reviewer discusses findings with the pharmacist and conducts an educational dialogue with the staff to cover any quality concerns. The reviewer then uploads the completed preliminary audit onto a secure site, which is then downloaded at the Pharm/DUR offices shortly thereafter.

After a secondary review by a Pharm/DUR in-house pharmacist, the pharmacy is sent a preliminary report and is given approximately 30 days to submit any post-audit documentation that might mitigate the noted discrepancies. Results of the audit are presented to WHI for review and appropriate follow-up action. Recoveries are deducted from a pharmacy's future payments and are shared with affected clients within 30 days of the closing of an audit; typically in the form of a credit.

Controlled Substances

Controlled substances continue to pose one of the greatest opportunities for fraud in the pharmacy industry today. For that reason, WHI's in-house claims adjudication system has an edit

specifically designed to rein in substance abuse. The current default value for this edit is to flag any instances where greater than six controlled substances are dispensed within 30 days. This check is performed for all controlled substance claims submitted for eligible clients. If the member has received more than six controlled substance prescriptions during the previous 30-day timeframe, a soft edit is returned to the pharmacy. The message reads, "6 controlled RX in 30 days" and is populated in the free text response section of the pharmacist's screen. While this serves as the system default, WHI is also able to customize the edit to the County's wishes.

MedMonitor®24

MedMonitor24 has the unique ability to merge pharmacy claims information with medical claims data to create a snapshot of the member's whole health picture. Armed with this information, our team of clinical pharmacists is able to identify instances of atypical utilization within a Plan's members. Some of the edits MedMonitor24 offers include those that detect:

- Overuse of Hydrocodone/Chlorpheniramine polistrex
- Overuse of Tramadol-containing products
- Overuse of Long-Acting Morphine
- Overuse of Long-Acting Oxycodone
- Overuse of Methadone
- Overuse of Short-Acting Opioids (Multiple Prescribers)
- Overuse Long-Acting Opioids (Multiple Prescribers)
- Overuse of Acetaminophen-containing products
- Overuse of Propoxyphene HCL-containing products
- Overuse of Transmucosal Fentanyl
- Overuse of products containing Propoxyphene Naps
- Therapeutic Duplication.

With more than 1,500 clinical edits encompassing multiple therapeutic categories, MedMonitor24 is a comprehensive tool that ensures members are receiving optimal therapeutic regimens.

155. Do you monitor individual physician prescribing patterns? If so, what is monitored and what action is taken?

Yes. Our first-level physician profiling program focuses on financial/resource utilization measures related to clinical outcomes. Cost, service and resource utilization data are dimensions of measuring quality. The ultimate goal is improving clinical outcomes. *Informed Prescribing* educates prescribers and members on issues such as appropriate financial utilization of the most cost-effective therapy. Our *Informed Prescribing* staff use a technologically advanced system to identify missed generic opportunities and prescriptions appropriate for intervention activities based on established criteria of clinical appropriateness.

Intervention activities can include contacting prescribers and members regarding Dispense as Written (DAW) prescriptions, activities directed toward formulary adherence, member adherence with medication regimens and other related clinical issues determined by the plan. In both cases, we educate the member on the safety, efficacy and cost savings of the generic medication. In addition, WHI can review utilization, identify members using multi-source brand drugs and create targeted alert letters informing them of what generic alternatives are available. We can also create communication materials promoting the use of appropriate generics. Our *Go Generic* brochure provides the member simple, easy to understand facts revealing the importance of substituting brand name drugs with appropriate generics.

As part of our management reporting package, a report summarizing the top 25 prescribers by total prescriptions is available. Specifically, this report lists the rank by prescription volume and ingredient cost, prescriber's name, ID number, number of prescriptions, number of utilizing members, plan cost per utilizing member per month, percent DAW1, percent generic and percent formulary compliance. Please see *Attachment K* for a copy of this report.

Available through MedMonitor24, second-level education includes a Physician Clinical Conflict Summary report that identifies the prescriber with the most clinical conflicts and summarizes the conflict type with alert messages by prescriber.

General Communication to all Prescribers

We can also provide general communications to prescribers. The general communication piece provided includes an informational letter about the WHI formulary, new generics and potentially important issues having clinical impact. This intervention can be sent to all County prescribers in a designated period of time or selected prescribers based on consultation with the County (such as geography, specialty, minimum number of claims, etc). This information letter is sent annually for a fee of $1.50 per letter.

156. How do you monitor pharmacy errors? List the top five reasons for errors. What is your corrective action and service recovery process when pharmacy errors occur?

Pharmacy errors are monitored through desk and onsite audits. The central focus of WHI's desk audit program is a randomly generated claims file provided to Prudent Rx on a monthly basis. Once cleared, the data is loaded and analyzed using Prudent Rx's Central Script Review procedures. This process runs WHI's data against approximately 90 proprietary edits designed to detect anomalies. These edits include but are not limited to:

- Incorrect Package Size
- Excessive Quantities
- Duplicate Therapy
- Unusual Package Size
- Frequent Early Refills

Some observations uncovered in a desk audit that may lead to an on-site audit include any prior audit history (e.g., certain billing patterns identified or prior audits that have resulted in charge backs), unusually high claim volume and erroneous billing of compounds or other high-dollar drugs. Similar to desk reviews, if specifics such as (but not limited to) excessive quantity for days' supply, duplicate claims, excessive early refill claims, invalid quantity for a single package item, or the presence of an invalid DAW are discovered, an on–site audit may be necessary. Feedback from pharmacists, clients and members is also seriously considered.

Focused Investigation Audit Program

Should an onsite visit uncover a substantial trend in questionable practices, a Focused Investigation Audit may be conducted. This investigation is conducted by Pharm/DUR professionals and is reserved for cases where other audits have determined a strong potential for egregious fraud. These audits correlate and reconcile numerous facets of pharmacy operations,

including patient foot traffic, billings from electronic records, stock on hand, and purchasing practices. Results from these audits are reported to WHI and can form the basis for further action.

157. Describe your process and timeline for notifying Maricopa County and members regarding a disruption in the retail pharmacy network.

The stability of our network means that member disruption is rarely an issue. Should network composition cause significantly affect your members' ability to access a pharmacy your account team will inform you of the change and work with you to identify convenient alternatives.

158. Do you have any network pharmacy chain contracts with who you are currently in negotiations? Are any major contracts expiring and will need to be renegotiated before the beginning of this contract? If yes, please explain.

We are not presently in contract negotiations with chains that could affect our ability to continue serving your plan. No major contracts are expiring or in need of renegotiation.

Clinical Programs

159. Describe in detail your Drug Utilization Review (DUR) and Retrospective Drug Utilization Review (RDUR) programs.

Concurrent Drug Utilization Review

Our Concurrent Drug Utilization Review (CDUR) is an effective tool in monitoring drug use to assure that it is appropriate, safe and effective. The system itself adheres to the National Council for Prescription Drug Programs standards for pharmacy data transmission. Each prescription drug claim must pass more than 100 rigorous edit categories before being paid. The edits are designed to not only check for plan eligibility, but also duplicate claims and quantity limitations which may indicate potential misuse. Our system monitors claim submissions across all pharmacies and physicians, compares each claim with the active prescriptions of individual members, and sends alerts back to the pharmacist should any drug interaction occur. If a drug-related problem is detected during the process, the pharmacist will be notified through our online, real-time messaging system. The pharmacist then uses his/her professional judgment to determine the most appropriate intervention. The prescription may require additional counseling of the member, further research or a conversation with the prescriber.

WHI's adjudication system differentiates itself from other PBMs by allowing maximum flexibility where pharmacy edits are concerned, hard or soft. Our CDUR program gives clients the flexibility of utilizing messages from our standard library and/or customized messages, which support client-specific initiatives such as generic utilization and formulary compliance. Soft edits can be customized at the GCN, NDC, and therapeutic class levels per client request. The most invaluable component of this program is that the entire process occurs before prescriptions are dispensed and provides members with safe and comprehensive care.

According to internal studies, WHI's Concurrent Drug Utilization Review (CDUR) program has demonstrated a much higher intervention rate (37 percent acceptance of reviewed CDUR edits) than what the industry has reported, 11.9 percent.[1]

MedMonitor®24

MedMonitor®24 is a daily medication evaluation program that will continue to help the County save on expensive and preventable healthcare costs, while improving member wellness. Unlike traditional drug utilization review programs, MedMonitor24 identifies inappropriate utilization by reviewing every prescription, every day. MedMonitor24 works to prevent the County's healthcare costs from escalating by providing a safety net for your entire membership and keeping them out of the most expensive, extreme-risk segment of your population.

Operational Overview

MedMonitor24 is based on reviews of members' claims by a team of clinical pharmacists after the prescription has been filled. It includes all prescription and medical claims, and is not limited to plan-specific parameters to identify possible interventions to prescribers. The program can review everything from members with a single provider and a single identified disease to members with multiple providers and multiple disease states. MedMonitor24 analyzes the merged prescription and medical claims from the prior 72 hours to help identify members who may be at risk for potential drug-related events. On average, 40 percent of conflicts are reversed within the first 72 hours of the prescription fill.

During the last three years, MedMonitor24 has saved the County $734,574 and delivered a 4.3 to 1 Return on Investment.

MedMonitor24 patients are identified based on a proprietary patient-risk-stratification scoring system. A MedMonitor24 clinical pharmacist reviews the profiles of higher-risk patients, or those patients for whom potentially severe conflicts are identified. If the pharmacist determines that the conflict is significant and has the potential to cause an adverse outcome, the providers involved in the patient's care are alerted via one of multiple modes of communication: fax, phone, letter or online. Each alert acknowledges the provider's judgment and emphasizes patient care. The alert informs the provider of the situation by stating the medications involved and any possible outcomes that may be observed. Every communication includes the citation(s) to the relevant medical literature from which the specific conflict edit was created, as well as a patient prescription and medical profile. A voluntary provider feedback form is included to allow the provider the opportunity to submit information for inclusion in the patient's healthcare history for future clinical evaluations. Providers may also offer comments used for the continuous quality improvement of our program.

A recent analysis showed that 41 percent of prescribers who received an alert and provided feedback would change their patient's therapy.

During 2009 alone the County realized total financial savings of $200,973 from MedMonitor24. Twenty seven percent of interventions were for drug-drug interactions and almost twenty percent of interventions were for overutilization. Over six percent of interventions were for conflicts

[1] Reported by Chui and Rupp, JMCPharm 6(1): 27-32 (2000).

identified using medical claims data. We are happy to share these book-of-business case studies as further evidence of the positive impact MedMonitor®24 can have on prescriber behavior.

Case Study 1

A MedMonitor clinical pharmacist identified a young female for a drug-disease interaction between a contraceptive and history of thromboembolic disorders. The patient had a history of warfarin use, a drug commonly prescribed for patients with thromboembolic disorders, and recently had a contraceptive filled which was prescribed by a different prescriber. The pharmacist contacted the prescriber who prescribed the contraceptive and made a recommendation to discontinue the contraceptive in an effort to prevent thromboembolic complications.

Feedback: The prescriber stated that he was not aware of the patient's history of warfarin use for thromboembolic disorders. The prescriber agreed with the recommendation to discontinue the contraceptive and instructed the patient to discontinue use immediately.

- **Clinical Impact: Discontinuation of the contraceptive medication**
- **Prescription Financial Impact: $113.40**
- **Medical Financial Impact: $2,176.20**
- **Total Healthcare Savings: $2,289.60**

Case Study 2

A MedMonitor clinical pharmacist identified a 58-year-old female for a drug-disease interaction between estrogen hormone replacement therapy and thromboembolic disorders. The patient had a history of using Plavix, which is used to treat thromboembolic disorders, and had a recent fill for Premarin, an estrogen-containing hormone replacement medication. Both medications were prescribed by separate physicians. When used in combination, there is an increased risk for thromboembolic complications. The pharmacist contacted the two prescribers involved with each drug therapy to alert them to the drug interaction.

Feedback: The prescriber of the Premarin medication noted that she, on multiple occasions, tried to convince the patient to discontinue the hormone replacement therapy in an effort to prevent a thromboembolic complication; however, the patient had insisted on continuing the medication. The prescriber noted that she will readdress the concern with the patient.

- **Clinical Impact: Discontinuation of Premarin**
- **Prescription Financial Impact: $90.23**
- **Medical Financial Impact: $2,176.20**
- **Total Healthcare Savings: $2,085.97**

160. Do all of your pharmacies' online systems have real-time edits or controls for all of the following? If not, please explain.

- **Eligible employee and dependents**
- **Eligible drug**
- **Contract price of drug**
- **Lesser of logic (as previously described)**
- **Drug interactions**
- **Drug allergies**
- **Drug disease interactions**
- **Duplicate prescription**

- **Refill too soon**
- **Proper dosage**
- **Proper days supply**
- **Generic availability**
- **Member copayment or coinsurance**
- **Out-of-Pocket Maximums**
- **Inappropriate drug due to age**
- **Inappropriate drug due to gender**
- **Over utilization**
- **Under utilization**
- **Possible narcotic abuse (provide detail)**
- **Fraud and abuse (provide detail)**
- **Quantity limits**

Yes. Our adjudication system includes real-time edits or controls for all of the above. Please note allergy information is considered whenever it is provided.

161. What edits occur at point of sale and which occur retrospectively?

WHI's CDUR program is intended to provide safety alerts that can be communicated to the patient, without stopping claim payment at the pharmacy counter. All safety messages provided by the CDUR program are clinical soft edits that are solely intended to contribute to a complete drug utilization review and provide optimal drug therapy. However, at the request of the County, CDUR soft edits can be set to reject claims (made into hard edits). Some of the more common concurrent edits include:

➢ Fill too Late	➢ Fill too Soon- Clinical
➢ Drug-Known Disease	➢ Drug-Drug
➢ Duration of Therapy	➢ Minimum Dose
➢ Maximum Dose	➢ Duplicate Therapy
➢ Duplicate Ingredient	➢ Drug-Gender
➢ Drug-Lactation	➢ Drug-Pregnancy
➢ Drug-Prior Adverse/Allergy Reaction	➢ Drug-Inferred Disease
➢ Controlled Substance	➢ Drug-Geriatric
➢ Drug-Pediatric	

The MedMonitor rules engine, developed by our in-house development team, utilizes over 1,500 conflict rules, including more than 100,000 edits, to identify patients at risk for dangerous and expensive drug-related problems across over 100 therapeutic drug classes. Approximately 72 hours after loading, our rules engine analyzes 100 percent of claims and generates conflicts based on the patients' disease states, demographics and 120 to 365 days of claims history. Some of the edits reviewed include:

- ➢ Therapeutic Appropriateness
- ➢ Over and Under Utilization
- ➢ Drug Disease Contraindications
- ➢ Therapeutic Duplication

- Incorrect Dosage
- Inappropriate Duration of Treatment

162. Provide a sample of your standard DUR and RDUR reports.

Sample Concurrent and Retrospective Drug Utilization Review reports can be found in *Attachment K.*

163. How are high-cost claimants identified, monitored and reported?

WHI monitors and tracks high-cost claimants through standard reports, MedMonitorXR and personalized clinical advice. We offer several reports that are designed to highlight instances of above average claim costs. For example our reports outline:

- Members with over ten prescriptions in the previous three months
- Members with over $300 in prescriptions in the previous three months
- Members with over five prescriptions in the same therapeutic class in the previous three months
- Members with the same drug from different prescribers in the previous month
- Members with five or more prescribers in the previous three months

The County and its account team can also utilize our online reporting tool, *RxVision* to build custom reports and generate results based on most any data captured within our system.

MedMonitorXR (Medication Therapy Management)
MedMonitorXR provides the County with another tool for identifying high cost claimants. Through the use of leading-edge technology and a nationwide network of over 15,000 pharmacies, we are able to promote face-to-face encounters with patients directly at the pharmacy counter. Using a provider web portal, MedMonitorXR pharmacies can access a patient's profile. Pharmacists have immediate access to members' individual medical and pharmacy history, allowing them to offer face-to-face consultation and influence appropriate medication regimens.

Our MedMonitorXR program focuses on the County's most at-risk utilizers (patients with a drug spend of at least $43,000 per year, two or more disease states, and six or more maintenance medications). Our individualized medication management review process ensures appropriate utilization, improved outcomes and enhanced patient care. Through the integration of medical and pharmacy data, our clinicians will optimize your drug spend to improve health outcomes. The program offers four intervention options appropriateness of therapy, inappropriate medications in the elderly, compliance and persistency and polypharmacy.

WHI also partners with third party organizations to optimize member and client outcomes. Our clinical directors communicate on a regular basis with medical and utilization vendors to discuss high cost or complicated member cases. WHI's clinical team has developed reporting around high narcotic utilization, new specialty patients and other high cost claimants to ensure effective and comprehensive management of patient cases. WHI will partner with the County's care management company to identify members early when they are candidates for case management. For additional information on MedMonitorXR please see *Attachment G.*

164. Describe your prior authorization and/or step-therapy protocols. Will you share the protocols with Maricopa County? How are fees charged for prior-authorization and step-

therapy? How do you identify drugs that should be subject to prior authorization and/or step therapy? Provide a list of your prior authorization and step-therapy medications.

Our Medication Management programs are designed around the simple goal of ensuring safe and effective medication use. We offer more than 40 different prior authorization programs; the majority of which focus on the top 25 therapeutic classes by cost. These programs target high cost, high risk medications to ensure optimal health outcomes. The protocols we recommend are intended to save overall healthcare dollars by giving our clients the means to continue covering medically appropriate and necessary medications that might otherwise be excluded. Each program's protocols are based on nationally recognized guidelines, FDA-approved indications, off-label uses and accepted standards of practice.

Our Medication Management programs yielded an average 11 to 1 Return on Investment during Q1 2010with an average net savings of $408.33 per intervention.

The Authorization Process

Clinical Prior Authorization (CPA) responsibilities are handled through a dedicated Clinical Call Center (CCC). This places the process in the hands of our licensed pharmacists and pharmacy technicians; the CCC is an integral component of our programs. Our CPA process decreases phone calls and paperwork and ensures rigorous enforcement of both clinical protocols and plan parameters.

Our CCC staff generates a drug–specific prescriber fax form, based upon the County's program parameters. The form indicates the time that the request was initiated, and is faxed to the prescriber. We then log the request as pending. If a response is not immediately received, the form is re–faxed daily for up to three days. If there is no response, the medication is denied, and a letter is sent to the member explaining the reason for the denial. If the prescriber responds in a timely manner, our staff reviews the request and approves or denies the request, based on program protocol.

If the request is **approved,** the CCC staff:

- Calls the initiator of the request (Prescriber, pharmacy, or member);
- Enters the prior authorization within the online, real–time system;
- Generates and sends the approval letter stating the time period for which the approval is valid to the member.

If the request is **denied,** the CCC pharmacy staff:

- Calls the initiator of the request (Prescriber, pharmacy, or member);
- Describes the reason for the denial, and notes it on the prior authorization form;
- Generates and sends the denial letter to the member;
- Generates and sends a notification of denial to the client.

Once the process is completed, our staff changes the status of the authorization from pending to approved/denied and time stamps this outcome.

Throughout the years your clinical director has worked with the County to choose the right combination of programs to accomplish your goals. Each time we identify new or existing drugs that have potential for abuse/misuse or potential cost savings, they are evaluated for inclusion based on clinical and cost/benefit rationale. When new programs are created and approved by our

Pharmacy and Therapeutics Committee, plan specific modeling is done to estimate potential impact for the County. These potential savings and clinical rationale are presented to the County for consideration. By doing this proactively, rather than just during quarterly or annual review periods, implementation is accelerated while member disruption is minimized.

The County has already adopted 27 clinical prior authorization program, including those addressing diabetic wound healing agents, topical analgesic agents and ophthalmic immunomodulators that are scheduled to begin January 1, 2011.

During the last three years the County avoided over $2.3 million in pharmacy costs as a result of medication management. When considering fees, this represents a return on investment of 14 to 1.

In addition to CPAs, WHI the County will continue to have access to an online plan prior authorization system that gives you the ability to override various elements in a claim that normal editing would reject. Online prior authorizations take place within our online system. The County will have the ability to enter Plan Authorizations at no additional charge (WHI-entered prior authorizations are $1.00/authorization).

If the County continues to utilize the Medication Management programs currently in place, we will guarantee a 5 to 1 Return on Investment.

Step Care Therapy

WHI's Step Care Therapy programs generally require the utilization of an efficacious first-line agent before alternative therapies may be covered under the prescription benefit plan. It allows prescriptions that meet established guidelines and/or have a generic alternative to be used as the first-line agent before second-line agents are authorized. Claims for second-line agents will be rejected unless evidence exists in the patient's prescription profile or medical history that the first-line agent has been tried or is not recommended.

The County currently utilizes seven step care programs that target medications such as anti-depressants, leukotriene antagonists and bisphosphonates. During the last twelve months these seven step care programs resulted in **$369, 947** in denied savings. Fees for both clinical prior authorization and step care programs are established on a per intervention basis. Please see *Attachment H* for a list of Medication Management CPA and Step Care programs.

165. Describe any clinical intervention and cost-savings program (e.g. voluntary pill splitting) program that you are proposing. Provide benchmark information showing improved outcomes and return on investment.

As the incumbent, we recommend that Maricopa continue its current clinical intervention and cost-saving programs including Medication Management, MedMonitor Complete, Voluntary Tablet Splitting Program, Specialty Pharmacy management including split fill oral oncology program, Smoke Free Telephonic Coaching Program, Walgreens Optimal Wellness. Some of these programs are outlined below.

