Rx Advocacy Program Adoption and Fee Agreement

Employer Information:			
Employer Name:			
Street Address:			Effective Date:
City:		State:	Zip:
Billing Address:			
City:		State:	Zip:
Tax ID Number:		Phone:	
Business Type:	SIC Code:	PBM:	TPA:
Number of Full-Time Employees:		Number of Enrolled Employees:	
Program Election:	Full SHARx Program ☐	Specialty Only ☐	
Authorized Representative:			
Name:		Title:	
Phone:		Email Address:	
Billing Contact:			
Name:		Title:	
Phone:		Email Address:	
Benefits Contact:			
Name:		Title:	
Phone:		Email Address:	

Monthly Eligibility:				
Source:	Employer ☐	TPA ☐	BenAdmin/HRIS ☐	
Contact:				
Method of Delivery:	Secure Email ☐	EDI ☐	API ☐	SFTP ☐

Shared Health Alliance, 3155 Sutton Blvd, Ste. 201, St. Louis, MO 63143

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Payment Method:	
Payments will be made via ACH. Please include the business name that will be on the checking account, the bank, routing and account number.	
Company Name on Checking Account:	
Bank:	
Routing Number:	Account Number:
NOTE: Required to document where ACH payments will come from.	
I hereby authorize Bill.com, Inc., on behalf of Shared Health Alliance (SHA), to initiate entries to the bank accounts that I enter, or enable SHA to enter, on the Bill.com, Inc. web site [in order to pay amounts that I owe to SHA in accordance with instructions entered by SHA on the Bill.com web site] and, if necessary, to initiate adjustments for any transactions credited or debited in error. I represent that I have authority to bind the organization that owns the bank accounts, and to authorize all transactions to the bank accounts that are initiated through Bill.com, Inc. I acknowledge that transactions initiated to the bank accounts must comply with the provisions of U.S. law. This authorization will remain in effect until the organization notifies Bill.com, Inc. in writing to cancel it in such time as to afford Bill.com, Inc. and the bank reasonable opportunity to act on it.	
☐ I have read, understand and acknowledge the information above and authorize these transactions by signing my full legal name below:	
Authorized Signature:	Print Name:

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Shared Health Alliance

FEE AGREEMENT

THIS FEE AGREEMENT ("Agreement") is made this ___ day of _____ 20__, by and between (i) **SHARED HEALTH ALLIANCE**, a limited liability company ("SHA"), and (ii) _____, a _____ **("Client").**

Purpose

A. SHA provides an advocacy savings programs for eligible employees of employers and their eligible dependents, generally as described in Sections B-E and made a part hereof (the "SHARx Program").

B. The SHARx Program is provided through a strategic relationship between SHA and Rx Help Centers ("RxHC") to Client. Access to the advocacy program is provided to those employees (and former employees) determined under Client's group health plan to be eligible to use it ("Eligible Employees"), as well as to the spouse and eligible dependents of Eligible Employees.

C. Best results are obtained with the use of Pharmacy Benefits Management ("PBM") services through True Rx or Southern Scripts. SHA will work with other approved PBMs on a stand-alone, non-integrated, basis and does not take responsibility for the PBM's processes, formulary, or customer service.

D. Client understands that not all medications can be filled through RxHC and medications that are filled through RxHC will not always be available to the participants at no cost. While no access fee will be required through the SHARx Program, some prescriptions may require a cost share.

E. SHA warrants that it has no control over whether a drug can be accessed at no cost, and as such shall be held harmless should a drug not be available at no cost or a reduced cost.

Fees and Eligibility

A. Client elects to engage the SHARx Program on a limited scope basis for drugs over $50,000 per dose.

B. Client will pay a Per Employee Per Month (PEPM) fee of $4.67 for the SHARx Program for the initial medication. Any additional medications would increase the PEPM fee to $13.50.

C. If Client chooses to elect the SHARx Specialty Only Program after this agreement is in effect, then Client fee will be to a Per Employee Per Month (PEPM) fee of $13.50.

D. Neither Eligible Employees no other Participants will be responsible for the RxHC monthly advocacy fee.

E. Program fee will remain unchanged for 12 months as of the effective date elected by Client

F. SHA will guarantee a 1:1 return on investment (ROI) for the SHARx Program provided the following guidelines are met. If savings at the termination of the SHARx Program (after the initial 12-month period) are less than the fees collected, then the difference will be returned to the Client. Example, company saves $100,000 after 12 months and fees paid for the program are $120,000, then $20,000 will be returned to company.

a. Specialty medications

i. Are excluded by the PBM

ii. No overrides are given without the use of patient assistance unless:
    1. Patient Assistance fails to provide an option, or
    2. Patient Assistance is in progress

b. Infusions and injectables in outpatient setting (if elected)
    i. Our recommended list is excluded by the Pre-Certification Vendor
    ii. No overrides are given without the use of patient assistance, unless:
        1. Patient Assistance fails to provide an option, or
        2. Patient Assistance is in progress

Client

By:_____

Name: _____

Title: _____

Date: _____