LAKE HAVASU UNIFIED SCHOOL DISTRICT EMPLOYEE BENEFIT TRUST

NOTICE OF PUBLIC MEETING

Thursday, October 18, 2018 5:00 p.m.
2200 Havasupai Blvd. – Governing Board Conference Room
Lake Havasu, AZ 86403

MEMBERS OF THE LAKE HAVASU UNIFIED SCHOOL DISTRICT EMPLOYEE BENEFIT TRUST BOARD OF TRUSTEES WILL ATTEND EITHER IN PERSON OR BY TELEPHONE CONFERENCE CALL.

AGENDA

REGULAR MEETING SESSION: **5:00 p.m.**

1. **Routine Opening of Meeting** - Call to Order — Chairperson
   - 1.1 Roll Call
   - 1.2 Pledge of Allegiance/Moment of Silence
   - 1.3 Call for an Executive Session

   (If the situation warrants, an Executive Session may be held during the meeting, pursuant to A.R.S. §38.431.03 (A)(2) for "Discussion or consideration of records exempt by law from public inspection, including the receipt and discussion of information or testimony that is specifically required to be maintained as confidential by state or federal law" or (A)(3) for "Discussion or consultation for legal advice with the attorney or attorneys of the public body.")

2. **Call to the Public** — Chairperson

   (Form BEDH-E is required to address the Board during Call to the Public. Form must be turned in to the Secretary before the meeting starts. There will be a five (5) minute time limit. At this time, the Chairperson will call for comments from members of the public on items not on the agenda. Because of restrictions imposed by A.R.S. §38.431.01, discussion and action on items brought before the Board during this time will be limited to directing staff to study the matter or rescheduling the matter for further consideration and decision at a later date.)

3. **Old Business (Action Items)**
   - 3.1 Discussion and Possible Action re Void Contracts — ECA
   - 3.2 Update on 07/01/18 Prescription Co-Pay Implementation — ECA

4. **New Business (Action Items)**
   - 4.1 Approval of Meeting Minutes: July 19, August 20, August 29 and September 12, 2018 — Chairperson
   - 4.2 Review of Financial Report through July 31, 2018 — ECA
   - 4.3 Discussion and Possible Action re Emergency Checks At District Office — Chairperson
   - 4.4 Presentation of 2018 Clinic Report — Cerner
   - 4.5 Administrative Update — ECA

5. **Adjournment** Chairperson

NEXT SCHEDULED REGULAR MEETING OF THE LHSEBT TRUST BOARD **January 17, 2019 @ 5:00 p.m.**

ECA
Erin P. Collins & Associates, Inc.

Phone: 928.753.4700 x300
Fax: 877.866.5732
1115 Stockton Hill Rd., Ste. 101
Kingman, AZ 86401
erinp@ecollinsandassociates.com

MEMORANDUM

TO: **LHSEBT Trustees**

FROM: **ERIN P. COLLINS & ASSOCIATES, INC. (ECA)**
Erin Collins, President

DATE: October 11, 2018

RE: Update on Vendor Contracts

As Trustees are aware, the Trust has been advised that various of the agreements between it and specific vendors are void as a matter of Arizona law because they were not approved in accordance with the Arizona Open Meeting Law (OML). To correct this, ECA has been working with the involved vendors and Mike Hensley, counsel to the Trust, to draft new agreements and bring them before the Trust for approval. This item is intended to provide an update on the current status of the efforts to get to acceptable agreements as shown below:

1. American Health Group (AHG) – AHG provides Precertification, Utilization Review, Case Management and related services to the Trust. We have successfully completed the contracting process with AHG and their agreement is attached and ready for signature by the Chairperson upon approval by the Trust.

2. GDK CPA, LLC (GDK) – GDK (Mike Bonney) provides accounting and financial reporting services to assist the Trust in the presentation of financial statements. We have successfully completed the contracting process with GDK and the engagement letter is attached and ready for signature by the Chairperson upon approval by the Trust.

3. Wisconsin Rx/CVS-Caremark (Wisconsin Rx) – Wisconsin Rx provides Prescription Benefit Management (PBM) services to the Trust. Their agreement is attached and is expected to be the topic of a brief executive session. In short, the agreement is:

    a. For a term of three (3) years and operates on a calendar year basis with a scheduled effective date of 01/01/19 and an end date of 12/31/21.
    b. Includes penalties for early termination including:
        i. Loss of the most recent calendar quarter's unpaid rebates;
        ii. $5.00 per participant penalty (waived); and

iii. Additional potential risk due to the presence of language that reads that the above are: "in addition to any other remedy available in law or equity."