Voluntary Tablet Splitting

This program targets high cost medications like statins that can be safely split in two, while maintaining clinical efficacy without significantly complicating the patient's medication regimens. The costs of some medications are similar regardless of tablet strength. Because members

purchase half the quantity of the "double-strength" tablets, splitting can reduce prescription unit costs by as much as 50 percent. For example, if members are taking one tablet daily of Lipitor® 40 mg, they will split one tablet of Lipitor 80 mg and take half a tablet daily. As a result, members have a lower copay, and the plan incurs lower medication costs. Participating members receive a tablet splitter covered by the program. The program provides the member with greater choices and encourages them to take an active role in decreasing their out-of-pocket drug spend while, at the same time, having the potential to increase patient compliance with their medication.

While WHI does not support mandatory tablet splitting policies, the voluntary program the County has adopted resulted in gross savings of $48,309 (2007-2009), with a return on investment of 2.6 to 1.

Further information and projected savings can be found in *Attachment E*.

Specialty Pharmacy Prior Authorizations

Appropriate specialty pharmacy utilization is controlled first and foremost through Specialty Prior Authorizations (SPAs). Working with pharmacy claims, we are able to tightly integrate and manage specialty utilization through our specialty prior authorization process. Our reimbursement specialists and pharmacists collect patient and prescriber data, verify completeness and submit this information to a dedicated Clinical Call Center (CCC). The Clinical Call Center's sole purpose is to manage all clinical prior authorizations for our clients, rigorously implementing clinical and plan rules. CCC pharmacists and technicians review the data provided by the reimbursement specialists and make a determination using our Specialty Prior Authorization criteria.

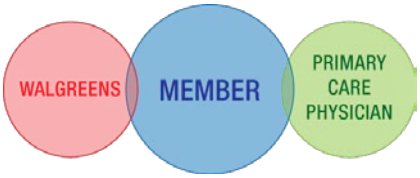
Our SPA programs provide evidence-based medical rationale for proper use of a medication at the appropriate dose. SPAs are designed to ensure that a prescriber is educated and is encouraged to use a treatment protocol that calls for less-expensive, clinically appropriate medications prior to initiation of therapy of a higher-cost specialty drug. These guidelines provide a specific list of criteria that should be met for therapy to be deemed warranted. In addition, our treatment protocol ensures that we are providing the appropriate medication at the right dose to our complex care members to best manage the potential for waste and/or hoarding.

During 2009 the County utilized 19 specialty pharmacy programs resulting in $531,359 in denied savings.

A list of recommended programs can be found in *Attachment H.*

Walgreens Optimal Wellness™

In healthcare, presence drives member participation, thereby leading to behavior change.



Walgreens has a strong presence in Arizona and in communities throughout the country, giving clients like the County the opportunity to positively affect member well-being. As the County already knows, Optimal Wellness focuses on Type 2 diabetes. By integrating capabilities across all of our platforms, patients can better control their diabetes through education and face-to-face engagement.

The average diabetic sees his/her doctor twice a year for roughly 20 minutes, and only 28 percent ever see a Certified Diabetes Educator. Using data provided by our clients, we identify those

members affected by diabetes. When members visit a Walgreen community pharmacy, they are provided with helpful tips about diabetes and an invitation to participate in further consultations. During the coming months, these individuals meet four times with a health coach dedicated specifically to this initiative. One-on-one sessions create an open environment for learning about diabetes and lifestyle changes that bring about positive outcomes. With nearly 18 million Americans diagnosed with diabetes, Walgreens Optimal Wellness is one of the many ways Walgreens is helping clients create cost-saving opportunities, while providing members with the skills they need to live healthy and active lives.

From July 2008 to July 2009 the County has seen a return on investment of 1.8 to 1. As of January 1, 2011, 31 of the County's diabetes patients have registered Walgreens Optimal Wellness. Of these people, 232 have already had their first appointment with a coach. This represents engagement of over 20 percent of the County's diabetic population.

Oral Oncology Program

The Walgreens Oral Chemotherapy Cycle Management Program provides optimized clinical management and support to patients who receive certain oral chemotherapy drugs. Patients are contacted at predetermined intervals during their first month of therapy to educate them about their medication and potential side effects, assess for side effects and confirm medication adherence. If an adverse event is noted, our team responds according to established protocols and contacts the physician as necessary.

Because physicians often have concerns about relying on patients to take these medications as prescribed, the program provides support and communication throughout the patient's medication cycle. At the conclusion of the first month of therapy, the physician receives a report that details the date the patient started therapy, the stop date and cycle (if applicable), adverse reactions or side effects and interventions performed on the patient's behalf. All program services are based on drug-specific clinical protocols recommended by our Oncology Advisory Board, composed of nationally recognized oncologists.

Our cycle management program includes an optional monitored dispensing component that helps reduce expenses resulting from the medication waste associated with early therapy discontinuation or dose reductions due to side effects. With this option, a partial supply of the month's medication is initially shipped. A mid-cycle assessment is performed and once it is determined that the patient is tolerating therapy, the remainder of the month's supply is shipped.

If serious side effects or problems are identified during the mid-cycle assessment, the remainder of the month's supply is held, thus preventing medication waste and saving payers between $2,000 and $4,000 per monthly dispense. This option offers payers direct cost savings by significantly reducing the expense resulting from medications that go unused. In addition, increased therapy monitoring may help avert incremental healthcare costs associated with adverse events.

Outcomes

Nineteen months after program inception, a retrospective claims analysis was performed to identify discontinuations, and potential savings tied to monitored dispensing. A total of 1,178 patients of Nexavar®, Sutent® and Tarceva® between June 1, 2008 and December 31, 2009 were analyzed.

After one month in the program, 69 percent of all participants were persistent with their therapy—that is, they were still taking their medications. Of those who were persistent after the first month, 71 percent were also persistent after the second month. Of these, 77 percent were persistent after the third month. The increase in persistency reflects the benefits of access to clinical support between physician office visits. In the first month alone, the total cost of the three drugs for all program participants would have been $7,617,907 without the monitored dispensing option. If all patients had participated in the monitored dispensing option during the first month, the total medication cost would have been $6,521,101. In this example, the monitored dispensing option would yield a savings of $1,096,806 – 14.4 percent of total medication costs. Potential savings continue into the second and third months with medication cost savings of $706,914, or 13.5 percent of total costs and $379,078, or 10.2 percent of total costs, respectively.

Healthful Living™ Smoke Free

Our Healthful Living™ Smoke-Free initiative offers your members a solution to smoking and the smoking cessation challenge. Through education and proactive telephonic coaching, our healthcare experts support the quitting smoker by reinforcing positive messages that lead to a healthier lifestyle choices.

Offered in collaboration with Alere, a leading provider of disease management and wellness programs, our Healthful Living Smoke-Free program utilizes trained health professionals to aid members in the process of becoming smoke-free. Our experts can work in collaboration with the County's administrators to help members establish the fundamentals of positive behavior change and attainable goals.

During 2009 the County saw $120,611 in savings from medical and productivity cost avoidance. This represents a 1.5 to 1 return on investment.

166. How do you control the filling of separate prescriptions for the same medication at different pharmacies during the period when it is too early to refill the prescription?

Our claims processing system does not allow a duplicate claim to be paid, whether that second claim is submitted at the point of service from a pharmacy, entered manually as part of a Direct Member Reimbursement request, submitted via mail, or for any other reason. It is rejected as a duplicate. Our systems review each claim for duplication. This edit is performed by reviewing all pharmacies when claims are submitted. Our system also includes edits for duplicate therapy, duplicate ingredients and refill-too-soon, which would arise if a second claim was submitted within five days of the initial fill.

We can accommodate most any early refill timeline our clients wish to establish. Our default value is 60 days; if a refill request is within 60 days, the mail service facility will keep the request on file and process it when this date arrives. A letter is sent to the member communicating this new date. If the next fill date is more than 60 days away, the order would be returned to the member with a letter stating the reason for return. All member communications are sent within two business days. At the County's request your members are required to use 70 percent of the medication or be within 63 days of the stated refill date. This approach is suitable for the County's members and can easily be continued.

167. Does your system have the capability of restricting the member to having prescriptions filled by only one prescribing physician and/or at one pharmacy?

Yes.

168. Do you have a prior authorization requirement for claims that exceed a maximum reimbursement dollar limit?

Yes. We recommend continuation of the County's current strategy which calls for a prior authorization for any traditional medications that exceed $1,500 (30 day supply) or $4,500 (90 day supply). Cancer injectables and six other classes of concern require a prior authorization if the claim exceeds $5,000 (30 day supply) or $15,000 (90 day supply). High cost drugs at risk for delay of therapy (VFend, Valcyte, Actiq, Fentora, Fentanyl and Duragesic) are subject to prior authorization once the cost exceeds $10,000 (30 day supply) or $30,000 (90 day supply).

169. Can you set a maximum reimbursement dollar limit on all claims and notify Maricopa County when the limit is exceeded the same day the prescription is filled?

Yes.

Reports

170. Do you agree to provide the following reports on a monthly, quarterly and year-to-date basis (based on Maricopa's fiscal year) at no cost to Maricopa County?

- **Eligibility report showing outcomes of updates and changes**
- **Paid claims summary report showing total number of claims, ingredient cost, days supply, dispensing fee, member cost, plan cost, and total cost**
- **Paid claim detail report showing utilization and ingredient cost by each member claim, drug name, dosage, submitted charge, allowed charge, member cost, and plan cost**
- **Detailed utilization report showing number of prescriptions submitted as single-source brand, multi-source brand and generics, including average AWP, ingredient cost, dispensing fee, days supply and discount percentage, PMPM and PEPM, and generic efficiency**
- **Top 100 drug report by cost**
- **Top 100 drug report by volume**
- **High cost claimant report**
- **Therapeutic exchange report showing the number of PBM initiated exchanges**
- **Drug utilization review and retrospective drug utilization review activity report showing savings by type of edit**
- **Formulary savings and rebate report**
- **Prior authorization and other clinical program outcomes reports**
- **Annual utilization and trend reports including overall analysis of plan-level performance and customer complaints, grievances and appeals and recommendations for changes and improvements.**
- **Quarterly specialty pharmacy utilization dashboard and summary of activity, and clinical and economic impact by prevalent diseases.**
- **Monthly call center metric reports including answer speed, call abandonment rate, number of calls answered by a live representative, number of calls resolved in one call, type of calls specific to Maricopa County members and call quality monitoring results.**
- **Monthly appeal activity reports including summary and detail level of all levels (complaint, grievance and appeal) including number received, pended or resolved, and results with a summary of causes/reasons on all internal and external levels.**

Yes. WHI will continue to provide the County with a series of clinical, financial and management reports that outline every aspect of your program. The metrics not included in our standard reports are routinely retrieved by your account team using *RxVision* or other internal modeling tools. Additional reports specific to on-site health center and pharmacy outcomes can be found on the CD-ROM included within this proposal.

171. Provide a sample of all monthly, quarterly and annual prescription management reports you will provide to the County. Will you agree to break such reports out by the general medical option in which the members are enrolled and then for retirees, COBRA participants, and active employees (County's account structure)?

The reports we provide will drill down by groups (actives, COBRA participants, and retirees) as well as by the medical option each member utilizes. A series of sample prescription management reports can be found in *Attachment K.*

172. Describe any other reports you would be able to supply to Maricopa County on a quarterly basis at no additional fee in order to help manage benefit cost.

We also provide the County with reports showing pharmacy, medical claim and cost utilization data for its CCP plan versus its PML plan. These reports are excellent ways of comparing effectiveness and ensuring that members in the CCP plan are not foregoing medical care which tends to increase costly emergency room visits.

173. Do you provide annual claims paid statements to members? If so, please describe how they are distributed.

Rather than paper statements, WHI provides every member with the ability to view their claim history online. *WalgreensHealth.com* archives 18 months worth of pharmacy transaction data, allowing your members to instantly retrieve and download a comprehensive snapshot of their prescription history. If a member does not have Internet access a claim history can be requested by calling the Walgreens Customer Care Center.

Onsite Pharmacy

174. Can you provide an onsite pharmacy located in the County Administration building at 301 W Jefferson St., Phoenix? If yes, describe hours of operation and capabilities of the pharmacy.

Yes. In January 2009 Walgreens opened a new Take Care Health Clinic inside the Maricopa County Administration Building in downtown Phoenix. At this facility, County employees and eligible family members can visit a nurse practitioner, get flu shots, receive blood pressure screenings and other services. Office hours are 7am to 5pm Monday through Friday, excluding government recognized holidays.

Members can also get their prescriptions filled at the onsite pharmacy. This workplace pharmacy program offers many other benefits as well, including:

- Direct relationship with a trusted pharmacist providing employees immediate access for medication counseling and advice

- Customized pharmacy programs and formularies that are designed for your employee population and benefits plan
- Increased treatment, compliance and medication adherence
- Significant cost savings and care improvements through improved rates of generic substitutions, appropriate antibiotic usage and other pharmacy clinical initiatives
- Complete implementation, staffing, operations, clinical management and reporting

Our programs and capabilities include:

Administrative Responsibilities

- Apply for and maintain the necessary pharmacy license
- Open and close the pharmacy at agreed upon hours
- Fill prescriptions for all formulary brand and generic medications for 30 and 90 day supplies
- Provide and manage professional interaction with the client, the employees, and our pharmacy staff, as well as outside medical professionals
- Collect prescription co-pays and balance cash register at the end of each day
- Oversee the computerized inventory control system and use prescription and/or wholesaler reports to set order points
- Send and receive medication orders via the pharmacy processing system
- Arrange delivery service to specified locations to allow easier access for employees
- Send automated refill reminders
- Perform inventory audit, as applicable under the state law
- Manage inventory turnover
- Fill prescriptions by mail order, if so desired by the client
- Return outdated stock to manufacturers for credit, as applicable
- Ensure proper handling and storage of all controlled substances as required by State and Federal regulations
- Prepare pharmacy reports as requested
- Comply with policies and procedures concerning confidentiality

Clinical Responsibilities

- Address questions from applicable health professionals
- Assure excellent patient care and make sure all staff are adequately trained regarding:
    - Reviewing medication profiles for medication interactions, adverse drug effects and/or allergies
    - Preventing medication errors
    - Providing employee education in compliance with COBRA regulations
    - Maintaining positive attitudes toward all employees
- Work with Maricopa's administrators to define the pharmacist's role in disease management, case management, formulary management and quality improvement programs
- Enhance application of WHI clinical programs by:
    - Providing physician and staff education with respect to utilization of pharmaceuticals, i.e., Drug Utilization Review
    - Implementing corporate formulary directives
    - Promoting generic substitution and therapeutic interchange of pharmaceuticals to help control pharmaceutical costs and maintain the financial benefit of the pharmacy for the client
- Assure compliance with our preferred product list to maximize discounts/rebates

Through reduced absenteeism, improved member well being and affordable services we are helping clients like Maricopa County control costs, while providing value-added, convenient services to their people.

In the two years since the first prescription was filled, your onsite pharmacy has received accolades for promoting generic utilization, making appropriate therapeutic interchanges and providing an exceptional pharmacy experience. Of all prescriptions filled at the pharmacy, 97.1

percent were for generics. This exceeds the already high 96.8 percent seen in Walgreens pharmacies throughout the County. Through three simple interchanges (brand to generic Topamax, brand ARB to generic ACE-inhibitor and Ambien CR to Zolpidem) your onsite pharmacy produced $5,648 in member cost savings and $3,248 in plan cost savings per year. Beyond savings, your members receive personalized care that translates into testimonials like the one recently submitted:

"I have never had such a positive experience with any pharmaceutical staff ever! When you walk into the store and they greet you by name, then you know that is the place where you are going to receive the best service and feel good about your visit… Because of this supportive group, I have improved my efforts and attitude in the daily management of my diabetes. Thanks Walgreens. You are treating me very well."

175. Can you operate an acute care convenience care clinic staffed with a nurse practitioner or physician's assistant? If yes, describe hours of operation and capabilities of the clinic.

Yes. An integrated Walgreens pharmacy and Take Care Health Center opened in January 2009. Office hours are 7am to 5pm Monday through Friday, excluding government recognized holidays. Our Nurse Practitioners working in an acute/episodic setting typically provide care on a limited basis to those patients whose illness or injuries are minor and are expected to resolve within five visits to the on-site provider. A patient whose illness or injuries are significant or expected to require more than five visits to the on-site provider to resolve will be referred for treatment to his or her primary care physician or a specialty provider, as appropriate. Specific conditions which may be treated at the health center include but are not limited to:

- Musculoskeletal complaints (such as back pain, sprains, and strains)
- Upper respiratory infections (such as sore throat, colds, and flu)
- Earaches
- Toothaches
- Headaches
- Minor gastrointestinal complaints
- Allergies
- Minor wound care (including tetanus vaccine)
- Skin complaints (such as rashes, itching, and wart removal)
- Stress
- Routine Immunizations (such as flu shots)
- Minor complaints of pain
- Allergy injections – These are administered according to order supplied by the patient's treating health care provider. Health Center staff will not administer the first dose from a vial, and the injections are administered only when a health care provider is on site.

Our health centers do not typically address:

- Chronic health conditions (such as diabetes, hypertension, and asthma). The health center will monitor these conditions (such as blood pressure readings, blood glucose, Hgb A1C, and peak flow) and coordinate care with the employee's primary care physician.
- Prenatal care
- Depression
- After Hours Call – The health center staff will not be available for health care treatment or questions after office hours
- Hospital care

To keep County employees healthy, prevention is a key focus. Our clinicians will:

- Incorporate age appropriate preventive/screening recommendations into each visit as well as coordinate with outside vendors, physicians, and hospitals to come in for tabling events to speak directly to the employees about various health concerns and the preventions and screenings needed.
- Provide preventive services including, but not limited to:
  - Skin cancer screenings
  - Immunizations (such as tetanus, flu, diphtheria, and pertussis)
  - Specified Women's Health Issues
  - Specified Men's Health Issues

Lastly, to ensure that health education is a primary focus of the health center, our staff will:

- Facilitate expert speakers to correspond with Maricopa County's wellness calendar.
- Incorporate health education around lifestyle and chronic disease management into the routine visits.
- Schedule specific visits around health education as requested by the employees.
- Encourage referrals from community physicians to the health center for health education.

In 2009 Take Care Health Nurse Practitioners asked Maricopa members "If you had not gone to the Take Care Clinic, where would you have gone for treatment?" Respondents said they would have either not sought treatment, waited for a primary care physician or used urgent care. The total cost for these alternatives across all respondents was $272,218. When compared to a Take Care Clinic total cost of $175,560 the County saved $96,658.

176. Describe how you will be able to leverage the onsite pharmacy and convenience care clinic to the Durango Street and Southeast campuses.

Walgreens can offer several strategies that help the County expand service to the Durango Street and Southeast campuses. One such solution could be to offer remote prescription delivery. Following discussions with your administrators, we can create a process whereby deliveries are made to designated sites at pre-determined times. A pharmacy technician would remain onsite during the specified timeframe and provide prescriptions directly to members. HIPAA forms and pharmacy consultation would also be offered. Any prescriptions not picked up during scheduled times would be returned at the end of the day to the originating pharmacy by the technician. State regulations have some impact on the required onsite staffing and delivery options, which can be discussed in further detail if this option is selected. The cost of this program would be based on the staffing and operational costs needed to meet the County's needs. Although currently only legal in Illinois, we are also exploring pharmacy kiosk and telepresence technologies that may prove useful once approved in other states.

Infusion Therapy (Optional)

177. If you are proposing a separate infusion program, please describe your capabilities of managing infusion products at the lowest cost to the plan (for drug and place of service) and the member and how your program will improve member outcomes and provide a defined return on investment for the County.

Walgreens is proposing a separate infusion program that promotes positive member outcomes, while reducing costs to the County. In today's evolving healthcare marketplace, it's not only the type of drug, but also the complexity of the clinical and patient management needs that determine

the optimal setting for patients to receive infusion therapy. Biotech medications will continue to have an expanding influence on the healthcare landscape. Appropriate delivery and management of these medications will improve health outcomes and rein in expenditures. Walgreens is better positioned – from a financial, presence, experience and personnel standpoint – than any other provider to deliver an integrated model that precisely and passionately treats the County's specialty and infusion members.

Our capabilities span the range of infusion therapies with particular focus on Nutrition, Heart Failure, Hemophilia, Immune Globulin, and Anti-infective therapy. Each program is implemented through our Center of Excellence and is supervised by a designated Program Director. Key factors that contribute to the success of our clinical programs are the high level of our clinician education and our expert patient management process.

Our pharmacy and nursing staff work with each patient and caregiver to provide the following:

- ✓ Training and support necessary to ensure successful clinical outcomes;
- ✓ Individualized clinical patient care planning;
- ✓ Personalized Nursing Services, primarily through Walgreens employees;
- ✓ Coordination of care with other healthcare providers;
- ✓ Routine laboratory monitoring, follow-up, and clinical recommendation to the prescriber to ensure safe appropriate therapy;
- ✓ State-of-the-art USP <797> compliant pharmacies that are fully automated to provide the highest quality compounding services;
- ✓ 24/7/365 on-call services by local clinicians and staff to ensure resources are available and appropriate patient needs are met; and
- ✓ Discharge planning to ensure the patient and caregiver are well-educated on the next steps of care. This is of particular importance in cases of continuous therapy such as Inotropes, PN, pain management.

Our proven clinical processes, standardized training and multiple points of care are key advantages of our programs. One of our greatest differentiators is the level of care we provide to the patient through our clinicians. Walgreens is focused on coordination of care and assessment of our patient's physical and psychosocial needs, including nutrition, pain and safety. Our nurses develop a treatment plan based on physician orders; provide interventions such as venous access device placement and maintenance; perform or assist in drug administration; and provide patient education and medication administration demonstrations with the goal of patient self-care. Our nurses also assess caregiver support and create a learning environment for the patient. Clinicians focus on empowering the patient or caregiver to fully understand how to safely manage their infusion and access device and to recognize and report early signs and symptoms of complications so appropriate clinical interventions can reduce or avoid emergency room visits or re-admissions. Together with the pharmacy, our nurses monitor the pharmacokinetics of the medication to ensure optimal care and a safe, therapeutically appropriate course of therapy to increase adherence.

Benefit Design Options

Walgreens delivery model and proven therapy management programs will drive cost efficiency for the County. Our goal is to ultimately improve outcomes. Providing care for patients in the most appropriate and cost effective setting will increase member and physician satisfaction and decrease the need for hospitalizations and in-patient and outpatient treatments. Walgreens distribution plan for the County consists of a central intake and a clinical management platform which allows for consistent patient and a prescriber experience and access to specialty pharmacy services.

We have experience supporting benefit designs that promote the use of medications or preventive therapy to minimize negative medical outcomes. As an example, Walgreens worked directly with a payer to implement a benefit change for members with chronic conditions who were receiving specialty medications. Based on claims data, patients were identified as potential candidates to enroll in the program. We worked directly with the payer and its case managers to disseminate a targeted outreach campaign to educate members on the benefit change and the services available through Walgreens. For a select group of specialty medications, members received a $0 copay when therapy was provided through a Walgreens alternate treatment site. The program provided an alternate solution for members to receive treatment outside the acute care setting. In addition, the benefit design change eliminated member out-of-pocket costs, encouraged compliance, decreased absenteeism and reduced overall costs to the payer. Please see *Attachment F* (*RxMatters*) for further details on this program, which we are happy to implement for the County.

Describe education and training and level of staff.

All of our facilities are staffed by a group of clinicians (clinical pharmacists, registered nurses, registered dietitians and technicians) whose mission is to provide patients with the best care available. We prefer to higher infusion professionals who have prior experience with another home infusion provider or have worked in a hospital setting. Our professionals are required to meet all applicable state qualifications as well as numerous internal corporate standards. For example, our infusion staff must complete competency training and testing every six months to monitor any technique changes in therapies. Each registered pharmacist must complete 30 hours of Continuing Education every two years to maintain his/her license. Dietitians must complete 75 hours every five years. Walgreens corporate office performs ongoing reviews of policies and procedures to make sure all facilities and staff are current in standard practices. An electronic learning management system ensures all clinicians complete the required programs on a routine basis. The competency of each staff member is reviewed yearly with a supervisor/manager. All credentials are verified before employment and annually thereafter.

Patients receiving higher risk therapies such as Inotropes, Factor, or Parenteral Nutrition are served by clinicians who have received special training in clinical management of these therapies. Our program directors for these unique therapies ensure that policies/procedures and training remain current with updated guidelines and standards.

Describe place of service, alternate treatment sites, multi-channel distribution and the specific clinical programs and infusion products included.

Given the County's projected needs, we recommend an approach that offers your members the ability to receive infusion services in their choice of settings. With over 30 years of experience, Walgreens currently stands alone as the largest infusion provider in the country. We can provide you with unprecedented access to infusion services in manners consistent with industry practices and member needs. All these services are coordinated through a series of Walgreens facilities strategically located to offer convenient service. Our footprint includes:

- Over 7,650 Walgreens Community Pharmacies
- Over 90 Home Infusion Pharmacies
- Over 70 Alternate Treatment Sites
- Over 73,000 Healthcare Providers
- Over 1,000 Registered Nurses and 60 Dietitians directly employed by Walgreens
- Six Specialty Pharmacy Facilities

These options facilitate cost-effective care in the most appropriate setting. At every site, we offer consistent clinical support and therapy management to raise medication adherence levels, reduce costs through clinical interventions and improve overall patient and physician satisfaction and clinical outcomes.

In addition, our continued relationship will allow for more consolidated pharmacy and medical data across delivery points to help better monitor and predict trends within this high-cost healthcare segment. Additional data provides visibility which will enable the County to make informed decisions that can ultimately result in higher quality of care and lower costs.

Unlike other companies which are limited to centralized fulfillment, Walgreens is positioned to manage medications across multiple channels. Walgreens delivery model and therapy management programs will drive cost efficiency for County. Our goal is to ultimately improve outcomes. Providing care for patients in the most appropriate and cost effective setting will increase member and physician satisfaction and decrease the need for hospitalizations and in-patient and outpatient treatments.

A National Footprint

Our national presence provides unprecedented access to multiple points of care for specialty medications offering better value to members, physicians and the County. In addition, it allows us to provide urgent delivery of services that is unmatched in the industry. Our distribution plan for the County is coupled with Walgreens reputation for compliance with industry standards and our experience with clinical protocols, training programs, and quality assurance procedures. Our national footprint also allows us to provide uninterrupted, continuity of care for patients who travel or relocate.

A Local Touch

Walgreens local touch signifies local infusion pharmacy and alternate treatment site dispensing, featuring in-house nursing support within your members' communities. Our dedicated and specially trained nurses are critical to ensuring the best care for your members. Walgreens local sales support is available every step of the way to educate the physicians on alternative options for care in lieu of the hospital outpatient setting. Our goal is to educate and empower patients to remain adherent to the therapy prescribed by their physician.

Walgreens medication distribution model places a proactive emphasis on the health of patients. Our proven therapy management programs offer physicians and patients cost effective options to minimize hospitalizations and increase the effectiveness of the medication and treatment regimen. Walgreens integrated platform provides national support, while our trained local healthcare teams provide one-on-one assistance. This system results in improved patient adherence, physician acceptance, and cost effective services for the County.

Alternate Treatment Sites

Walgreens network of over 70 ATS provides a convenient, cost-effective alternative to physician office and hospital outpatient care for patients that may require injectable and/or infusible medications. ATS may be utilized for patients with chronic conditions such as: immune deficiency disorders, cancer, rheumatoid arthritis, infections, pulmonary hypertension and the prevention of respiratory syncytial virus. Services available include:

- Drug Administration (Infusion and Injectable)
- Patient assessments
- First dose protocols
- Catheter insertion and maintenance
- On-site self-injection training
- On-site RN, RPh and RD consultations
- Blood draws and processing
- Patient training and education

With 245 Walgreens community pharmacies in Arizona, our Alternate Treatment Site network can easily be expanded to accommodate the geographic dispersement of the County's population. Our infusion and market planning professionals would be happy to meet with you to design a custom solution to fit your member's unique characteristics.

Our nursing experience is of particular note, as we believe this is a unique capability of our company. Walgreens employs over 1,000 nurses located throughout the United States. Through this infrastructure, Walgreens nurses are responsible for over 93 percent of all nursing visits. Using our own nursing teams provides continuity of care, ensuring the best clinical and financial outcome through increased compliance, decreased hospitalizations, decreased emergency room visits, and reduced cost. Contracted agencies must also meet Walgreens strict clinical guidelines prior to providing care to a client.

Nutrition Support Program

Walgreens is one of the largest nutrition support providers in the country, serving over 21,000 enteral and parenteral nutrition patients per year. We served our first patient (parenteral nutrition) over 30 years ago. Since that time, we have built a reputation of superior clinical practice in this specialized area of home infusion.

Upon intake, our multi-disciplinary team works closely to develop an individualized plan of care to meet the unique needs of each patient. Every new enteral and parenteral nutrition referral is subject to a thorough review by our clinical team, which includes pharmacists, nurses and registered dietitians certified in nutrition support through the American Society of Enteral and Parenteral Nutrition (ASPEN). We employ over 60 registered dietitians who specialize in nutrition support, as their unique role within the home nutrition support team contributes to optimal care and cost savings. Each nutrition prescription is examined for appropriateness and accuracy to avoid underfeeding, overfeeding and/or re-feeding syndrome. In addition, each order is examined to ensure appropriate hydration levels. In this specialized area of nutrition, few physicians are experts and they rely on our knowledge and experience to assess and prescribe the home nutrition support formula.

In our enteral program we differentiate ourselves by offering clinical monitoring of patients in addition to providing formula and supplies. The enteral program is becoming the patient's preferred method of feeding (less invasive and costly), and we recognize these patients are sicker and leaving the hospital quicker than ever, requiring a higher level of care to avoid readmissions. Our qualified corporate and local reimbursement staffs review all referrals to assure complete information is at hand to qualify the patient for appropriate therapy and specialized formulas if indicated.

Successful patient adherence to therapy often is related to effective teaching and ongoing communication with the home infusion team. We have processes in place to assure a thorough assessment of the home environment and the ability of the patient and/or caregiver to take on daily responsibilities. Close, regular interactions with staff, including standardized questions, help us maintain the safest provision of home nutrition support. Our internal training programs; quarterly case reviews with acclaimed, outside nutrition support professionals; policies and procedures; involvement with research; clinical interventions tracking; and oversight by a Nutrition Support Medical Director create an environment that keeps us operating at the highest levels of care.

Our clinicians are skilled at initiating parenteral nutrition in the home setting for appropriate patients, which typically mitigates a three-day hospital stay. With the help of registered dietitians, our teams proactively transition patients off higher risk therapies, such as parenteral nutrition to enteral nutrition or oral nutrition, as soon as possible. All of these daily clinical interventions coincide with our program mission statement: *To ensure the provision of clinically appropriate, cost effective enteral and parenteral nutrition support therapies resulting in optimal outcomes and improved quality of life for patients.*

Immune Globulin Therapy Management Program

Immune Globulin (IG) is now utilized to treat a broad range of complex chronic conditions. In 2007, data reported that 65 percent of IG utilized was for off-label use. Of this, 80 percent was prescribed for patients with neuromuscular disorders. The costs associated with IG therapy are substantial. Our IG therapy management program offers physicians and patients a cost-effective solution by minimizing complications and hospitalizations, increasing the effectiveness of the medication and treatment regimen, and offering an aggressive acquisition cost for the product. By leveraging Walgreens extensive healthcare assets, our IG clinical team provides one-on-one assistance to physicians, payers and members.

Upon intake, our multi-disciplinary team works collaboratively to develop an individualized plan of care to meet the unique needs of each patient. Each new case is subject to a thorough review by our clinical team, which includes pharmacists and nurses with extensive experience in IG therapy. The diagnosis is examined for accuracy and to determine if the patient qualifies for treatment with IG. In the area of rare chronic conditions, the correct diagnosis is often elusive. Accurate diagnosis relies on thorough evaluation of nerve conduction, IG blood levels, and other testing specific to the patient's condition. Review of the diagnosis and related tests are the first steps to ensure the patient is receiving appropriate treatment.

Walgreens offers assistance with medical policy review to ensure appropriate utilization of IG therapy by diagnosis. Authorization for IG infusion therapy should be tailored to each specific diagnosis. We recommend that each case be assigned an initial authorization of approval – typically three months – and be matched to the likelihood of response. At set intervals, re-authorization is linked to adjustment of therapy (drug dosage, treatment interval and product selection) and based on the results of objective clinical measures.

Regardless of administration location, each infusion session results in an encounter with a qualified clinician. Objective assessment becomes a part of each infusion session, providing the information needed to make educated decisions at the time of re-authorization. Since infusions occur at frequent intervals, a clinical pathway of the patient's progress is trended and evaluated. If indicated, therapy is adjusted or discontinued, which results in appropriate utilization. Response to therapy, the patient's physical status, and objective measures of strength and function are each determined and documented at every encounter by means of evidence-based testing. The data collected on patient outcomes will be used to communicate with the prescribing physician and the payer, and will help support the clinical effectiveness of therapy and appropriate utilization. Walgreens works with the prescribing physician to become an extension of his/her office, since communication and trust of the prescriber is a key factor in the success of this program. Our IG program provides multiple saving opportunities such as IG product cost, site of administration savings, decreased utilization secondary to the clinical interventions, reduced number of hospital re-admissions, effective authorization savings and savings by monitoring treatment outcomes.

Bleeding Disorder Program

Walgreens currently stands as one of the largest bleeding disorder providers in the country, serving over 1,200 patients. Serving the bleeding disorder community has become a core competency for our company, one for which we continue to be recognized. For example, Walgreens was recognized at the 59th annual National Hemophilia Foundation meeting for leadership displayed in the care of bleeding disorder patients receiving continuous factor infusion. Our bleeding disorder patients know they can call our toll-free hotlines (English and Spanish) to obtain excellent clinical care, 24/7.

When patients require nursing services, competitors often subcontract. Walgreens challenges this standard of practice by employing over 1,000 registered nurses to manage this highly complex patient population. This establishes virtually immediate availability, creates relationships between the patient and the nurse and integrates the nurse, into the patient care plan – thus establishing a continuity of care not readily available in a subcontracted arrangement.

In addition to local, in-house nursing, if an urgent situation arises, Walgreens is positioned to quickly serve these patients to avoid unnecessary emergency room visits. We have nurses and pharmacists in our local offices, as well as two national hotlines (English and Spanish) available 24/7 for patient support. We understand the clinical importance of expedient and accurate assessment as well as timely access to factor, ancillary medications and supplies in order to improve outcomes. We have the ability to distribute bleeding disorder medications and supplies throughout the nation through our local infusion pharmacies, specialty pharmacy (central fill), air freight, community pharmacy depots and manufacturer relationships. Our presence within the local communities allows us to provide emergency delivery of product that is unmatched in the industry.

Walgreens has a dedicated Clinical Care Team with expertise in bleeding disorder management. This national team is multidisciplinary in nature and provides assistance for patients during financial/employment difficulties through manufacturer, federal, state and community resources (i.e. Patient Assistance Programs). Our clinical experts can provide in-services to emergency rooms, schools, day cares, families and other caregivers in bleeding disorder education, monitoring/assessment, lifestyle precautions, and proper infusion techniques, including self-infusion.

Continuous infusion of factor can improve outcomes (e.g., post-op) by maintaining a constant therapeutic level while reducing factor units needed by up to 20 to 50 percent. Our ability to provide continuous infusion of factor through our national footprint of infusion pharmacies is a significant Walgreens differentiator. Due to the short stability of compounded factor products, a local presence is required to deliver this specialized service. Compounding of factor in a local clean room that adheres to stringent USP 797 guidelines, allows for the provision of long-term continuous infusion.

If a patient requires adjunctive therapy, such as hepatitis medications or intravenous antibiotics (e.g. for port infection), Walgreens is uniquely prepared as a full service pharmacy solution, allowing comprehensive continuity of care. We also provide ancillary bleeding disorder medications, such as oral Amicar, Stimate nasal spray, intravenous/subcutaneous desmopressin and tranexamic acid.

Assay Management

Prescriptions for factor products are written within a range of units per dose based on patient's weight. Vials containing factor, known as assays, are produced in varying ranges. Industry practice has been to fill and bill prescriptions for as much as 10 percent over the prescribed amount. Additional factor administered beyond the prescribed dose may not affect the clinical outcome and can significantly increase the cost of therapy. Our practice is to fill these prescriptions within 2 percent of the prescribed amount. We achieve this through our rigorous inventory management procedures. Our comprehensive agreements with manufacturers gives us access to a wide array of products and assays in different sizes to prevent waste, minimize unneeded assays and reduce costs. Our assay-specific approach to product management not only prevents waste, but also prevents unnecessary cost associated with medication hoarding. This practice is supported by over six years of data and as a result, delivers potential cost savings on the factor products bleeding disorder patients require on a lifelong basis.

Walgreens actively tracks patient outcomes, including number of bleeds, locations of bleeds, emergency room visits, unplanned hospitalizations, unplanned doctor visits, missed school or work days and patient satisfaction. This allows clinical staff to quickly identify appropriate interventions in an effort to improve care and avoid unnecessary, costly expenditures and enables the plan to better manage this population. Walgreens meets or exceeds the National Hemophilia Foundation's Medical and Scientific Advisory Council (MASAC) recommendations regarding standards of service for pharmacy provider of clotting factor concentrates for home use to patients with bleeding disorders. We are proud to be one of 21 pharmacies in the country that adhere to these guidelines. In addition, our infusion and specialty pharmacy (central fill) locations are also accredited by ACHC.

Hemophilia Treatment Centers (HTCs) offer a comprehensive health care program (i.e. dentistry, orthopedics, genetic testing) for people living with bleeding disorders. HTCs play an important role in this community, from a broad scope perspective. Our local footprint and clinical expertise can be used to complement the services provided by an HTC and are often viewed as an extension of their program. For patients that require local or acute assistance for adjunctive therapies (i.e. anti-infectives, hepatitis, Stimate, Amicar, Rituxan), DME and catheter care – which are not typically provided by an HTC – Walgreens is available to fulfill these needs. Our goal is to partner with all applicable payers and providers involved in the bleeding disorder community to enhance patient care.

From service and patient care to delivery integrity, Walgreens has policies and procedures in place to ensure that we maintain a high-quality, high-value program for our customers. It is our staff's commitment and dedication to our patients that allows us to be an industry leader in healthcare.

Bleeding Disorder Patient Management

Walgreens utilizes a streamlined intake process for new patients to ensure customer satisfaction. This process includes:

- 24/7 central intake
- Insurance verification, benefit investigation and authorization
- Coordination with patient assistance programs (PAP)
- Dose verification

The Walgreens intake process is uniquely managed by a multi-disciplinary team trained to provide clinical, technical and reimbursement support. Each patient is assigned a patient care coordinator upon admission. The Walgreens patient care coordinator is assigned the lead role in working with the physician office and patient by providing:

- First call response and triage to the appropriate site of care
- Single point of contact for each individual patient
- Explanation of insurance coverage and benefit options
- Patient support program information and education
- Provide patient follow up (i.e. therapy compliance and inventory management)
- Service as a liaison between patient, parent and office during treatment
- Assistance in the coordination with case management as necessary

As a standard process, Walgreens does not auto-ship factor products. All patients are contacted in advance of their monthly treatments to prompt reorders. Dedicated English and Spanish Hemophilia Hotlines are available for ordering, which can be accessed 24/7/365. Orders can be placed by phone or fax. Confirmation of delivery, utilization review, and ongoing monitoring prevents patient hoarding of medication in the home. By monitoring patient inventory, product does not expire or become vulnerable to storage variability at home. This process drastically decreases the possibility of excess and/or wastage of this costly product.

Patient care coordinators make scheduled calls to patients to ensure appropriate product inventory levels are maintained in the home. Product and patient status are reviewed by a pharmacist and managed electronically through proprietary software. By monitoring product levels and patient status in the home, unscheduled hospitalizations and emergency room visits can be prevented. When nursing services are required, Walgreens nurses will also take inventory and assess home status.

Registered pharmacists and nurses are available 24/7/365 to answer questions from patients, caregivers, physicians and other individuals involved in patient care. We are dedicated to providing high quality customer service to ensure patient and physician satisfaction. Our proven customer service process includes, in part:

- Dedicated care teams - pharmacists, nurses, pharmacy technicians, patient care coordinators social workers and delivery technicians are assigned on an individual or therapy-specific basis;

- Nursing coordination – provided for patients requiring enhanced clinical service;

- Reimbursement assistance to maximize patient benefits, including coordination with patient assistance programs as appropriate;
- Proactive refill reminders - conducted by phone to the member for optimal medication persistency based on each individual care plan; and
- 24/7 availability.

For all patients, regardless of their setting Walgreens will:

- Provide a comprehensive therapy management program to increase patient adherence, quality of life and maximize their benefits;
- Establish a dedicated toll-free line for the County and its members;
- Be responsible for all aspects of clinical management of pre and post surgery patients, including but not limited to continuous infusion;
- Provide access to Walgreens Clinical Liaisons that are available in most major markets to promote early discharge of bleeding disorder patients from the acute care setting to the home and can easily be expanded to other areas based upon utilization data;
- Provide required adjunctive therapy requests as ordered by physician (i.e. IV antibiotics, antivirals, Rituxan, Hepatitis and HIV medications, etc.);
- Appropriately bill for all medications and nursing services per contracted rates;
- Coordination of care with hemophilia treatment centers as appropriate;
- Educate local Emergency Departments, primary care providers, case managers and community members regarding bleeding disorders; and
- Provide utilization and measurable outcomes reporting to the County.

Through our regular contact with the patient and hemophilia treatment centers, we quickly identify upcoming invasive procedures, such as surgery or dental operations. Following this, we proactively coordinate with the physician, hemophilia treatment center, and clinic to determine appropriate dosing. If treatment warrants, we can seamlessly provide continuous infusion. This can result in earlier hospital discharge and reduction of factor consumption up to 50 percent[2], while maintaining a constant therapeutic level in the bloodstream, thus improving outcomes.

Walgreens understands that stat delivery in times of urgent need is a key component to helping our patients attain the best possible outcomes. Improved outcomes generally come when emergency treatment is provided within three hours of bleed onset. Through proactive clinical and inventory management, Walgreens is able to avoid most last-minute product emergencies. With a national footprint of infusion pharmacies, specialty pharmacy (central fill) and strategically placed product

[2] Varon D, Martinowitz U. Hemophilia. 1998 Jul;4(4):431-5. There are numerous studies that show similar results from continuous infusion therapy; see also Nilsson IM, Berntorp E, Lfqvist T, Pettersson H. J Intern Med. 1992; 232: 25–32.

depots within our community pharmacies throughout the country, Walgreens can achieve an emergency response time of three to four hours in most cases.

Heart Failure Program

Walgreens specialized heart failure program is designed specifically for Stage D patients who meet the ACC/AHA Guidelines for inotropic therapy. Stage D patients are those who are at the end of the heart failure spectrum. If properly managed, the only additional options for these patients are transplant, ventricular assist device, chronic Inotropes, palliative care or participation in drug or device trials.

Patients currently on a heart transplant list or those who do not qualify or choose not to pursue transplant, may be able to decrease exacerbations and readmissions if maintained on continuous inotropic therapy. Our comprehensive program includes patient/caregiver education and self-management tools, as well as frequent assessment and telephone follow up by specially trained nurses and pharmacists. Five years of positive outcomes data proves the positive impact of this program for patients who qualify for home inotropic therapy.

Describe how you would implement this program.

Our implementation and account service philosophy is one of collaboration and open lines of communication. We believe in managing the program and members together to achieve the best possibly humanistic outcomes at the lowest possible overall treatment cost. Since we already provide many of the County's existing programs, a new implementation may not be necessary.

For new clients, we suggest meeting initially to discuss deadlines, milestones and responsibilities. Subsequent meetings and calls then take place on a pre-determined basis to cover outstanding items and track progress. Our implementation teams work with clients to determine the most effective method for transferring prescriptions. A dedicated Walgreens account team partners with internal Walgreens operations employees to develop an implementation plan based on each client's specific needs.

We develop and provide clients with a timeline of assigned responsibilities for the implementation period, and review it with them to ensure that each organization has the resources and personnel appropriately aligned for a smooth transition. We keep an "open issues" chart of what is outstanding, noting who is responsible for the deliverable and the date needed. During the implementation we schedule calls with clients to ensure everything is on track; frequency can range from daily to weekly, depending upon the stage of implementation. Walgreens also provides all applicable training and support for clients during the implementation process. The implementation manager and the clinical manger review applicable online tools. Demonstrations are informal, with packets provided, and Power Point demonstrations utilizing the actual tool, with meetings timed to match our clients' schedules.

How would you integrate this service with the general medical vendor?

One of our key differentiators is our ability and willingness to work in concert with medical vendors. In one such example, a large BCBS plan decided to mandate the use of Remicade and IVIG under the medical benefit, utilizing our central fill facility exclusively. We assisted with the identification of key prescribers, attended the meetings with key physicians prior to implementation, assisted with the drafting of communications, and provided field support (post-implementation) to educate physicians so they understood the initiative. Provider education

prevented patients from being shifted to the outpatient hospital for their infusion services, thus saving the plan additional cost. The plan realized savings of $3 million the first year.

Do you have other clients for whom you have successfully implemented this program?

Yes. Walgreens has successfully implemented its Bleeding Disorder program for Coventry and Blue Shield of California. Although Heart Failure is based strictly on physician choice and is not payer drive, over 50 percent of our Inotropic patients are from managed care organizations.

How are you proposing member cost-share be determined?

Substantial reductions in member cost-shares can often be achieved through a change in treatment setting. Walgreens recently worked with a large state agency with over 100,000 employees, many of which were receiving infusions of specialty medications at community hospitals and physician offices. The costs and limited availability of treatment options had a substantial impact on the plan's healthcare spend as well as on employee productivity. In some cases employees had to drive long distances on weekdays in order to receive treatment. This meant several hours away from work, home and family. Walgreens worked in consultation with the plan to establish an innovative benefit design that eliminated copays, deductables and co-insurance for specific conditions that were addressed in nearby Walgreens alternate treatment sites. These sites were staffed by registered nurses that specialized in infusion therapy. Employees were receptive to change because their costs were greatly reduced and they could spend more time with their families. The plan experienced a 17 percent reduction in medication costs alone, not including additional savings realized from moving employees to lower cost administration settings. Projected annual cost savings for employees enrolled in the program are currently $750,000 for Remicade® with a total annual savings for all services projected to be $3 million.

What reports are available?

We will provide the County with an enterprise-wide approach to reporting. Located in downtown Phoenix, your client service team will continue providing you with regular reports that document all aspects of your plan's performance. Your team will provide general and member-specific reports that will help the County track infusion utilization and outcomes. In addition, our corporate reporting team will generate trend data (utilization claims data), which will help the County manage its pharmacy and medical spend. We are able to provide utilization data from our *i-Emphsys* platform, and are able to query on any data point we collect. This includes, but is limited to:

- New referrals
- Patient demographics
- Utilization by therapy and medication
- Census for a particular insurance plan
- Prescribing physician

This information can be broken out by therapy or any other dimension. In addition to general utilization, we have the ability to provide the County with general outcomes data available on our infusion services, including, but not limited to:

- Unplanned hospital admissions
- Delayed or missed doses
- Medication incidents
- Adverse drug reactions

- Catheter infection rates
- Patient satisfaction
- Adherence to therapy

All therapy management programs have specific data points that are tracked and measured. Examples include our Inotropic Program for Stage D Heart Failure, Nutrition and IG. For Inotropic patients we track length of stay, emergency room visits, readmissions, complications and are beginning a quality of life assessment.

Please provide any positive outcomes and evidence of improved compliance through your benchmarking reports by disease state.

Our therapy management programs deliver the following benefits:

- ✓ *Heart Failure Program* – Of all Walgreens managed heart failure patients, 84 percent are re-hospitalized zero to one time per year versus national data that indicates up to one time per month.

- ✓ *Nutrition Program* – Data from 11 Nutrition Centers of Excellence (COE) was evaluated to measure the impact setting had on cost. In 22 percent of cases parenteral nutrition was successfully initiated in the home at an average cost of $195 per day. When compared to the estimated cost of a single day in the hospital ($2,000) savings of $1,805 were achieved.

- ✓ *Bleeding Disorder Program* – Walgreens 2009 overall Assay Guarantee averaged 1.59 percent versus the industry standard of 10 percent variance. A recent case study on a severe patient (3.6 million units) revealed estimated cost savings of $313,000 at 1.28 percent assay versus 10 percent.

- ✓ *Immune Globulin Program* – A recent study demonstrated that our program significantly decreases adverse events compared to national statistics. For example, the program can potentially reduce total cost of care by $2.4 million annually for a payer with an estimated $10 million in IG and administrative costs and $1.6 million in adverse drug reaction-related costs.

For additional information on our Infusion programs please see *Attachment F*.

Injectables (Optional)

178. If you are proposing a separate program to manage the cost of injectable medication, please describe your program and list which injectables and place of services are included in your program. Describe how you would implement this program. Do you have other clients for whom you have successfully implemented this program? How will your program provide a defined return on investment for the County? How are you proposing member cost-share be determined? What is the positive impact to the member? What reports are available?

Since our specialty pharmacy program encompasses injectables, a separate program is not being offered at this time.

Durable Medical Equipment (DME) (Optional)

179. If you are proposing a separate program to distribute DME that is available at a retail pharmacy, please describe you program. Provide a list of which DME products would be included. Describe how you would implement this program. Do you have other clients for whom you have successfully implemented this program? How will your program provide a defined return on investment for the County? How are you proposing member cost-share be determined? What is the positive impact to the member? What reports are available? In what system will claims be adjudicated?

At this time Walgreens is not positioned to offer the County a comprehensive DME distribution program. Instead we recommend a strategy that features a select number of items across four key categories that we feel will have the greatest impact on savings. These products will be available to County members through Walgreens community pharmacies. Our ability to adjudicate these products internally within our pharmacy claim system will provide documentation for reporting and tracking purposes, reduce administrative costs and promote savings opportunities for the County. Since there will be no additional cost to the County, this approach represents an economical way to expand the services you currently offer. We are open to this interim solution and would be willing to partner with the County in the future to add products that align with your goals. A list of the products being proposed is included on Attachment A-6 DME Pricing within Section 3.12.9.

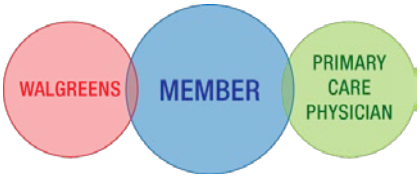
Wellness Programs (Optional)

180. If you are proposing a wellness program, including health screenings, please describe your program. Provide a list of services available. Describe how you would implement this program. How will you program provide a defined return on investment for the County? Do you have capabilities to track participation and earned incentives based on participation or improvements from the previous year? Will you share the information with the County so that a wellness data base can be developed? How are you proposing member costs be determined? What is the positive impact to the member? What reports are available? Do you have the capability to bill the general medical vendor for certain wellness services (e.g. flu and pneumonia shots)?

Positive wellness and financial outcomes all start with presence. Presence in the minds of prescribers and in local communities drives participation in many of life's activities. When presence and participation are in place the stage is set for long-term changes in behavior, both for members and prescribers. Walgreens will continue to provide the County with a suite of wellness initiatives, including health screenings, diabetes care, smoking cessation and immunizations. Each program is accompanied by robust reporting and the ability to bill to Cigna, as needed (i.e. immunizations).

Walgreens Optimal Wellness™

Walgreens has a strong presence in Arizona and in communities throughout the country, giving clients like the County the opportunity to positively affect member well-being. As the County already knows, Optimal Wellness focuses on Type 2 diabetes. By integrating capabilities across all of our platforms, patients can better control their diabetes through



education and face-to-face engagement.

The average diabetic sees his/her doctor twice a year for roughly 20 minutes, and only 28 percent ever see a Certified Diabetes Educator. Using data provided by our clients, we identify those members affected by diabetes. When members visit a Walgreen community pharmacy, they are provided with helpful tips about diabetes and an invitation to participate in further consultations. During the coming months, these individuals meet four times with a health coach dedicated specifically to this initiative. One-on-one sessions create an open environment for learning about diabetes and lifestyle changes that bring about positive outcomes. With nearly 18 million Americans diagnosed with diabetes, Walgreens Optimal Wellness is one of the many ways Walgreens is helping clients create cost-saving opportunities, while providing members with the skills they need to live healthy and active lives.

From July 2008 to July 2009 the County has seen a return on investment of 1.8 to 1. As of January 1, 2011, 31 of the County's diabetes patients have registered Walgreens Optimal Wellness. Of these people, 232 have already had their first appointment with a coach. This represents engagement of over 20 percent of the County's diabetic population.

Healthful Living™ Smoke Free

Our Healthful Living™ Smoke-Free initiative offers your members a solution to smoking and the smoking cessation challenge. Through education and proactive telephonic coaching, our healthcare experts support the quitting smoker by reinforcing positive messages that lead to a healthier lifestyle choices.

Offered in collaboration with Alere, a leading provider of disease management and wellness programs, our Healthful Living Smoke-Free program utilizes trained health professionals to aid members in the process of becoming smoke-free. Our experts can work in collaboration with the County's administrators to help members establish the fundamentals of positive behavior change and attainable goals.

During 2009 the County saw $120,611 in savings from medical and productivity cost avoidance. This represents a 1.5 to 1 return on investment.

Immunizations

Walgreens has successfully offered immunizations to the County throughout the length of our partnership. Working together we progressed from a pharmacy-based solution, to holding worksite events and most recently this past year, billing through your medical plan. With 245 Walgreen pharmacies throughout Arizona, we will continue to offer the County a unique opportunity to help safeguard your members' wellness during the flu season. Studies show that the average cost associated with a hospitalization due to flu complications is $15,000 per patient. This often translates into increased costs and lost productivity. Walgreens dispensed 7.4 million seasonal flu and H1N1 vaccines during the 2009-2010 flu season, saving employers an estimated $5 billion in healthcare costs. With all Walgreen pharmacies able to provide influenza immunizations, we are committed to helping clients maintain a healthy workplace. All flu vaccinations can be provided at the workplace or at local Walgreen pharmacies ever day, any time,

without an appointment. With 25,000 certified immunizers across the country, we have the community presence and expertise to help the County families stay well.

Population Health Excellence

Beyond those wellness programs already in place, we offer the County an additional suite of initiatives available through your onsite health center. In response to the resounding need and deep commitment to risk prevention and behavior change, we have dedicated our efforts to cultivate the **Population Health Excellence** suite of programs. We believe that these solutions provide methods that improve the health of all employees and by integrating these offerings with the trusted clinicians at the health center we can significantly improve health, enhance productivity and reduce expenses of your workforce.

Health Promotion

The Health Promotion engages participants in health and wellness activities and targets participants in the early stages of readiness to change. These programs are designed with a professional look and feel with the intent to drive brand awareness and further develop the County's culture of wellness. There are 12 topics in the complete program. These materials can be pre-packaged for 100 participants. Printed materials may include brochures, bookmarks, wallet logs, quizzes or handouts and a CD-ROM that contains a PowerPoint and a news article PDF.

Lifestyle Risk Brochures & Display Rack

The Lifestyle Risk Brochures address behavioral risk factors. This light, easy-to-read health information is aimed at increasing awareness and desire to change behavior in the at risk population. Display racks (29"x28") are available with brochures for all 10 risk factors. Brochures are branded, professionally printed and packaged in sets of 50. Co-branding is also available for this program for an additional fee.

Lifestyle Risk Management Programs

Lifestyle Risk Management programs are designed to be implemented at onsite locations by clinical, wellness or fitness professionals. The Stop Smoking and Weight Management programs address the top risks facing clients with more intensive facilitator guided interventions. Participants are engaged with in-class activities, skill building and goal setting. These programs are developed internally and can be modified by onsite health professionals to fit the needs of the population. They can be delivered in one-on-one or in small group (up to 20 participants) settings. Each program includes material to support 100 participants.

Wellness Coaching

The Take Care Health Systems Wellness Coaching Program is designed to help clients achieve a lasting lifestyle change in the area of weight, stress, nutrition, exercise, smoking cessation, work/life balance and life satisfaction. All wellness coaching services are 100 percent confidential

and provided by a certified wellness coach. Wellness coaching sessions can be conducted face-to-face or over the phone. During the initial session, the wellness coach and client co-create a wellness plan and set long and short-term goals. This typically takes 60 minutes, but can be broken into two 30-minute sessions to meet the clients' schedule. Follow up sessions focus on goal review and discussion and typically last 30 minutes.

The frequency of sessions is co-determined by the coach and client and is flexible. The County may adjust the frequency of sessions and duration of coaching depending on his coaching needs. A wellness coaching client who is in the process of making a significant lifestyle change can expect to meet with her coach for approximately three to six months, on a weekly or bi-weekly basis. However, clients can continue to meet with the wellness coach until they have reached their intended goals.

Disease Management

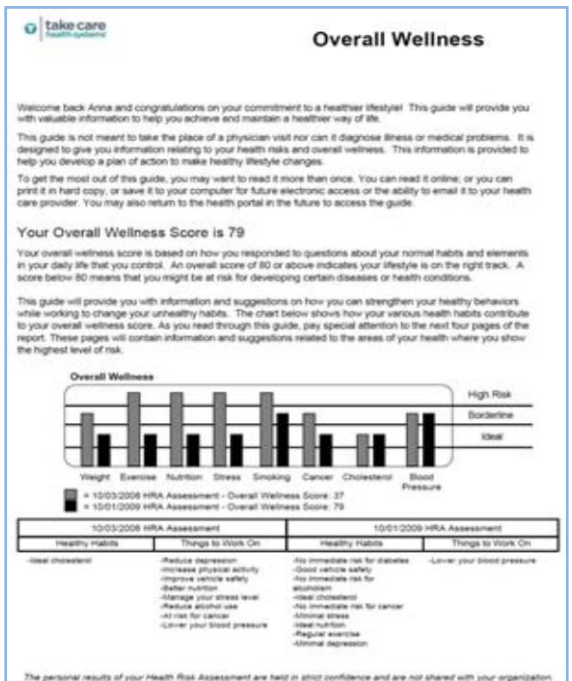
Our Disease Management team conducts case management and clinical care outreach to close care gaps among its patients. Identification of patients at risk with diagnosed disease states occurs during clinic exams, screening events, patient self-report, data warehouse analytics and clinic outreach programs. Our program utilizes a comprehensive database and medical management reporting tool. Individual patients are managed through the use of embedded protocols that guide the interaction and follow progress. Reporting capabilities allow for tracking participant/program progress and staff productivity.

Targeted Diseases

- Type 2 diabetes
- Coronary artery disease
- Heart failure
- Hypertension
- COPD
- Low Back Pain
- Asthma (pediatric & adult)

Identification Opportunities

- Clinic exams
- Screening events
- Patient self-report
- Data warehouse analytics
- Clinic outreach programs



Health Risk Assessment (HRA)

A web or paper based health risk assessment tool in which participants respond to questions about their health history and habits and receive immediate feedback on their health risks. This product enables employers to measure the collective health status of their workforce compared to national goals and averages and identify areas of risk that could be supported by the planning of health benefits and wellness programs and

activities. With the completion of the health risk assessment, the individual is provided with a personalized health report of their individual health status and lifestyle behaviors by risk category.

The report indicates three things: healthy habits and things to work on, recommended actions for minimizing health risks and readiness to change related to health risk behaviors. Individual results are aggregated to provide the client with a collective assessment to gauge the health and readiness to change of their workforce. The TCHS HRA is GINA compliant and includes questions around productivity, presenteeism and use of the healthcare system.

Biometric Screenings

Through health and biometric screenings, employees who are presently high-risk or who may be borderline high-risk for various health conditions can be identified and made aware of their health status. This increased employee awareness helps to create a greater consumer-health focus which is critical in an era of rapidly-increasing medical costs and increased employee cost-sharing. Standard biometric screening measures include: height, weight, fasting blood sugar, total cholesterol, HDL cholesterol, LDL cholesterol, triglycerides and blood pressure. Other screenings are available for an additional fee.

Web Based Health Fair

Take Care Health is redefining the biometric screening data capture process with a web-based Health Fair application. At the point of the screening, the metrics are entered directly into the application versus manually tracking with post event data entry. This process creates efficiencies and reduces the likelihood for errors in the reporting process to the individual and aggregate reporting back to the client. Data sharing is streamlined to TCHS secure servers with capability for custom feeds to approved client vendors, data warehouses and to our Health Risk Assessment and EMR.

We welcome the opportunity to explore each of these unique wellness solutions with the County and to provide further details that address the questions posed above.

~~EXHIBIT B-3~~
(Cancelled Eff. 06/30/2016)
~~PHARMACY AND HEALTH CENTER SERVICES~~

~~TAKE CARE EMPLOYER SOLUTIONS, LLC, a Delaware limited liability company, directly and via its applicable affiliates (collectively, "Take Care"), a wholly-owned subsidiary of Walgreen Co., assists employers by establishing, operating and managing employer-sponsored pharmacies and health centers.~~

~~County owns a facility located at 301 West Jefferson Street, Phoenix, Arizona 85003, and desires to establish an employer-sponsored pharmacy ("Pharmacy") and health center (collectively with the Pharmacy, the "Health Center") at such facility (the "Building").~~

~~Contractor has entered into a subcontractor agreement with Take Care for the provision of dedicated pharmacy and health services at the Health Center to serve the needs of County's employees and such other individuals as mutually agreed to by Take Care and County (collectively, "Participants"). Take Care desires to accept such retention and engagement.~~

~~Pursuant to the terms of this Exhibit B-3, Take Care will provide or arrange for the provision of dedicated pharmacy and health services at the Health Center to serve the needs of the Participants.~~

~~Each of Take Care and County is referred to in this Exhibit B-3 individually as a "Party" and collectively as the "Parties." The Parties agree as follows:~~

~~Section 1 – Engagement.~~

~~1.1 Engagement. In accordance with the terms of this Exhibit B-3, Take Care will provide or arrange for the provision of Services (defined in Section 2.1) to Participants at the Health Center. Take Care accepts such engagement, will perform the Services, and will delegate to an Affiliated PC (defined in Section 1.2) the responsibility to perform those Services that are considered to be the practice of medicine. Take Care will provide certain of the Services through Take Care's affiliates, which Services will be provided in accordance with Take Care's standard policies and procedures. References to Take Care in this Exhibit B-3 shall include, where applicable, Take Care's affiliates.~~

~~1.2 Affiliated PC. An "Affiliated PC" means a professional corporation duly qualified in the state where the Health Center is located with which Take Care maintains a services agreement. Notwithstanding any restriction on subcontracting set forth in the Contract, the Parties acknowledge and agree that Take Care may, in its sole discretion, delegate to the Affiliated PC its obligation to perform certain of the Services because Take Care does not engage in the practice of medicine and nothing in this Exhibit B-3 should be construed to the contrary. The Affiliated PC will be controlled by a licensed physician as required by the law of the state in which the Health Center is located. When this Exhibit B-3 refers to "Take Care," the reference includes, as appropriate, the Affiliated PC.~~

~~Section 2 – Take Care Services and Health Center Implementation.~~

~~2.1 Services. In consideration of the compensation set forth in Section 4, Take Care will provide to County and Participants the services, staffing, supplies and equipment described in this Exhibit B-3 and Attachment B-3-A attached to this Exhibit B-3 and incorporated herein (collectively, the "Services"). The Services will be consistent with the generally accepted standards established in the community within which the Health Center is located. County agrees that Take Care will have sole authority regarding clinical decisions and operations. Take Care will undertake implementation activities in order to operate the Health Center. Subject to completion of the build-out of the Health Center and other implementation activities contemplated herein, and provided all required licenses and permits have been obtained, Take Care will commence the Services on or about July 1, 2012.~~

~~2.2 Implementation Items. Prior to the conversion of worksite operations at the Health Center, if practicable, Take Care will purchase for the Health Center, as applicable: (a) the items required for the Health Center to commence operations as described in Section 3 and detailed in the Budget (defined in Section 4.7), and (b) all other stock items, including pharmaceuticals and supplies, if applicable, initially required for the converted Health Center to commence operations. These items are referred to as "Implementation Items." Take Care will provide to County price estimates for the Implementation Items and will obtain County's written approval prior to~~

~~purchasing the Implementation Items. Upon payment for the Implementation Items in accordance with Section 4, and except for pharmaceuticals provided by the Pharmacy, County will be the owner of the Implementation Items. Each of the Parties will use its reasonable efforts to determine the final Implementation Items 90 days prior to the commencement of operations at the Health Center.~~

~~2.3 Additional Services, Equipment and Supplies. With County's prior written consent, which County will not unreasonably withhold or delay, Take Care will provide or secure any additional services, equipment and supplies which do not fall within the definition of Services but are (a) reasonably necessary to deliver the Services and operate the Health Center or (b) desired by the County. These additional services, equipment and supplies are referred to as "Additional Items and Services." County will reimburse Take Care for costs associated with Additional Items and Services in accordance with Section 4 and, upon such reimbursement, will be the owner of such equipment and supplies.~~

~~2.4 Take Care Personnel. Take Care will provide the Services utilizing the personnel described on Attachment B-3-A ("Take Care Personnel"). In Take Care's discretion, Take Care Personnel will be employed or contracted by Take Care or the Affiliated PC. Upon County's request, Take Care shall perform a background check on Take Care Personnel pursuant to Take Care's policies and procedures. If required by applicable rule, law or regulation, each of the Take Care Personnel will be duly licensed or certified in the state in which such individual is rendering Services under this Exhibit B-3. In addition, if required in Take Care's reasonable judgment, Take Care will cause Take Care Personnel that are physicians to obtain and maintain local hospital privileges. The Parties acknowledge and agree that in no event will County exercise control and/or management over the employment, discharge, compensation and/or working conditions of any Take Care Personnel.~~

~~2.5 Information Systems. Take Care will provide its standard software applications and systems support required to deliver the Services. Such software and applications are the property of their respective owners, and this Exhibit B-3 does not constitute a license for County to use such software and applications. County will be responsible for all network connection and service costs. In order to keep current with evolving technologies, Take Care may, in its discretion, upgrade and/or make changes to the software platform and hardware utilized at the Health Center. Costs associated with such upgrades and changes shall be the responsibility of County unless otherwise mutually agreed to by the Parties. Take Care shall review any such charges with County in advance to obtain the County's approval.~~

~~2.6 Legal Compliance. Each Party will comply with all applicable federal, state and local laws, statutes, regulations, and ordinances including labor laws; laws applicable to handling, storage and dispensing of pharmaceuticals; and laws about the disposal of medical waste and expired or unusable drugs.~~

~~2.7 Filings and Applications. Each Party will cooperate fully with the other Party in furnishing any necessary information required in connection with the preparation, distribution and filing of any filings, applications and notices which may be required by any federal, state and local government or regulatory agencies relating to the operation of the Health Center.~~

~~2.8 Reports. Take Care will furnish County with quarterly reports regarding the Health Center in accordance with Attachment B-3-A.~~

~~2.9 Co-Pays and Third Party Billing.~~

~~(a) Co-Pays. If mutually agreed to by the Parties, Take Care will determine each Participant's type of insurance coverage and will either collect the appropriate co-payment in advance for Participants who are covered by a medical plan that requires a co-payment or bill Participants who are covered by medical plans that require co-insurance and/or deductibles.~~

~~(b) Third Party Billing. If applicable, and upon terms as mutually agreed to by the Parties, Take Care will bill any applicable third-party payor for the Services received by Participants at the Health Center in accordance with the applicable network agreement between Take Care and the third-party payor.~~

~~(c) All monies collected by Take Care pursuant to subsections (a) and (b) above will be credited to Contractor, which Contractor will credit to County, less any mutually agreed upon processing fees charged by Take Care.~~

~~Section 3 – Health Center Operations and Other Matters.~~

~~3.1 Health Center Premises.~~

~~(a) County will make available, without charge to Take Care, suitable premises (the "Premises") for the location of the Health Center and the delivery of the Services. County will ensure, without charge to Take Care, that the Premises are acceptable for their intended use, meet all applicable zoning ordinances, occupancy rules, and similar rules, ordinances, orders and laws, and are secure and meet Take Care's specifications, which specifications may include Health Center size, location and lay-out. County will grant Take Care an exclusive license to occupy the Premises for the purpose of operating the Health Center pursuant to the terms and conditions stated herein. With respect to the Premises for the Pharmacy, County shall deliver possession of such Premises to Take Care no later than July 1, 2012. Upon delivery of possession of the Premises for the Pharmacy and the Health Center, the Premises shall be in good condition and repair, properly zoned for Take Care's intended use of the Premises as contemplated by this Exhibit B-3, free of any Hazardous Substances (defined below), and free of any tenancies or other occupants. County represents and warrants that Take Care Personnel will have a non-exclusive license to access the Premises, and restrooms, hallways, doorways, accessways, parking areas, receiving and/or delivery areas and any other common areas in or near the Premises. County hereby represents that (i) County holds fee simple title to the Building (including the Premises); (ii) has the full right, power and authority, without the consent or approval of any other party, to grant Take Care the right to use the Premises for the purposes herein stated; and (iii) there are currently no restrictions or other encumbrances affecting the Premises that would limit, prohibit or otherwise restrict Take Care's intended use of the Premises.~~

~~(b) County represents that it has no knowledge concerning any current or previous use of the Premises which would lead a reasonable person to suspect that Hazardous Substances (as defined below) were deposited, stored, released, disposed of or placed upon, about or under the Premises. In order to make the foregoing representation, County states that it has made due inquiry or investigation as appropriate. County shall grant Take Care and its environmental engineer access to any future Premises prior to delivery of possession for the purpose of conducting an environmental site assessment and asbestos survey (collectively, the "Environmental Report"), determining the presence of any Hazardous Substances located in, on or under any future Premises. In the event the Environmental Report discloses the existence of any Hazardous Substances in, on or under any future Premises (or in the event any Hazardous Substances are otherwise discovered), County shall, at County's sole cost and expense, properly remove and dispose of any such Hazardous Substances and remediate such future Premises. In such event, the date for providing the Services shall be extended for a period equal to the delay caused by such disposal, removal and remediation. Any such disposal, removal and remediation required hereunder shall be conducted in accordance with all applicable Environmental Laws.~~

~~(i) "Hazardous Substances" shall mean any hazardous or toxic chemical, waste, byproduct, pollutant, contaminant, compound, product or substance, including, without limitation, asbestos, polychlorinated biphenyls, petroleum (including crude oil or any fraction or by-product thereof), underground storage tanks, and any material the exposure to, or manufacture, possession, presence, use, generation, storage, transportation, treatment, release, disposal, abatement, cleanup, removal, remediation or handling of which is prohibited, controlled or regulated by any Environmental Law.~~

~~(ii) "Environmental Law" shall mean any federal, state, regional, county or local governmental statute, law, regulation, ordinance, order or code or any consent decree, judgment, permit, license, code, covenant, deed restriction, common law, or other requirement presently in effect or hereafter created, issued or adopted, pertaining to protection of the environment, health or safety of persons, natural resources, conservation, wildlife, waste management, and pollution (including, without limitation, regulation of releases and disposals to air, land, water and ground water), including, without limitation, the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended by the Superfund Amendments and Reauthorization Act of 1986, 42 U.S.C. 9601 et seq., Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act of 1976 and Solid and Hazardous Waste Amendments of 1984, 42 U.S.C. 6901 et seq., Federal Water Pollution Control Act, as amended by the Clean Water Act of 1977, 33 U.S.C. 1251 et seq., Clean Air Act of 1966, as amended, 42 U.S.C. 7401 et seq., Toxic Substances Control Act of 1976, 15 U.S.C. 2601 et seq., Occupational Safety and Health Act of 1970, as amended, 29 U.S.C. 651 et seq., Emergency Planning and Community Right to Know Act of 1986, 42 U.S.C. 11001 et seq., National Environmental Policy Act of 1975, 42 U.S.C. 300(f) et seq., and all amendments as well as any similar state or local statute or code and replacements of any of the same and rules, regulations, guidance documents and publications promulgated thereunder.~~

~~3.2 Health Center Maintenance. County will, without charge to Take Care, maintain the Health Center and Building in good repair and working order, including their interior, exterior, structure and roof. County will, without charge to Take Care, provide all other items and services of a non-medical nature reasonably necessary to operate the Health Center including office furniture, environmental (including medical waste) and janitorial services of common areas and exam rooms, computer networking connections, and utilities such as electricity, water, heat, plumbing, and air conditioning, all in accordance with Take Care's specifications. Janitorial services will include daily cleaning services of common areas and exam rooms reasonably acceptable to Take Care under standards applicable to similar medical and pharmacy facilities. In addition, County will, without charge to Take Care, maintain all buildings and surrounding areas in a tenantable and safe condition, free of debris, ice, and snow.~~

~~3.3 Health Center Operations. The Parties agree that the Health Center will be open for operation in accordance with the hours of operation as set forth on Attachment B-3-A; provided, however, that the Health Center will be closed on all federal holidays as well as those holidays established in accordance with County's human resources policies, which County will notify Take Care of in writing prior to the commencement of operations at the Health Center.~~

~~3.4 Refusal to Provide Services. County acknowledges and agrees that Take Care may withhold Services to any Participant for good cause, including but not necessarily limited to, requests by a Participant for quantities of drugs in excess of prescribed quantities or refill limitations or where, in the professional judgment of the pharmacists, physician or other health care professional, Services should not be provided. Take Care reserves the right to discontinue the provision of Services to any Participant who is disruptive or poses a threat to Take Care Personnel or other Participants.~~

~~3.5 Data Delivery. For Take Care to properly deliver the Services, Take Care must have, and County will ensure that Take Care is furnished with, continuous access to, among other things, data about the Participants as necessary for Take Care to render the Services, all in accordance with the information systems and technology services schedule attached as Attachment B-3-A-I to Attachment B-3-A of this Exhibit B-3. With respect to the Pharmacy, County will ensure that Take Care receives Participant enrollment and benefit coverage information including, but not necessarily limited to, Participant co-payments, deductible limits, covered drugs, days' supply, and participating physicians (including any updates, deletions, or additions to the foregoing within 15 days of such updates, deletions or additions). This information will be transmitted to Take Care at the time of dispensing through the on-line electronic transmission link maintained between County or its prescription drug benefit manager ("PBM") and Take Care ("On-Line System"). Take Care will use this information to determine a Participant's eligibility and prescription benefit coverage at the time of dispensing. County is solely responsible for the accuracy, completeness, reliability, and timeliness of all information provided to Take Care, and any omissions or errors in the information are the sole responsibility of County. When applicable, County will provide Take Care with hard-edit messages to block the dispensing of generic medications that cost Participants higher co-payments than the brand name medications. County shall provide to Take Care, on a quarterly basis and in a format designated by Take Care, full medical and pharmacy claims data with respect to County's eligible population, subject to applicable law, to enable Take Care to report on cost savings and undertake other analyses in connection with the Health Center.~~

~~3.6 Eligibility. County shall ensure that Take Care is a participating provider in every County health plan and PBM retail network, as applicable, covering the Participants. County agrees to implement and/or provide Participants with co-payment incentives to encourage the purchase of prescription products and pharmacy services at the Pharmacy, except with respect to prescription products and pharmacy services furnished to a Participant which are covered by a Federal health care program, as that term is defined at 42 U.S.C. §1320a-7b(f), in which case County will not furnish any such copayment incentives. All prescription products covered by County's health plans shall be adjudicated at the prices and co-payments determined by County and communicated to Take Care at the time of dispensing via the On-Line System. Take Care may charge Participants who are not enrolled in County's health plans or PBM retail networks but enrolled in other health plans at the rates set forth in Take Care's contracts with such health plans or PBM retail networks, if applicable. If a Participant receives a prescription product and is not enrolled in a health plan or PBM retail network for which Take Care is a participating provider, then Take Care shall be permitted to charge that Participant Take Care's usual and customary fee for such prescription product and require the Participant to pay the fee at the point of sale. County agrees that such actions by Take Care shall not be cause for termination of this Exhibit B-3 by County.~~

~~3.7 Pharmaceutical Contracts. Take Care contracts directly with pharmaceutical manufacturers and suppliers to purchase pharmaceuticals. County may not request or demand Take Care take any action, including~~

~~adjust any drug formulary or agree to any pharmacy benefit management contract term, that would violate or breach Take Care's agreements with pharmaceutical manufacturers and suppliers. Take Care will own all pharmaceuticals and OTC Supplies (defined in Section 4.4) to be dispensed at the Health Center.~~

~~Section 4 – Compensation and Other Matters.~~

~~4.1 Implementation Items. County must pay Take Care's invoiced cost of the Implementation Items. Pursuant to the Budget (defined in Section 4.7) Take Care will bill such costs monthly, as incurred, and County must pay the invoice for the Implementation Items within 30 days of the invoice date. The implementation management fee associated with any implementation services (the "Implementation Management Fee") will be included in the invoices for any Implementation Items or other mutually agreed upon implementation fees.~~

~~4.2 Fees.~~

~~(a) County will pay to Contractor and Contractor will pay to Take Care:~~

~~(i) The "Take Care Personnel Expense," which includes the wages, salaries and benefits for Take Care Personnel, whether they are Take Care employees or independent contractors.~~

~~(ii) The base annual management fee (the "Management Fee"), which, in each year, will be equal to 9% of the total amount of Take Care Personnel Expense for the applicable year.~~

~~(iii) The G&A (general and administrative) expenses applicable to operating the Health Center, which, in each year, will be equal to 21% of the total amount of Take Care Personnel Expense for the applicable year.~~

~~(iv) Operating costs, including all other costs of Take Care to operate the Health Center. Operating costs include, but are not limited to, pharmacy, medical and office supplies utilized at the Health Center, travel expenses, janitorial services to common areas and exam rooms, waste removal, and phones, as set forth in the Budget.~~

~~4.3 Additional Items and Services. County must pay for all agreed upon Additional Items and Services provided by Take Care. Take Care will invoice to Contractor and Contractor will invoice to County for Additional Items and Services monthly, and County must pay to Contractor, and Contractor will pay to Take Care the amount due within 30 days of the invoice date.~~

~~4.4 Pharmaceutical Costs.~~

~~(a) Take Care will be responsible for providing any over the counter drugs and supplies ("OTC Supplies") at the Health Center, and County will be responsible for reimbursing Take Care for any such OTC Supplies in accordance with the terms set forth in this Exhibit B-3.~~

~~(b) The cost of pharmaceuticals dispensed at the Pharmacy will be determined as follows:~~

~~(i) For Brand Name Drugs and Generic Drugs, Take Care will charge County a price set forth in a price table generated by Take Care, which table shall indicate Take Care's net acquisition cost.~~

~~(ii) For all other pharmaceuticals, including OTC Supplies, Take Care will charge the County Take Care's net acquisition cost.~~

~~4.5 Taxes. County is solely responsible for payment of any wholesale distributor Tax (defined herein) or any other excise or value added Tax or governmentally instituted imposition however styled if based upon purchases at wholesale or prescriptions dispensed to Participants. County also will reimburse Take Care any applicable federal, state or local sales Tax liability or liability for governmental impositions based upon the sales of prescriptions dispensed (including prescription over the counter medications) or goods and services provided by~~

~~Take Care to County or Participants. "Tax" means any sales tax, imposition, assessment, excise tax or other government levied amount based on Take Care's sale of prescriptions to Participants either on gross revenues or by transaction, whether such tax is designated a sales tax, gross receipts tax, retail occupation tax, value added tax, health care provider tax, transaction privilege tax, assessment, pharmacy user fee, or charge otherwise titled or styled. It includes any tax in existence or hereafter created whether or not the bearer of the tax is the retailer or consumer. Take Care shall be responsible for collecting and remitting all retail Sales Tax at the time of sale.~~

~~4.6 Insurance Costs. County must pay all costs of professional liability consistent with the Budget (including the Tail Coverage set forth in Section H of Schedule B-3-5.1) reasonably required and evidenced to the sole satisfaction of the County to operate the Health Center. Take Care will invoice County for all insurance costs and County must pay such amount within 30 days of the invoice date.~~

~~4.7 Budget. A detailed description of the projected expenses relating to the implementation of the Pharmacy is attached as Exhibit B-3-B(i) to this Agreement and incorporated herein (the "Implementation Budget"). A detailed description of the projected expenses relating to the operation of the Pharmacy and the Health Center are attached as Exhibit B-3-B(ii) and Exhibit B-3-B(iii), respectively, to this Agreement and incorporated herein (the "Operating Budget" and, collectively with the Implementation Budget, the "Budget"), with the final Operating Budget to be mutually determined by the Parties, working diligently in good faith, after the commencement of operations at the Health Center. The projected expenses are based upon estimated utilization of the Health Center and incorporate certain reasonable assumptions. In the event Participant count and/or utilization of the Health Facility exceeds estimated utilization, Take Care and County will work in good faith to jointly reevaluate the Budget. The Parties will agree upon the revised Management Fee, Take Care Personnel Expense, operating costs, and G&A expenses for the upcoming contract year at least 60 days prior to the beginning of each contract year following the first full contract year. If the Parties have not agreed by the beginning of each contract year on the revised Management Fee, Take Care Personnel Expense, operating costs, and G&A expenses, then each category of expense will increase by a maximum of 10%, which will constitute the budget for that contract year.~~

~~Section 5 – Insurance and Indemnification.~~

~~5.1 Insurance. Take Care shall not be required to maintain the insurance set forth in Section 6.2 of the Contract; instead, the Parties shall procure and maintain insurance as set forth in the attached Schedule B-3-5.1.~~

~~5.2 County Indemnity. County will indemnify and defend Take Care and Take Care's parents, subsidiaries, other affiliates, and their respective officers, directors, trustees, employees, agents, contractors or other representatives (collectively, the "Take Care Parties") from any actual or threatened legal or administrative action, claim, liability, penalty, fine, assessment, lawsuit, litigation, or other loss, expense, or damage, including without limitation reasonable attorneys' fees and costs (together, "Liability"), brought or otherwise claimed by a third party that Take Care or the Take Care Parties may incur directly or indirectly resulting from or based upon (a) any negligent act, error, mistake, or omission of County or County's parents, subsidiaries, other affiliates, and their respective officers, directors, trustees, employees, agents, contractors or other representatives (collectively, the "County Parties"); provided, however, that County will not be required to indemnify or defend Take Care or the Take Care Parties for any negligent act, error, mistake, or omission of Take Care or the Take Care Parties that, independent of any negligent act, error, mistake, or omission of County or the County Parties, gives rise to Liability; (b) the condition of the Health Center, including without limitation, environmental liabilities; (c) the physical condition and security of the Health Center or equipment provided by County or the County Parties; (d) any alleged breach of confidentiality by County or the County Parties that results from County's or the County Parties' access to Participants' medical records and unauthorized or illegal publication by County or the County Parties of information contained in the Participants' medical records; (e) application by County or the County Parties of their human resources policies; (f) denial of prescription benefit coverage whether by omission, decision or design; and (g) County's breach of any representation or warranty set forth in this Exhibit B-3.~~

~~5.3 Take Care Indemnity. Take Care will indemnify and defend County and the County Parties from any Liability brought or otherwise claimed by a third party that County or the County Parties may incur directly or indirectly resulting from or based upon any negligent act, error, mistake, or omission of Take Care or the Take Care Parties; provided, however, that Take Care will not be required to indemnify or defend County or the County Parties for any negligent act, error, mistake, or omission of County or the County Parties that, independent of any negligent act, error, mistake, or omission of Take Care or the Take Care Parties, gives rise to Liability.~~

~~5.4 Indemnity Procedure.~~

~~(a) If any action or proceeding is brought against a Party, or such Party receives a notice of a claim, for which action, proceeding or claim such Party (the "Indemnified Party") may seek indemnity under this Exhibit B-3 from the other Party (the "Indemnifying Party"), the Indemnified Party will promptly deliver written notice of such action, proceeding or claim to the Indemnifying Party (the "Indemnification Notice"). Failure to deliver the Indemnification Notice to the Indemnifying Party will not relieve the Indemnifying Party from its indemnification obligation under this Exhibit B-3, except (i) to the extent that the Indemnifying Party is prejudiced by such failure to deliver notice and (ii) the Indemnifying Party will not indemnify the Indemnified Party for any legal expenses and costs incurred by the Indemnified Party before the Indemnified Party delivers the Indemnification Notice.~~

~~(b) The Indemnifying Party may undertake, directly or through its insurer, the defense of any such action, proceeding or claim, and may contest or, settle such action, proceeding or claim on such terms as the Indemnifying Party may choose. The Indemnifying Party will deliver notice of intent to defend in whole or in part to the Indemnified Party within 60 days after receipt of the Indemnification Notice. If the Indemnifying Party or its insurer undertakes such defense, such defense will be conducted by attorneys retained by the Indemnifying Party or the insurer at the Indemnifying Party's or its insurer's cost and expense. The Indemnified Party, however, may participate in such proceedings through attorneys of its own choosing and at its own expense.~~

~~Section 6 – Records; Confidentiality; Policies and Procedures.~~

~~6.1 Medical and Pharmacy Records.~~

~~(a) Incidental to the rendering of Services under the terms and conditions of this Exhibit B-3, Take Care and the Affiliated PC will generate documentation, records, and reports necessary to render the Services.~~

~~(b) Take Care will maintain medical and pharmacy records in compliance with all applicable laws, rules and regulations, as may be amended from time to time, concerning the maintenance and confidentiality of such records. Notwithstanding Section 6.19 of the Contract, Medical records will be released to County solely in accordance with requirements of state and federal law and regulations, and County will maintain the confidentiality of any medical record released to it. All prescription records concerning Participants shall be the property of Take Care.~~

~~6.2 Confidential Information.~~

~~(a) Confidential information with respect to either Party means trade secrets, internal business practices, processes, plans, goals, strategies, software systems, protocols, policies, procedures, customers, employees, business partners, finances, any other written information marked "Confidential."~~

~~(b) Each Party agrees that (i) it will use its best efforts to keep secret and will not, directly or indirectly, use, except as provided herein, or disclose any confidential information of the other Party that it acquires from, or is afforded access to by, the other Party during the performance under this Exhibit B-3, except as authorized by the other Party in writing prior to such disclosure; (ii) it will exercise all reasonable efforts to prevent third parties from gaining access to confidential information of the other Party; (iii) it will not use or copy any confidential information of the other Party for itself or for any person except for the purpose of its performance under this Exhibit B-3; and (iv) unless otherwise agreed by the Parties, it will, at the option of the other Party, destroy or return to the owner thereof all documents, materials and other tangible items containing confidential information of the other Party (and all copies thereof) upon termination of this Exhibit B-3.~~

~~(c) Confidential information does not include any information which (i) at the time of the disclosure is already known to the recipient other than by way of prior disclosure under a confidentiality agreement; (ii) has been lawfully acquired by the recipient from a third party without violating the terms of this Exhibit B-3 or any provision of applicable law or has been independently developed by the recipient; (iii) is required to be disclosed pursuant to judicial or administrative process in connection with any action, suit, proceeding or claim or otherwise by applicable law (but only to the extent so required to be disclosed); provided, however, that the Party required to disclose such information will give the other Party whose information is proposed to be disclosed as much advance notice of such disclosure as possible; (iv) is or becomes available in issued patents, published patent~~

~~applications or printed publications of general public circulation other than by violation of this Exhibit B-3; or (v) is generally disclosed by the disclosing party to the public without restriction.~~

~~6.3 Confidentiality of Protected Health Information. The Parties hereto will comply with all applicable requirements and obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which governs any uses and disclosures of pharmacy, medical, and other individually identifiable health information specifically relating to Participants ("Protected Health Information" or "PHI") that may occur as a result of this Exhibit B-3. Both Parties warrant that they will maintain and protect the confidentiality of all PHI in accordance with the applicable requirements and obligations under HIPAA and all applicable federal and state laws and regulations. However, nothing herein will limit either Party's use of any aggregated patient information that does not contain or constitute PHI.~~

~~6.4 Policies and Procedures. In order to assure adequate and knowledgeable performance under this Exhibit B-3, County will provide Take Care with access to County's policies and procedures insofar as they relate to the Health Center and the Services. County acknowledges that Take Care's performance under this Exhibit B-3 will be inhibited if County does not provide Take Care with all applicable policies and procedures insofar as they relate to the Health Center and the Services.~~

~~6.5 Hazard Communications. Within a reasonable time period from the commencement of operations at the Health Center, County must provide to all on-site Take Care Personnel providing health services the hazard communication training, if any, required, by applicable law.~~

~~Section 7 – Performance by Take Care Personnel.~~

~~7.1 Nothing contained in this Exhibit B-3 is deemed to create a relationship of master/servant, employer/employee, partnership or joint venture between County and Take Care or between County and any Take Care Personnel.~~

~~7.2 Take Care is solely responsible for hiring and training its employees, and, to the extent necessary, training subcontractors and, therefore, all such persons are or will be the employees or subcontractors of Take Care. None of Take Care Personnel will be directly or indirectly employed by County and they will not be deemed to be employees or agents of County for any purpose whatsoever.~~

~~7.3 County does not have the right of control over the specific manner of performance of Take Care Personnel's duties hereunder. The right of control over the specific manner of performance of such duties is vested entirely in Take Care, except where the scope of professional practice is concerned, in which case control is vested in the appropriate Take Care Personnel.~~

~~Section 8 – Press Releases and Use of Names; Marketing.~~

~~8.1 Press Releases, Use of Names. Subject to the restrictions provided in this Section, each Party will have the right to issue press releases regarding this Exhibit B-3 to local, national and trade publications. In addition, each Party will have the right to identify the relationship in sales and promotional activities, including listing County in a list of clients. Any information disclosed by either Party to the public that references the other Party as contemplated in this Section will require that Party's prior approval.~~

~~8.2 Marketing Plan. Take Care and County agree that they will work together in good faith to develop a marketing plan that will increase awareness of the Health Center among Participants. County agrees to make available to Take Care, without charge, certain existing intracompany communications vehicles to communicate messages and/or print advertisements about the Health Center. These communication vehicles will include, but are not limited to, newsletters, direct mailings, payroll insertions and internal postings. Such advertisements and messages will appear in the communications vehicles as often as deemed reasonably necessary by the Parties to support the Health Center. In addition, County will accurately describe and represent the role of Take Care in providing the Services in all communications, including marketing and advertising materials to Participants.~~

~~Section 9 – Force Majeure. Neither Party will be deemed to be in default of this Exhibit B-3 if prevented from performing any obligation hereunder for any reason beyond its control, including but not limited to, acts of God, war, civil commotion, fire, flood or casualty, shortages of or inability to obtain labor, materials or equipment, governmental regulations or restrictions, or unusually severe weather. In any such case, the Parties agree to negotiate~~

~~in good faith with the goal of preserving this Exhibit B-3 and the respective rights and obligations of the Parties hereunder to the extent reasonably practicable. It is agreed that financial inability will not be deemed to be a matter beyond a Party's control.~~

~~Section 10 – Exclusivity and Non-Solicitation.~~

~~10.1 Exclusive Provider. Take Care has the exclusive right and authority to provide the Services to County for County's administrative Building located at 301 West Jefferson Phoenix AZ. 85003.~~

~~10.2 Non-Solicitation. Except with the prior written consent of Take Care or its affiliates or subcontractors, as applicable, during the term of the Agreement and for one year thereafter, County, its affiliates and vendors will not solicit the employment of or employ any current or former Take Care Personnel for medical clinic or pharmacy purposes.~~

~~10.3 Placement Fee. If County, its affiliates or vendors employs any individual in violation of Section 10.2, County will pay Take Care a placement fee equal to such individual's annual gross compensation for the first year in the new position. County will pay Take Care the fee set forth in this Section within 30 days after commencement of employment of the individual with County or its affiliates or vendors, as applicable.~~

~~Section 11 – Miscellaneous.~~

~~11.1 Integration and Amendment. This Exhibit B-3, as may be amended from time to time, and any exhibit or other attachment to this Exhibit B-3 represent the entire understanding of Take Care and County with respect to the subject matter hereof and supersede all prior negotiations, understandings, agreements and representations, including any confidentiality or non-disclosure agreement entered into between the Parties related to the subject matter hereof. This Exhibit B-3 will also control over any supplemental or inconsistent terms or conditions contained in or attached to any purchase order.~~

~~11.2 Successors and Assigns.~~

~~(a) This Exhibit B-3 and the rights and obligations of the Parties may not be assigned, nor the duties hereunder delegated, by either Party without prior written consent of the other, which consent will not be unreasonably withheld or delayed, and any attempt to do so will be null, void and of no force of effect, except that Take Care may assign its rights and delegate its obligations hereunder to its parent corporation or another subsidiary of its parent corporation without the prior written consent of County.~~

~~(b) Except as provided herein to the contrary, this Exhibit B-3 is binding upon and inures to the benefit of the Parties, their respective successors and permitted assigns.~~

~~11.3 Waiver of Default or Breach. No waiver by either Take Care or County of any default or breach of this Exhibit B-3 operates as a waiver of any future default or breach, whether of like or different character or nature.~~

~~11.4 Survival. Sections 5, 6.1, 6.2, 6.3, 10, and 11 will survive termination of this Exhibit B-3.~~

~~11.5 Severability. In the event that any one or more of the provisions contained in this Exhibit B-3 is for any reason held to be invalid, illegal or unenforceable in any respect, the invalidity, illegality or unenforceability of the provision will not affect any other provision hereof.~~

~~11.6 No Consequential or Punitive Damages. BOTH PARTIES SPECIFICALLY AGREE THAT NO CONSEQUENTIAL, INCIDENTAL, SPECIAL OR PUNITIVE DAMAGES MAY BE AWARDED AS A RESULT OF ANY BREACH OF THIS EXHIBIT B-3 OR THE RELATIONSHIP COVERED BY THIS EXHIBIT B-3 AND EACH WAIVES ITS RIGHTS THERETO. Both Parties understand and agree that recovery by Take Care of the Management Fee payable under the terms of this Exhibit B-3 represents direct damages not excluded by this Section.~~

ATTACHMENT B-3-A

HEALTH CENTER SERVICES AND OPERATIONS

Take Care and its Affiliated PCs will provide the services described in this Statement of Work (the **"Services"**) at the Health Center.

I. Program Implementation.

Take Care will lead the implementation process for any new or additional services with input from Client. Where applicable, Take Care will provide a detailed project plan to include deliverables and due dates for Client consideration.

II. Program Management.

a. **Take Care Corporate Personnel**. Take Care will provide the following corporate personnel to support the Services at the Health Center (the **"Corporate Personnel"**). For clarity, Corporate Personnel are not included within the definition of Take Care Personnel and are not billable.

i. Client Services Director. Take Care's designated Strategic Account Executive (the **"SAE"**) will be responsible for ensuring the Services are meeting Client's goals and objectives and will coordinate any new or additional services. The CSD will be supported by Take Care's Vice President, Client Services.

ii. Director of Site Operations. Take Care's designated Director of Site Operations (the **"DSO"**) will be responsible for the coordination, implementation, and day to day delivery of the on-site health, wellness, and medical initiatives. The DSO will be supported by Take Care's Regional Vice President.

iii. Regional Medical Director. Take Care's designated Regional Medical Director (the "**RMD**") will provide clinical oversight and periodic consultation with the Health Center physician. The Regional Medical Director will be supported by Take Care's Corporate Medical Director.

b. **Management Oversight**. The Corporate Personnel will provide the following:

(i) Overall responsibility of Services provided at the Health Center

(ii) Oversight of daily operations for the Health Center.

(iii) Oversight of all aspects of the hiring, retaining, training and certifying, as applicable, of the Take Care Personnel at the Health Center.

(iv) Participation in regularly scheduled reviews of financial and operational performance with Client.

(v) Assuring completion of applicable continuing education for the Take Care Personnel at the Health Center regarding medical, nursing, and other professionally related health issues.

(vi) Performance of periodic performance reviews of the Take Care Personnel at the Health Center.

(vii) Periodic, on-site visits to perform quality assurance reviews of all healthcare services and ensure these services adhere to Take Care's policies and procedures.

III. Services

a. **Participants**. Take Care will provide the Services described in this Statement of Work to the following Participants:

(i) Employees of County who are members of a County's benefit plan.
(ii) Dependents of County employees who are members of a County's benefit plan.
(iii) Retirees of County who are members of a County's benefit plan.
(iv) Certain other individuals or groups that the County has determined to receive services. Notwithstanding the foregoing, County agrees to work in good faith and revise the budget as necessary in the event Take Care determines that the current budget will not reasonably support the individuals or groups that the County desires to receive Services pursuant to this Statement of Work.

b. **On-site Health Services.** Take Care will provide the following Services during the regular operating hours of the Health Center as set forth in Article VIII, below.

(i) **Emergency Services.** Take Care will attempt to stabilize a patient that has a life threatening condition and either treat or arrange for emergency transport for the patient to the nearest hospital. The scope of care may include basic life support measures with the use of an automated external defibrillator and/or appropriate treatment within the skill set of the Take Care Personnel. Take Care will notify Client of all emergencies requiring any patients transfer to a hospital, as permitted by applicable law.

(ii) **Laboratory Services.** The Health Center will operate as a CLIA-waived laboratory. CLIA waived testing includes, but is not limited to urine dip, hematocrit, pregnancy, rapid strep, glucose monitoring, PT/INR.

Laboratory services are provided following a physician or other licensed health care provider's order. Collection and testing of samples can be performed regardless if the ordering provider is providing health care services through the Health Center or is a provider in the surrounding community. If laboratory testing is performed at the direction of a provider in the surrounding community, then the test results will be sent directly to the community provider from the reference laboratory.

For all non-waived testing, the Health Center will act as a collection station only. Take Care will contract directly with a national reference laboratory for testing services. Billing for testing services will be conducted by the laboratory through the patient's health insurance plans.

(iii) **Wellness Coaching/ Coordination Services.** Wellness services include the following services:

- Deliver Health Risk Assessments.
- Deliver biometric screenings (delivery outside of the Health Center). Delivery model and potential supporting vendor to be determined and mutually agreed upon between Take Care and Client.
- Review online Health Risk Assessment (HRA) and health screening results with patients.
- Access health needs, including readiness for change.
- Provide face-to-face health risk consultation on primary prevention, lifestyle behavior risks (e.g., smoking cessation, hypercholesterolemia, weight management, and stress), compliance with treatment plans, and closing gaps in care.
- Teach classes, facilitate group activities, and conduct other health promotion outreach as mutually agreed upon with client.
- Provide sub-specialist referrals.
- Become familiar with and refer Participants to other available services such as telephonic and online disease management and lifestyle behavior coaching, health-

related educational materials, Employee Assistance Program (EAP), social services, network providers.

- Provide general self-care education.
- Provide nutrition counseling and support.

(iv) **Episodic Acute Care.** Episodic Acute Care services are those Health Center Services provided to those Participants whose illness or injuries are minor, non-recurring and are expected to resolve within a limited timeframe. A Participant, whose illness or injuries are outside the scope of services contemplated herein or are chronic in nature, will be referred for treatment to the Participant's primary care physician or a specialty provider, as appropriate. Specific conditions which may be treated at the Health Center include but are not limited to:

Respiratory Illnesses, including but not limited to: Bronchitis, Common Colds, Coughs, Ear Infections, Flu, Laryngitis, Sinus Infections, Sore Throat, Strep Throat, and Upper Respiratory Infections

Additional Treatments including but not limited to: Allergies – Seasonal, Bladder Infections (Female, ages 12-65), Diarrhea, Nausea, and Vomiting, Early Lyme Disease, Fever (<72 hours), Head Lice, Mononucleosis, Pink Eye and Styes, Scalp Rash, Swimmer's Ear, and Swimmer's Itch

Skin Conditions including but not limited to: Acne, Athlete's Foot, Cold Sores, Dry Skin, Impetigo, Itchy Skin, Poison Ivy/Poison Oak, Rashes, Ringworm, Scabies, Shingles, Skin Infections, Sunburn, Tick/Insect Bites, and Wart Evaluation

Diagnostic Testing including but not limited to: PPD/Tuberculosis and Pregnancy

Minor Injuries including but not limited to: Abrasions, Burns (minor), Splinters, Sprains/Strains, and Staple/Suture Removal

(v) **Immunizations.** Immunizations will be administered as supply is available, as covered by County's summary plan description and allowed by state law.

(vi) **Medication Therapy Management ("MTM").** The worksite pharmacy and health center will serve as a primary location for face-to-face consultations on issues like appropriateness of therapy, polypharmacy, compliance and persistency and the proper use of medications by the elderly.

(vii) **Participate in annual County and patient satisfaction survey.**

(viii) **Other Services as mutually agreed upon by County and Health Center.**

c. **Referral Management Program.** The Referral Management Program provides employees/patients the needed medical and specialist referrals to providers within the Client's network/ healthcare plans. The referral management program includes:

- Establishment of an informal specialist referral list, which contains network providers who have demonstrated quality and compliance with follow-up, such as reports, appointment accommodations, etc.
- Health Center criteria for appropriate referrals

d. **Disease Management Program.** Disease Management is an integrated information-based process involving the continuing improvement of all aspects of health care: prevention, treatment, and management. Take Care utilizes a customized diabetes, hypertension and hyperlipidemia Care Plan (flow sheet) to both trigger care where it serves as a reminder to the clinical staff, and to document care. Care includes preventive health, status of the disease through evaluation of symptoms, education, and lab monitoring. The chronic disease states for which comprehensive components exist include the following:

- Asthma
- Diabetes Mellitus
- Hypertension
- Hyperlipidemia

e. **Administrative Manual.** Take Care utilizes its proprietary operating manual to manage all aspects of the Health Center.

g. **Utilization Review.** Take Care manages utilization using a comprehensive approach that includes:

- Providing preventive care as a method to eliminate or reduce the need for treatment of illness/injury
- Providing health education on a one-to-one basis and through screening and other health education programming
- Using therapeutic substitution as appropriate in drug therapy
- Facilitating provider in-hospital follow-up of all inpatient care

Take Care evaluates the effects of its utilization management by collecting data on prescribing practices, use of ancillaries, referral rates, hospitalization rates, and provider productivity and then making comparisons among site providers, among Take Care managed sites, between the site and the community, and against national averages.

IV. Take Care Personnel.

a. **Personnel.** The following Take Care Personnel will provide the Services at the Health Center.

Physician – 0.10 FTE
Nurse Practitioner – 0.00 FTE
NP Health Center MGR – 1.00 FTE
Medical Assistant – 0.00 FTE

b. **Qualifications**. The Take Care Personnel will have the following qualifications:

(i) *Physicians*. Physicians will be licensed to practice medicine, as either an M.D. or a D.O., in the state in which the Health Center is located and be in good standing with all applicable state agencies and regulatory bodies. The physicians will be board certified in Family Medicine or in another primary care specialty, with knowledge of primary care medicine issues.

(ii) *Midlevel Providers*. Midlevel Providers will be licensed in the state in which the Health Center is located and will be in good standing with all applicable state licensing agencies and regulatory bodies. The Midlevel Providers will have experience in occupational medicine, ICU, ER, or community health. The nurses will be CPR and ACLS certified. Evidence of meeting any continuing education requirement is required.

c. **Other Staffing Issues**.

(i) *Vacant Take Care Personnel Staff Positions*. If there is a vacant position of any of the Take Care Personnel, Take Care will assign temporary staff to cover the duties assigned to such vacant position at the current budget year rate. associated with using temporary staffing as appropriate.

(ii) *Short-Term Absences of Take Care Personnel*. In the event of a sickness, vacation or other short-term absence of the Take Care physician or nurse practitioner, Take Care will assign temporary staff to cover the duties assigned to the Take Care Personnel during such personnel's short–term absence in accordance with the established back-fill plan.

(iii) *Off-Site Meetings*. A Party will notify the other Party in advance of any planned Take Care Personnel absences for meetings, seminars, and the like.

V. Budget.

The Services will be provided under the payment terms set forth in the Agreement and based upon the budget attached to the Agreement as Exhibit B.

VI. Reports.

Take Care will provide the following standard reports. Item (i) will be provided monthly. Items (ii) through (x) will be provided quarterly.

(i) Budget-to-actual YTD performance
(ii) Health Center Performance Summary
(ii) Direct Cost Avoidance
(iii) Indirect Cost Avoidance
(iv) Benchmarks, as appropriate
(v) Total Unique Patients (a Unique Patient is a patient who is utilizing the Health Center for the first time in a given period (per month, per quarter, or per year, as applicable)
(vi) Visits
(vii) Top Diagnoses based on performance review criteria
(viii) Labs
(ix) Referrals

VII. Information Systems.

a. Take Care will provide the information systems as described on Attachment 1 to this Exhibit A.

b. In order to keep current with evolving technologies, Take Care may, in its discretion, change the software platform and the hardware at the Health Center. If Take Care reasonably determines that updated hardware is required, then Take Care will provide Client with a budget for Client's review and approval for the purchase of the hardware. Upon payment of the hardware, Client will be the owner of such hardware. If Client does not reimburse Take Care for the hardware, then Take Care will retain ownership of such hardware at all times.

VIII. Hours of Operation.

The Health Center will be open Monday through Friday from 8:00am to 5:00pm. There will be a one hour lunch period during which the Health Center will not be open. Additionally, the Health Center will not be open on holidays or any other day on which the County's building is not open.

ATTACHMENT B-3-B

SCOPE OF SERVICES - PHARMACY

I. General:

Program Implementation.

Take Care will lead the implementation process for any new or additional services with input from Client. Where applicable, Take Care will provide a detailed project plan to include deliverables and due dates for Client consideration.

Program Management.

a. **Take Care Corporate Personnel**. Take Care will provide the following corporate personnel to support the Services at the Pharmacy (the **"Corporate Personnel"**). For clarity, Corporate Personnel are not included within the definition of Take Care Personnel and are not billable.

(i) Client Services Director. Take Care's designated Strategic Account Executive (the **"SAE"**) will be responsible for ensuring the Services are meeting Client's goals and objectives and will coordinate any new or additional services. The CSD will be supported by Take Care's Vice President, Client Services.

(ii) Director of Site Operations. Take Care's designated Director of Site Operations (the **"DSO"**) will be responsible for the coordination, implementation, and day to day delivery of the on-site health, wellness, and medical initiatives. The DSO will be supported by Take Care's Regional Vice President.

(iii) Regional Medical Director. Take Care's designated Regional Medical Director (the "**RMD**") will provide clinical oversight and periodic consultation with the Health Center physician. The Regional Medical Director will be supported by Take Care's Corporate Medical Director.

b. **Management Oversight**. The Corporate Personnel will provide the following:

(i) Overall responsibility of Services provided at the Pharmacy.

(ii) Oversight of daily operations for the Pharmacy.

(iii) Oversight of all aspects of the hiring, retaining, training and certifying, as applicable, of the Take Care Personnel at the Pharmacy.

(iv) Participation in regularly scheduled reviews of financial and operational performance with County.

(v) Assuring completion of applicable continuing education for the Take Care Personnel at the Pharmacy regarding medical, nursing, and other professionally related health issues.

(vi) Performance of periodic performance reviews of the Take Care Personnel at the Pharmacy.

(vii) Periodic, on-site visits to perform quality assurance reviews of all healthcare services and ensure these services adhere to Take Care's policies and procedures.

Licenses

Take Care will maintain the licenses necessary to operate the Pharmacy including, a DEA license, a state Pharmacy license, business licenses (if applicable) and any other licensure necessary to provide the Pharmacy services.

II. Services

Take Care will provide the services described in this scope of services to the following individuals:

(i) Employees of County who are members of a County's benefit plan.
(ii) Dependents of County employees who are members of a County's benefit plan.
(iii) Retirees of County who are members of a County's benefit plan.
(iv) Certain other individuals and groups that the County has determined to receive services. Notwithstanding the foregoing, County agrees to work in good faith and revise the budget as necessary in the event Take Care determines that the current budget will not reasonably support the individuals or groups that the County desires to receive Services pursuant to this Statement of Work.

Notwithstanding the above, any County employees, dependents or retirees may purchase over the counter drugs and supplies at the Pharmacy.

Take Care will:

- Open and close the Pharmacy at agreed upon hours.
- Fill prescriptions for Participants.
- Be responsive to questions from Participants, Pharmacy staff and outside medical professionals.
- Manage day to day operational issues with the Pharmacy services and address any concerns of County regarding the delivery of the Pharmacy services.
- Collect prescription co-pays and balance cash register at the end of each day.
- Call a physician's office to renew prescriptions as necessary.
- Provide computerized inventory control system and use prescription and/or wholesaler reports to set order points.
- Send and receive medication orders via the computer system.
- Perform periodic inventory audit as required under state law.
- Manage inventory turnover.
- Return outdated stock to wholesaler for refund or credit, as applicable.
- Ensure proper handling and storage of all pharmaceutical as required by State and Federal regulations and manufacturer recommendations.
- Comply with Take Care policies and procedures.
- Assure excellent patient care and make sure that all staff are adequately trained regarding:
    - Treating patients with integrity and respect.
    - Preventing medication errors.
    - Providing patient education
    - Reviewing medication profiles for medication interactions, adverse drug effects and/or allergies.
- Work with County employees to provide a Pharmacy role in existing disease management, case management, formulary management, and quality improvement programs.
- Lead in the Pharmacy & Therapeutics Committee's work when combined with a Health Center by:
    - Providing physician and staff education with respect to utilization of pharmaceuticals, i.e., Drug Utilization Review.
    - Implementing corporate formulary directives.
    - Promoting generic substitution and therapeutic interchange of pharmaceuticals to help control pharmaceutical costs and maintain the financial benefit of the Pharmacy for County.
- Oversee pharmacy participation in Take Care Pharmacy Division's clinical and administrative programs.
- Provide mail order Pharmacy services. The parties will mutually determine the states in which Take Care will provide mail order Pharmacy services. County will reimburse Take Care for the costs of any licenses, registrations or other qualifications incurred by Take Care for the purposes of providing the mail order Pharmacy services.
- Provide immunization services. Immunizations will be administered as supply is available, as covered by County's summary plan description and allowed by state law.
- Participate in Medication Therapy Management ("MTM") through Contractor's MTM network. The worksite pharmacy and health center will serve as a primary location for face-to-face consultations on issues like appropriateness of therapy, polypharmacy, compliance and persistency and the proper use of medications by the elderly.

- Participate in annual County patient satisfaction survey.
- Other Services, including, but not limited to, Walgreens Optimal Wellness ("WOW") and medical delivery.
    - WOW focuses on Type 2 diabetes through education and face-to-face engagement. Using information provided by Contractor, the Pharmacy will flag the diabetes portion of the patient population for this program. When diabetes patients visit a Walgreen community pharmacy, they are provided with helpful tips about diabetes and an invitation to participate in further consultations. During the months following enrollment, these individuals meet up to four times with a certified diabetes counselor dedicated specifically to this initiative. These one-on-one sessions create an open environment for learning about diabetes and lifestyle changes that bring about positive outcomes. Pharmacy is also able to bill the County's medical provider directly for these services. The program also offers enrolled members Point of Care (POC) testing that includes a Cholestech Full Lipid Profile (TC, HDL, TG, LDL) as well as Bayer A1C Now testing. POC testing is conducted by trained health coaches in the 19 centralized locations throughout Arizona. Members are encouraged to have POC testing done at each appointment however it is not mandatory. The worksite pharmacy and health center will service as a primary location for these face-to-face consultations. Additional chronic disease states may be added at a later time.

III. Staff

Take Care will recruit, hire and train all staff members as applicable to the Health Center. The pharmacist and Pharmacy techs will be appropriately licensed or certified, as applicable, to provide the Pharmacy services. The staff providing the Pharmacy services at the Health Center is listed in the budget applicable for each year of the term.

IV. Staffing Model.

Pharmacy Manager – 1.00 FTE
Pharmacist – 0.00 FTE
Pharmacy Technician – 1.20 FTE

V. Hours of Operation.

The Pharmacy will be open Monday through Friday from 8:00am to 5:00pm. There will be a one hour lunch period during which the Pharmacy will not be open (the Pharmacy shall be open between the hours of 12 pm and 1 pm). Additionally, the Pharmacy will not be open on holidays or any other day on which the County's building is not open.

ATTACHMENT B-3-B(i)

IMPLEMENTATION BUDGET

Projected Implementation Budget - Health Center		
		Estimated Implementation Budget
Start Up Salaries, Wages and Benefits [1]		
	Physician	1,492
	NP Health Center Manager	7,358
	Pharmacy Manager	10,086
	Pharmacy Technician	2,628
	Total Salaries	21,564
	Total Benefits	6,900
Total Start Up Salaries, Wages and Benefits		***$ 28,464***
Build-out / Furnishings / Equipment / Supplies		
	Estimated Build-out/Remodeling [2]	-
	Furnishings and Equipment [2]	-
	Security System	-
Total Build-out / Furnishings / Equipment / Supplies		***$ -***
Information Systems Support Expense		
	Information Systems Support Expense [3]	11,750
	Computer Usage & Maintenance [4]	-
	Datalines Expense [5]	-
Total Information Systems Support Expenses		***$ 11,750***
Staff Recruitment [6]		**$ 150**
Promotion and Communication [7]		**$ 10,010**
Miscellaneous [8]		**$ 6,458**
Implementation Management Fee [9]		**$ 5,683**
Total Projected Implementation Budget - Health Center [10,11]		**$ 62,515**
Expenses Paid Through TCHS (T)		$ 62,515
Expenses Paid Directly by Client (C)		$ -

1 Start-up salaries, wages and benefits include 4 weeks of training per FTE before the worksite health center/pharmacy is open

2 We assume that there is existing space for an onsite health center and that no build-out, remodeling or equipment is required. However, we reserve the right to adjust projections as needed following the pre-implementation site audit.

3 Additional training costs may apply if an accelerated timeline is required for site implementation.

4 Assumes Client will run the data and voice wiring in the health center to TCHS specifications. Assumes that Client has computer equipment and T1 line in place

5 There will be a $1,000 charge if the connectivity needs to be established in an accelerated timeline.

6 Please note that the amounts applied for recruiting efforts are estimates only at this time, as actual expense may vary by location and implementation timeline. Further, please note that this estimate does not include placement fee from a recruitment agency. If determined necessary, this will first be discussed with the client as all fees will be passed back to the client at cost. Assumes that current NP will remain at site.

7 Please note that this cost projection is allocated between the health center & pharmacy and is based on a PEPY rate. As a result, this estimate is subject to adjustment if a change in employee population size or scope of service occurs.

8 Miscellenous includes unforseen expenses that are not accounted for in other line items in the implementation budget. Any miscellaneous items will be discussed with the client before incurred.

9 Implementation Management Fee is calculated at 10% of total start up expense excluding build-out.

10 Please note that the pricing projections provided are utilized as a baseline cost budget for Take Care Health System's Cost-Plus pricing structure. Under a Cost-Plus pricing structure, actual expenses are billed as incurred. While actual costs may be lower, no cost would exceed the rates provided without client approval. Please note that these initial estimates are good for a 90-day period and may require readjustment to market conditions if the term between this proposal and the actual contract negotiation exceeds this time period.

11 These projections are an estimate at this time and will be refined once the design of the health center and scope of work is finalized.

ATTACHMENT B-3-B(ii)

OPERATING BUDGET – PHARMACY

Projected Operating Expenses - Pharmacy

	Year 1	Year 2	Year 3	Year 4	Year 5
Total Prescriptions	13,998	15,422	16,886	18,390	19,936
Number of Licensed Pharmacists	1.0	1.0	1.0	1.0	1.0
Total Employees	2.20	2.20	2.20	2.20	2.20
Hours of Operation	40	40	40	40	40
Facility Square Feet	1,000	1,000	1,000	1,000	1,000

		Year 1	Year 2	Year 3	Year 4	Year 5
T	**Salaries, Wages and Benefits**	**$ 218,169**	**$ 226,895**	**$ 235,971**	**$ 245,410**	**$ 255,226**
T	Replacement Costs [1]	14,049	15,470	16,983	18,592	19,335
	Total Salaries, Wages and Benefits	***$ 232,217***	***$ 242,366***	***$ 252,954***	***$ 264,002***	***$ 274,562***
	Pharmacy Inventory Ownership Expenses					
T	Cost of Capital	8,172	8,600	9,661	10,794	12,006
T	Shrink	163	172	193	216	240
	Total Pharmacy Inventory Ownership Expenses	***$ 8,336***	***$ 8,772***	***$ 9,854***	***$ 11,009***	***$ 12,246***
	Supplies					
T	Pharmaceutical Supplies	7,570	8,674	9,877	11,187	12,613
T	Concierge Pharmacy [2]					
T	Office Supplies	2,184	2,502	2,849	3,227	3,638
	Total Supplies	***$ 9,754***	***$ 11,176***	***$ 12,726***	***$ 14,414***	***$ 16,251***
	Information Systems Support Expense					
T	Information Systems Support Expense	12,000	12,480	12,979	13,498	14,038
T	Pharmacy Automation [3]	-	-	-	-	-
T	Datalines	6,000	6,240	6,490	6,749	7,019
	Total IT-Related Expenses [4]	***$ 18,000***	***$ 18,720***	***$ 19,469***	***$ 20,248***	***$ 21,057***
	Fees - Other					
T	Bank Fees	4,992	5,192	5,399	5,615	5,840
	Total Fees - Other	***$ 4,992***	***$ 5,192***	***$ 5,399***	***$ 5,615***	***$ 5,840***
	Insurance					
T	Professional & General Liability Insurance	6,676	6,676	6,676	6,676	6,676
	Total Insurance	***$ 6,676***	***$ 6,676***	***$ 6,676***	***$ 6,676***	***$ 6,676***
	Total Utilities [5]	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
	Taxes					
T	Sales & Use Tax	61	70	80	90	102
	Total Taxes	***$ 61***	***$ 70***	***$ 80***	***$ 90***	***$ 102***
	Other Expenses					
T	License & Permits	260	270	281	292	304
T	Staff Recruitment [6]	1,040	1,082	1,125	1,170	1,217
T	Other Expenses	3,019	3,277	3,557	3,861	4,176
T	Promotion & Communication [7]	2,603	2,707	2,815	2,928	3,045
	Total Other Expenses	***$ 6,921***	***$ 7,335***	***$ 7,778***	***$ 8,250***	***$ 8,741***
T	**General & Administrative Services [8]**	**$ 48,766**	**$ 50,897**	**$ 53,120**	**$ 55,440**	**$ 57,658**
T	**Management Fee [9]**	**$ 20,900**	**$ 21,813**	**$ 22,766**	**$ 23,760**	**$ 24,711**
	Total Projected Operating Expenses [10]	**$ 356,623**	**$ 373,016**	**$ 390,822**	**$ 409,506**	**$ 427,844**
	Per Rx	**$ 25**	**$ 24**	**$ 23**	**$ 22**	**$ 21**
	Expenses Paid Through TCHS (T)	$ 356,623	$ 373,016	$ 390,822	$ 409,506	$ 427,844
	Expenses Paid Directly by Client (C)	$ -	$ -	$ -	$ -	$ -
	G&A Services/Management Fee as a % of Drug Spend	**7.1%**	**7.0%**	**6.5%**	**6.1%**	**5.7%**

1 Replacement costs have been calculated to allow full coverage of all positions for PTO (Paid Time Off) allocation.

2 Please note that there will be a charge of $300/month for Concierge/Delivery Services if the average weekly volume is less than 30 prescriptions.

3 The purchase price for a pharmacy automation system is included based on the number of projected onsite prescriptions, where applicable. If an automation system is not desired when actual utilization warrants, then the proposed pharmacy staffing model may need adjustment.

4 Please note that these cost projections assume that Take Care Health purchases and maintains ownership of all IS hardware & software.

5 This assumes that Maricopa County currently incurs these expenses.

6 Please note that the amounts applied for recruiting efforts are estimates only at this time, as actual expense may vary by location and implementation timeline. Further, please note that this estimate does not include placement fee from a recruitment agency. If determined necessary, this will first be discussed with the client as all fees will be passed back to the client at cost.

7 Promotion & Communication includes all Project Management & Production Costs but no Mailing expenses; however, this assumption can be adjusted as needed. Please note that this cost projection is allocated between the health center & pharmacy and is based on a PEPY rate. As a result, this estimate is subject to adjustment if a change in employee population size or scope of service occurs.

8 General & Administrative Services are calculated at 21% of Salaries, Wages and Benefits. Take Care's General & Administrative Services include, but are not limited to, the following: Medical Center Operations, Medical Management Services, Risk Management, Finance, Reporting, Purchasing, Human Resources and IT Support.

9 Management Fee is calculated at 9% of Salaries, Wages and Benefits.

Please note that the pricing projections provided are utilized as a baseline cost budget for Take Care Health System's Cost-Plus pricing structure. Under a Cost-Plus pricing structure, actual expenses are billed as incurred, with the exception of Benefits & Taxes, which are charged at 32% of annual salaries. While actual costs may be lower, no cost would exceed the rates provided without client approval. Please note that these initial estimates are good for a 90-day period and may require readjustment to market conditions if the term between this proposal and the actual contract negotiation exceeds this time period. Ongoing budgets are developed collaboratively with the client over the term of the contract based on actual expenses and services and adjusted accordingly.

ATTACHMENT B-3-B(iii)

OPERATING BUDGET – HEALTH CENTER

Projected Operating Expenses - Health Center

		Year 1	Year 2	Year 3	Year 4	Year 5
	Total Acute/Episodic Care Provider Visits	1,803	1,888	1,988	2,088	2,186
	Total Procedures	2,513	2,631	2,768	2,910	3,046
	Number of Providers	0.10	0.10	0.10	0.10	0.10
	Total Employees	1.10	1.10	1.10	1.10	1.10
	Hours of Operation	40	40	40	40	40

		Year 1	Year 2	Year 3	Year 4	Year 5
T	**Salaries, Wages and Benefits**	**$ 151,863**	**$ 157,938**	**$ 164,255**	**$ 170,825**	**$ 177,658**
T	Replacement Costs [1]	8,202	9,032	9,915	10,854	11,288
	Total Salaries, Wages and Benefits	***$ 160,065***	***$ 166,969***	***$ 174,170***	***$ 181,680***	***$ 188,947***
	Supplies					
T	Medical Supplies	3,994	4,350	4,763	5,203	5,665
T	OTC Pharmaceuticals [2]	1,850	1,987	2,147	2,314	2,485
T	Vaccination/Injection Supplies	4,508	4,916	5,366	5,879	6,406
T	Office Supplies	2,231	2,430	2,661	2,907	3,165
T	Lab Supplies	501	545	596	653	711
	Total Supplies	***$ 13,085***	***$ 14,228***	***$ 15,533***	***$ 16,955***	***$ 18,431***
	Professional Fees					
T	Professional Fees - Laboratory	3,008	3,271	3,577	3,917	4,263
T	Encounter Processing & Billing	10,018	10,855	11,823	12,852	13,933
	Total Professional Fees	***$ 13,025***	***$ 14,126***	***$ 15,401***	***$ 16,769***	***$ 18,196***
	Information Systems Support Expense					
T	Information Systems Support Expense	660	2,122	2,206	2,295	2,387
T	Computer Usage and Maintenance [3]	-	-	-	-	-
	Total IT-Related Expenses	***$ 660***	***$ 2,122***	***$ 2,206***	***$ 2,295***	***$ 2,387***
	Fees - Other					
T	Bank Fees	4,992	5,192	5,399	5,615	5,840
	Total Fees - Other	***$ 4,992***	***$ 5,192***	***$ 5,399***	***$ 5,615***	***$ 5,840***
	Insurance					
T	Professional & General Liability Insurance	9,490	9,490	9,490	9,490	9,490
	Total Insurance	***$ 9,490***	***$ 9,490***	***$ 9,490***	***$ 9,490***	***$ 9,490***
	Total Utilities [4]	***$ -***	***$ -***	***$ -***	***$ -***	***$ -***
	Taxes					
T	Sales & Use Tax	194	212	232	253	276
	Total Taxes	***$ 194***	***$ 212***	***$ 232***	***$ 253***	***$ 276***
	Other Expenses					
T	License & Permits	260	270	281	292	304
T	Staff Recruitment [5]	1,040	1,082	1,125	1,170	1,217
C	Medical Waste Removal	1,716	1,785	1,856	1,930	2,007
T	Promotion & Communication	TBD	TBD	TBD	TBD	TBD
	Total Other Expenses	***$ 3,016***	***$ 3,137***	***$ 3,262***	***$ 3,393***	***$ 3,528***
T	**General & Administrative Services [6]**	**$ 33,614**	**$ 35,064**	**$ 36,576**	**$ 38,153**	**$ 39,679**
T	**Management Fee [7]**	**$ 14,406**	**$ 15,027**	**$ 15,675**	**$ 16,351**	**$ 17,005**
	Total Projected Operating Expenses [8]	**$ 252,547**	**$ 265,566**	**$ 277,944**	**$ 290,953**	**$ 303,778**
	Per Month	**$ 21,046**	**$ 22,130**	**$ 23,162**	**$ 24,246**	**$ 25,315**
	Promotion & Communication [9]	5,205	5,413	5,630	5,855	6,089
	Expenses Paid Through TCHS (T)	$ 250,831	$ 263,781	$ 276,088	$ 289,023	$ 301,771
	Expenses Paid Directly by Client (C)	$ 1,716	$ 1,785	$ 1,856	$ 1,930	$ 2,007

1 Replacement costs have been calculated to allow coverage of all positions for PTO (Paid Time Off) allocation.

2 OTC Pharmaceuticals include items like ibuprofen, Benedryl, etc. that may be administered by the NP during an office visit

3 This projected expense includes incremental computer hardware and phones, where applicable. Please note that replacement hardware costs have not been included at this time, but typically are needed beginning in Year 4.

4 This assumes that Maricopa County currently incurs these expenses.

5 Please note that the amounts applied for recruiting efforts are estimates only at this time, as actual expense may vary by location and implementation timeline. Further, please note that this estimate does not include placement fee from a recruitment agency. If determined necessary, this will first be discussed with the client as all fees will be passed back to the client at cost.

6 General & Administrative Services are calculated at 21% of Salaries, Wages and Benefits. Take Care's General & Administrative Services include, but are not limited to, the following: Medical Center Operations, Medical Management Services, Risk Management, Finance, Reporting, Purchasing, Human Resources and IT Support.

7 Management Fee is calculated at 9% of Salaries, Wages and Benefits.

8 Please note that the pricing projections provided are utilized as a baseline cost budget for Take Care Health System's Cost-Plus pricing structure. Under a Cost-Plus pricing structure, actual expenses are billed as incurred, with the exception of Benefits & Taxes, which are charged at 32% of annual salaries. While actual costs may be lower, no cost would exceed the rates provided without client approval. Please note that these initial estimates are good for a 90-day period and may require readjustment to market conditions if the term between this proposal and the actual contract negotiation exceeds this time period. Ongoing budgets are developed collaboratively with the client over the term of the contract based on actual expenses and services and adjusted accordingly.

9 Promotion & Communication includes all Project Management & Production Costs but no Mailing expenses; however, this assumption can be adjusted as needed. Please note that this cost projection is allocated between the health center & pharmacy and is based on a PEPY rate. As a result, this estimate is subject to adjustment if a change in employee population size or scope of service occurs.

SCHEDULE B-3-5.1

INSURANCE

A. **Take Care Insurance.** Take Care shall acquire and maintain, at its own expense, written in US Dollars, in full force and effect, the policies of insurance outlined below:

i. **Worker's Compensation Insurance**, including statutory occupational illness and disease coverage, or other similar social insurance in accordance with the laws of the country, state, or territory exercising jurisdiction over Take Care Personnel and Employer's Liability Insurance with a minimum limit of $1,000,000 each accident, $1,000,000 policy limit, and $1,000,000 each employee.

ii. **Commercial General Liability Insurance**, including Personal Injury, and Broad Form Property Damage Liability coverage for bodily injury (including death) or damages to any property with a minimum of $2,000,000 per occurrence and $6,000,000 general aggregate, and products/completed operations with a minimum of $ 2,000,000 per occurrence and $ 6,000,000 aggregate.

iii. **Medical Professional Liability (Errors and Omissions),** covering acts, errors or omissions arising out of Services performed under this Exhibit B-3 in an amount no less than $2,000,000 per occurrence and $6,000,000 per aggregate. This policy shall have no deductible or self-insured retention. As a claims-made policy coverage ceases at the time coverage is not renewed or replaced or at the time this Exhibit B-3 is terminated, County shall be solely obligated to pay the cost of Tail Coverage pursuant to Section H of this Schedule B-3-5.1.

iv. **Commercial Property Insurance, such** policy on a Special or "All Risk" form covering Take Care property on County's premises, as well as County's property in Take Care's care, custody and control with a minimum limit adequate to cover such risks on a 100% replacement cost basis.

v. **Business Automobile Liability Insurance** covering Take Care use of all owned, non-owned, and hired automobiles with a minimum combined single limit of $1,000,000.

vi. **Commercial Crime (or equivalent) Insurance** policy, including employee dishonesty and computer fraud, covering losses arising out of or in connection with any fraudulent or dishonest acts committed by employees, officers, or agents of Take Care, acting alone or in collusion with others, including the property and funds of others in their care, custody or control, in a minimum amount of $5,000,000 per occurrence, and $5,000,000 aggregate.

B. **County Insurance.** Subject to B-3-5.1, C. below, during the Term, County shall acquire and maintain, at its own expense, written in US Dollars, in full force and effect, the policies of insurance or self-insurance outlined below with respect to County's ownership and operation of the building where the Health Center is located:

i. **Worker's Compensation Insurance**, including statutory occupational illness and disease coverage, or other similar social insurance in accordance with the laws of the country, state, or territory exercising jurisdiction over County personnel and Employer's Liability Insurance with a minimum limit of $1,000,000 each accident, $1,000,000 policy limit, and $1,000,000 each employee.

ii. **Commercial General Liability Insurance**, including Products, Completed Operations Liability, Personal Injury, Contractual Liability and Broad Form Property Damage Liability coverage for bodily injury (including death) or damages to any property with a minimum of $2,000,000 per occurrence and $4,000,000 general aggregate.

iii. **Commercial Property Insurance**, such policy on a Special or "All Risk" form covering County's property with a minimum limit adequate to cover such risks on a 100% replacement cost basis.

C. **Right to Self-Insure**. Each Party agrees to permit the other Party to self-insure its liability obligations hereunder under its parent or its company's programs of self-insurance. Evidence of a Party's coverage under such self-insurance programs is available to the other Party upon request. Each Party will be listed as Additional Insured under the other Party's self-insurance programs as required herein. Take Care acknowledges County is self-insured for workers' compensation and general liability exposures and not subject to B-3-5.1, D., J. and K. below.

D. **Insurance Coverage Requirements.** All coverage required hereunder will be provided by carriers having a minimum A.M. Best Rating of no less than A-, with a Financial Strength Rating of no less than VIII (8); provided, however, that certain Take Care coverage required hereunder will be provided through Green Hills Insurance Company, a non-rated Vermont-domiciled Risk Retention Group principally owned by Take Care, its subsidiaries and affiliates. Evidence of coverage hereunder will be provided prior to the commencement of Services under this Exhibit B-3 and such coverage shall not be subject to cancellation on less than 30 days' written notice.

E. **Cost of Coverage.** Take Care and County will each bear the cost of procuring and maintaining their own respective insurance coverages as set forth in this Section, except to the extent of Medical Professional Liability (malpractice) insurance coverage, which cost County shall bear subject to cost evidence to sole satisfaction of the County pursuant to the current Budget and as set forth in Section 4.6, but not to exceed the cost for those limits as agreed to between the parties outlined above ($2,000,000 per medical incident, with an annual aggregate of $6,000,000).

F. **Waiver of Subrogation.** Each Party agrees that their respective insurers must waive their rights of subrogation against the other Party, its employees, officers, and agents when applicable

G. **Primary and Non-Contributory.** Each Party agrees that all coverages respectively required of them respectively hereunder, whether primary or excess, shall always be primary to any insurance carried by the other Party, whether that be primary, excess, umbrella, or self-insurance.

H. **Extended Reporting Period Endorsement**. The Professional Liability insurance described herein is written on a claims-made basis. Claims-made coverage ceases to exist at the termination of the contractual relationship between County and Take Care. Therefore, in order to ensure continued coverage, County will purchase subject to budget considerations and the reasonable cost of insurance an Extended Reporting Period Endorsement ("Tail Coverage"), with a minimum term of two years, for professional liability claims which may be made against Take Care and County after contract termination and during the run-off of the professional liability through the statute of limitation or repose, as applicable. County will submit payment to Take Care for the Tail Coverage within 30 days of contract termination. Take Care will provide to County documentation from the insurance carrier (or applicable broker) as to the cost of such Tail Coverage, which shall not to exceed the last annual premium amount paid, or payable, by County under this Exhibit B-3.

I. **Obligations following Termination.** Notwithstanding any other provision in this Exhibit B-3, Take Care's indemnification obligations will not survive the termination of the contractual relationship between County and Take Care through the statute of limitation or repose, as applicable.

J. **Additional Insured.** Take Care and County will cause its respective policies to be duly and properly endorsed to provide for Additional Insured status of the other Party, limited to claims against the Additional Insured based on the negligence of the Named Insured, as follows:

i. **County,** its directors, officers, agents, employees, affiliates, subsidiaries and other authorized representatives will be included as additional insured under any policy or policies provided or maintained by Take Care as set forth above, except for the statutory workers' compensation specified in Section A.i above and Commercial Property insurance specified in Section A.iv above.

ii. **Take Care,** its directors, officers, agents, employees, affiliates, subsidiaries, its parent organization, and other authorized representatives will be included as additional insured parties

under any policy or policies provided or maintained by County as set forth above, except for the statutory workers' compensation specified in Section B.i above.

K. **Cancellation, Expiration, or other Reduction in Coverage.** Neither Take Care nor County will allow any of its respective policies or any part or portions thereof to be canceled, allowed to expire or reduced in scope of coverage (other than as a reduction in the limits of insurance solely due to claim payments) until advance written notice thereof has been sent to the other Party (only policies required of the respective Party, pursuant to this Section).

L. **Evidence of Insurance.** Prior to the commencement of operations, and annually thereafter, each Party will furnish to the other evidence of insurance showing that the aforesaid insurance and endorsements are in full force and effect.

M. **Failure to Maintain.** In the event either Party fails to procure or maintain in full force and affect any of the self-insurance, insurance or endorsements required pursuant to this Schedule B-3-5.1, the other Party shall have the right to immediately terminate this Exhibit B-3 as set forth in Section 6.1(b) of Exhibit B-3.

N. **Subcontractor Insurance.** Should Take Care engage a consultant or subcontractor, all of the coverage requirements set forth above will apply to each consultant or subcontractor.

O. **Deductibles & Self-Insured Retentions.** All self-insured retentions and/or deductibles on any referenced insurance coverages must be borne by the insured Party. Such Party shall be responsible for all claims expenses and loss payments within the policy deductible or self-insurance retention. If the policy is subject to an aggregate limit, replacement insurance may be required if it is likely that such aggregate will be exceeded. Such insurance shall be subject to the terms, conditions, and exclusions that are usual and customary for this type of insurance.

P. **Insurance Carrier Insolvency.** The insolvency, bankruptcy or failure of any insurance company, providing coverage as required herein, shall not relieve either Party of its obligations under this Schedule B-3-5.1.

EXHIBIT C TO CONTRACT PURSUANT TO 10082-RFP
PERFORMANCE GUARANTEES

Aggregate Annual Penalty Limit	**10% of total annual fees for ancillary services**

Performance Standard	**Performance Results**	**How Measured**	**Amount at Risk**
Implementation			
Open Enrollment Communications	Provide enrollment materials within a mutually agreed-upon timeframe	Maricopa County	$100 per late item
Member ID Cards	Produce and mail out member ID cards within 10 business days of receipt of eligibility file	Contractor Notice or Employee Complaints	$1.00 per late card
Eligibility Files	Load eligibility file, and check and report errors within 48 hours of receipt of file	Maricopa County, ADP, or Contractor Notice	$500-per file not loaded correctly, not loaded timely, or errors not identified and reported within 48 hours
Claim Processing			
Claims Processed	Process 99% of claims to completion each quarter within 10-15 calendar days from date received from provider	Claims System or Employee Complaints	$100 per late claim
Invoice Accuracy	Ensure 99% accuracy in invoicing each quarter based on all claims received for the quarter	Maricopa County, ADP, or Contractor Notice	$100 per inaccurate invoice
Claims Accuracy	Process 98% of claims accurately each quarter based on all claims received for the quarter	Claims System or Employee Complaints	$100 per inaccurate claim
Member Services			
Average Call Wait Time	Answer 98% of total calls waiting in queue each month within 30 seconds or less Agree to meet with deviation: Contractor's personnel shall answer calls from participating members on Contractor's help desk line within an average of thirty (30) seconds of the calls reaching their designated queue.	Call Center Report from Contractor	$500 per quarter

Call Abandonment Rate	Achieve a 3% or better abandonment rate on total calls in queue each month	Call Center Report from Contractor	$500 per quarter
Complaints/Grievance Resolution	Acknowledge member complaints/ grievances within 48 hours of receipt and resolve within 10 calendar days. Agree to meet with deviation: Acknowledge member complaints/ grievances within 5 business days of receipt and resolve within 30 calendar days.	Maricopa County, Contractor Notice, or Employee Complaints	$1,000 per quarter
Escalated Member Complaints	Resolve 98% of escalated complaints within 24-48 hours from date of receipt of complaint Agree to meet with deviation: Resolve 95% of escalated complaints within 10 days from date of receipt of complaint	Maricopa County	$500 per quarter
Appeals Resolution	Acknowledge member appeals within 48 hours of receipt and resolve within 15- 30 days Agree to meet with deviation: Contractor will resolve member appeals within 15- 30 days.	Maricopa County, Contractor Notice, or Employee Complaints	$1,000 per quarter
Customer Satisfaction Results	Achieve 90% or better positive responses on Maricopa County-specific Customer Satisfaction Survey	Survey Results	$5,000 per year
Reporting			
Claim Experience/Utilization Reports	Provide standard utilization reports to the County each month, by the 25th day of the month	Maricopa County or Contractor Data	$500 per month

During the second year of the Contract, the Parties agree to institute a performance guarantee with respect to the vanity line. The Parties agree that the actual performance guarantee instituted will be based upon data received and analyzed for the first year of the Contract pertaining to the vanity line. Once the Parties mutually agree on a performance guarantee for this standard, the performance guarantee shall become effective and shall be subject to the terms and conditions of this Contract. The Parties acknowledge and agree that institution of this performance guarantee shall not constitute a waiver of any of the existing performance guarantees.

General Agreement Regarding Penalties. If Contractor is prohibited or prevented in any way from meeting any of the above Performance Guarantees as a result of County's failure to perform any of its obligations as set forth in this Agreement or as a result, directly or indirectly of any change in federal, state, or local law, regulation or agency action, or for any reason beyond Contractor's control, including without limitation, acts of God or the public enemy, flood or storm, or strikes, Contractor shall not be in breach of such Performance Guarantees or be required to pay any Performance Guarantee failure penalty or special assessment associated with such Performance Guarantees.

Payment of Penalties. In the event that Contractor assesses that it has not met a given Performance Guarantee under which a Performance Guarantee failure penalty is payable to County, Contractor shall pay the corresponding Performance Guarantee failure penalty due County by crediting such amounts to pending invoices within one hundred twenty (120) days following the anniversary of the applicable Agreement year, calculated as twelve months after the Implementation Date or the anniversary of the

Implementation Date, or if no such invoices are pending, by direct payment to County. For purposes of calculating any failure penalty to County for failing to meet a Performance Guarantee, Contractor shall use total Participants as of the last day of the Agreement year.

Limited Liability for Penalties. Contractor's maximum cumulative liability to County for penalties for failure to meet any or all of the Performance Guarantees whether set forth above, regardless of the frequency of such failures, shall not exceed 10% of the total annual fees paid by County to Contractor for ancillary services performed during each applicable Contract year, in accordance with Exhibit A-1. The Performance Guarantee failure penalties outlined above shall be the sole remedy for all such identified failures.

AMENDMENT NO. 3 TO CONTRACT PURSUANT TO 10082-RFP

This Amendment No. 3 to Contract Pursuant to 10082-RFP ("Amendment") is entered into by and between Maricopa County ("County"), a political subdivision of the State of Arizona, and Catamaran PBM of Maryland, Inc. ("Contractor), a Nevada corporation.

RECITALS

1. County and Contractor are parties to that certain Contract Pursuant to 10082-RFP effective as of July 1, 2012, as amended ("Contract"); and

2. The Parties desire to amend certain of the terms of the Contract.

Therefore, in consideration of the covenants and agreements set forth herein, County and Contractor agree to amend the Contract as set forth in this Amendment, effective as of July 1, 2014, unless otherwise stated herein. Renewal pricing set forth in this Amendment will be implemented within thirty (30) days following Contractor's receipt of this signed Amendment.

AMENDED TERMS

1. Section 6.13 of the Contract is deleted in its entirety and replaced with the following:

   Contractor will provide core services to the County under this Contract; however, Contractor may utilize subcontractors to perform certain services under this Contract. Contractor shall remain responsible for the performance of any subcontractor. The parties acknowledge that Contractor's network of retail, mail and specialty pharmacy providers are not deemed to be or considered as subcontractors for the purpose of this Contract. Contractor may not assign this Contract to another party for performance of the terms and conditions hereof without the written consent of the County. The Parties agree that the prohibitions set forth in this Section 6.13 shall not apply to the onsite pharmacy and clinic services provided hereunder.

2. The notice address set forth for Contractor in Section in 6.5 of the Contract is deleted and replaced with the following address:

   CATAMARAN PBM OF MARYLAND, INC.
   1600 MCCONNOR PARKWAY
   SCHAUMBURG, IL 60173
   FAX: (224) 231-1932
   ATTENTION: LEGAL DEPARTMENT
   E-MAIL: LEGAL@CATAMARANRX.COM

3. Exhibit A of the Contract is deleted in its entirety and replaced with the attached Exhibit A. All discounts and pricing set forth in Exhibit A is based on post AWP-roll back pricing.

4. Section 2.2 of Exhibit B is deleted in its entirety and replaced with the following:

   2.2. Mail Service Pharmacy. Contractor shall provide the following services from its mail service pharmacy:

(i) receive prescriptions from Participants via U.S. mail or commercial carrier at an address as specified by Contractor from time to time, subject to and in accordance with the County's Plan.

(ii) fill prescriptions during normal business hours, subject to the professional judgment of the dispensing pharmacist, provided that the prescription is accompanied by the correct copay, deductible, or coinsurance amount as applicable;

(iii) provide Participants toll-free telephone access to a pharmacist and customer service representative;

(iv) provide to County promotional materials that explain to Participants how to use the mail service program, as well as any other materials Participants may require to begin using the mail service program and County shall distribute such information to Participants;

(v) provide computerized drug interaction monitoring of Participants based upon the Participant profile, programs for generic substitution and therapeutic intervention, pharmaceutical cost containment services and safety edits, and subject to prescriber approval, clinical appropriateness, the terms of the Plan and applicable law; and

(vi) ship all prescription orders to Participants via U.S. Postal Service or other appropriate carrier to the address provided by County and/or the Participant, as long as such addresses are located in the United States;

5. The heading of Section 2.9.6 of Exhibit B-1 of the Contract is revised to read as follows: Overall Effective Generic and Brand Discounts.

6. The first paragraph of Section 2.9.6 of Exhibit B-1 of the Contract is deleted in its entirety and replaced with the following:

   Contractor guarantees that the overall effective guaranteed discount of all generics dispensed hereunder for each channel will be as set forth in Exhibit A (hereinafter referred to as the "Generic Discounts"). Contractor guarantees that the overall effective guaranteed discount of all brands dispensed hereunder for each channel will be as set forth in Exhibit A (hereinafter referred to as the "Brand Discounts").The Generic Discounts and Brand Discounts are collectively referred to herein as the "Overall Effective Discounts." Contractor will measure Overall Effective Discounts from A WP in accordance with its standard methodology, which includes the following procedures. All generic claims (MAC list and non MAC list generics) that are filled during each contract year will be included in the Generic Discounts ("Measurement Period") and all brand claims that are filled during each contract year will be included in the Brand Discounts. Over-the-counter products, compound drug products, 340B claims, Indian Health Service and/or Tribal claims, direct member reimbursement claims, coordination of benefit claims, long term care claims, home infusion claims, vaccines, claims filled outside Contractor's network of pharmacies, and Specialty Pharmacy Drugs are excluded. Discount calculations are measured using original ingredient cost (i.e., MAC, discounted A WP, 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. Calculations for all distribution channels (e.g., retail-30, retail-90, mail) with the same Generic Discount will be combined. All results will be measured and reported annually. The Overall Effective Discounts

apply for any Measurement Period only if County has received Contractor's services for the full 12 months of such Measurement Period, provided this Contract has been executed by both parties prior to such Measurement Period. In the event the achieved Overall Effective Discounts are less favorable for County than the Overall Effective Discounts set forth in Exhibit A, Contractor will credit County's invoice for the difference between the proposed Overall Effective Discounts and the achieved Overall Effective Discounts within 30 days of Catamaran's completion and County's acceptance of each annual reconciliation.

7. The following Sections are added to Section 2.10 of Exhibit B-1 of the Contract:

   2.10.23. The Participating Pharmacy rates may vary and the amount paid to the Participating Pharmacy may not be equal to the amount billed to the County and Contractor shall retain any difference.

   2.10.24. "Net Paid Claim" means all paid Claims minus reversals for a single prescription fill.

   2.10.25. Dispensing fee refers to the amount paid to the Participating Pharmacy for filling a prescription.

   2.10.26. "Single source generics" or "Non-MAC generics" are Generic Drugs that have either recently come off patent and do not generate discounts traditionally delivered by Generic Drugs, or have an exclusive pharmaceutical manufacturer. Single source generics will be included in the overall generic drug guarantee.

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

   2.10.28. Contractor may, from time to time, receive reimbursement from pharmacies for its costs in connection with transmitting claims and discounts on its own behalf from wholesalers and manufacturers as a purchaser of pharmaceutical products for its mail service and specialty pharmacies.

   2.10.29. Contractor negotiates Rebates based on market share over its aggregate book of business and not on behalf of any client. Rebates shall be based upon per Net Paid Claims submitted on behalf of County, allocable to County. The three-tier Rebate guarantees above apply to a qualified three tier plan design with a minimum differential of $15 between preferred and non-preferred brand drugs and the County's 100% compliance with Contractor's preferred drug Formulary. Contractor and affiliated or unaffiliated third party contractors may retain reasonable administrative fees for its role in securing Rebates.

   2.10.30. County shall comply with other reasonable, generally applicable requirements for participation in the Rebate program and associated program parameters, as are communicated by Contractor to County from time to time, and must adhere to a Generic Dispense Rate (GDR) that is within 2% of the baseline GDR in place at the beginning of this Contract in any given quarter to retain rebate guarantees provided by Contractor. If the GDR change exceeds more than 2% in any given quarter, rebate guarantees may need to be modified. "Generic Dispense Rate" means, in any fiscal quarter, the number of Generic Drug prescriptions divided by the total number of all prescriptions for such contract quarter. County will earn rebates only on valid NDC's as identified as a valid NDC in the Medi-Span Drug Database.

2.10.31. Effective date of any changes to Rebate arrangements shall be at the beginning of a fiscal quarter following the Effective Date of the Contract.

2.10.32. Contractor specialty pharmacies shall be the exclusive specialty providers under this Contract and County Participants shall utilize only Contractor specialty providers. The provided Specialty Drug List may be updated from time to time.

8. The recitals set forth above are incorporated herein and made a part of this Amendment. This Amendment is hereby added to and incorporated into the Contract. The terms and conditions of this Amendment will control in the event of any conflict with the terms and conditions set forth elsewhere in the Contract or by subsequent amendment in writing, signed by the parties, except to the extent that such provisions of this Amendment are specifically referred to and amended or superseded by such amendments.

9. Except as expressly amended herein, all terms and conditions of the Contract shall remain in full force and effect. Any conflict between the Contract and this Amendment or the RFP response and this Amendment regarding the subject matters of this Amendment shall be resolved in favor of this Amendment.

IN WITNESS WHEREOF, the parties have executed this Amendment as of the day and year last written below.

MARICOPA COUNTY	CATAMARAN PBM OF MARYLAND, INC.
BY:	BY:
TITLE: CPO	TITLE: SVP-Finance
DATE: 2/26/15	DATE: 2/20/15

EXHIBIT A

SERIAL 10082-RFP
NIGP CODE: 94872

RESPONDENT'S NAME:	CATAMARAN PBM OF MARYLAND, INC.
ADDRESS:	1600 MCCONNOR PARKWAY SCHAUMBURG, IL 60173
TELEPHONE NUMBER:	800-282-3232
FAX NUMBER:	224-231-1901
WEBSITE:	catamaranrx.com
CONTACT:	Shannon Ross

CONTACT'S EMAIL ADDRESS: Shannon.Ross@catamaranrx.com

PAYMENT TERMS.

[X] NET 15 DAYS	PRESCRIPTION DRUGS
[X] NET 30 DAYS	ANCILLARY

1.0 PRICING (RETAIL):

1.1 RETAIL NETWORK

1.1.1 BRAND AWP LESS DISCOUNT (30 DAY)	20.00%	
1.1.2 DISPENSING FEE	$0.00	PER PRESCRIPTION
1.1.3 GENERIC DISCOUNT	74.25%	
1.1.4 BRAND AWP LESS DISCOUNT (90 DAY)	20.00%	
1.1.5 ADMINISTRATIVE FEE	$0.00	PER PRESCRIPTION
1.1.6 GENERIC DISCOUNT	74.25%	
1.1.7 REBATE ON ALL BRAND PRESCRIPTIONS	$4.00 per net paid claim minimum guarantee; 100% pass-through	

1.2 MAIL ORDER

1.2.1 BRAND AWP LESS DISCOUNT	20.00%	
1.2.2 GENERIC DISCOUNT	74.25%	
1.2.3 DISPENSING FEE	$0.00	PER PRESCRIPTION
1.2.4 ADMINISTATIVE FEE	$0.00	PER PRESCRIPTION
1.2.5 REBATE ON ALL BRAND PRESCRIPTIONS	$4.00 per net paid claim minimum guarantee; 100% pass-through	

1.3 SPECIALTY/INFUSION/INJECTABLE DRUGS

1.3.1 BRAND AWP LESS DISCOUNT	MININUM PER DRUG: AWP – 17.75% represents the overall aggregate specialty discount. Please refer to the provide specialty price schedule for drug-specific pricing. Drug-specific pricing is not guaranteed.	
1.3.2 DISPENSING FEE	$0.00	PER PRESCRIPTION
1.3.3 GENERIC DISCOUNT	17.75%	
1.3.4 ADMINISTRATIVE FEE	$0.00	PER PRESCRIPTION
1.3.5 REBATE ON ALL BRAND PRESCRIPTIONS	$4.00 per net paid claim minimum guarantee; 100% pass-through	

1.4 REBATES

1.4 GUARANTEED OVERALL REBATES ON ALL PRESCRIPTIONS	$4.00 minimum guarantee PER PRESCRIPTION

CATAMARAN PBM OF MARYLAND INC., 2441 WARRENVILLE ROAD, SUITE 610, LISLE, IL 60532-3642
~~CATALYST RX, 800 KING FARM BLVD. 4TH FLOOR, ROCKVILLE, MD 20850~~

PRICING SHEET: NIGP CODE 94855

Terms:	NET 30
Vendor Number:	2011001143 0
Telephone Number:	~~847/964-6059~~ **630/577-3100**
Fax Number:	~~847/572-7783~~ **630/328-2189**
Contact Person:	~~Richard A. Bates /~~ **Shannon Ross-Contract Administration**
E-mail Address:	**Shannon.Ross@catalystrx.com legal@catamaranrx.com**
Certificates of Insurance	Required
Contract Period:	To cover the period ending **June 30, 2017.**