I went through a series of emails and one phone call with the Wisconsin Rx representative during which I explained that we would like to conduct a competitive process to verify that the bottom line costs associated with these services are generally the most advantageous to the Trust. In that vein, I requested a six month extension of the current agreement and, failing that, that the agreement be modified to eliminate the "in addition to any other remedy available in law or equity" language. Chris Schanze of Wisconsin Rx advised that they are unable to modify the contract to accommodate these requests. The result is that ECA is recommending that the Wisconsin Rx agreement be signed as attached here, with the understanding that we will still conduct a competitive process for these services and, if a recommendation for award to any firm other than Wisconsin Rx is made, we discuss the impacts of the penalty language in light of the projected savings from the move.

4. Blue Cross Blue Shield of Arizona (BCBSAZ) – BCBSAZ provides Arizona medical network leasing services to the Trust. We requested and received the attached complete agreement as well as the CHS Rate Acceptance signed by Kari Thompson on June 18 of this year. In this case, we will be asking the Trustees to approve both the agreement and signed Rate Acceptance retroactive to the date of Kari's signature.

5. Ameritas – We have received and reviewed an updated contract from Ameritas. We replied to them with our edits and those from Mike Hensley and are awaiting their response. This contract will be on a future agenda for Trustee review and consideration.

6. Gilsbar – We drafted an agreement for Gilsbar on the same contract format as the attached for AHG. We have sent it to them for review and comment and are awaiting their response. This one too will be on a future agenda for Trustee review and consideration.

If you have any questions between now and the date of the meeting, I can be reached at (928) 753-4700 ext. 300 or via email at erinp@ecollinsandassociates.com.

AGREEMENT FOR UTILIZATION REVIEW SERVICES

This Agreement for pre-certification, concurrent review and large case management Services (the "**Agreement**") is made and entered into to be effective as of the 1st day of November 2018, by and between the Lake Havasu Schools Employee Benefit Trust (the "**Trust**") and American Health Group, Inc. (the "**Professional**" or "**AHG**").

RECITALS:

I. WHEREAS, the Trust is a public entity employee benefits Trust established pursuant to A.R.S. § 15-382 and A.R.S. § 15-502 in order to provide employee benefits including, without limitation Medical and Prescription drug, Dental, Vision, Life and Disability benefits; and

II. WHEREAS, the Trust desires to engage the services of a third party to provide certain health care cost containment management services, including without limitation pre-certification, concurrent review, retrospective review and large case management, (collectively "utilization review services") in accordance with the documents adopted by the Trust setting forth the terms of eligibility and benefits provided by the Trust (the "Plan Document") approved and as may be amended by the Trust from time to time, which Plan Document is incorporated herein by reference; and,

III. WHEREAS, Professional desires to provide those services to the Trust and represents that it is fully qualified and has the expertise, personnel, and resources to perform the desired services;

NOW, THEREFORE, in consideration of the foregoing recitals and the mutual covenants and agreements contained in this Agreement, the Trust and the Professional agree as follows:

AGREEMENTS:

I. Term and Termination:

A. **Term**. This Agreement shall become effective on November 1, 2018 and shall remain in effect through and including June 30, 2019 (the "Term"), unless terminated earlier as provided herein. Further, this Agreement shall renew automatically for additional one (1) year periods commencing July 01 of each year unless either (i) the Professional provides the Trust notice of its intent not to renew within one-hundred and twenty (120) calendar days of the end of the current Term, or (ii) the Trust provides the Professional notice of its intent not to renew within sixty (60) calendar days of the end of the current Term. Notwithstanding anything set forth above to the contrary, the Agreement is also subject to the termination provision set forth in Section IV (B) set forth below related to new rates.

B. **Termination Without Cause.** The parties may mutually agree in writing to terminate this Agreement at any time.

C. **Termination For Cause.** If either party to this Agreement believes the other party is not in compliance with the terms or conditions of this Agreement or that the other party is refusing or failing to properly perform the services or obligations it is required to perform under this Agreement, that party shall provide a written notice to the party alleged to be in non-compliance of such non-compliance, refusal, and/or failure (the "**Notice of Non-Compliance**") and provide the party alleged to be in non-compliance with not less than thirty (30) working days to cure the alleged deficiency(s) (the "**Cure Period**"). If the alleged deficiency(s) have not been cured within the Cure Period set forth in the Notice of Non-Compliance, the party issuing the Notice of Non-Compliance may unilaterally terminate this Agreement effective immediately upon providing the other party with written notice of termination for non-performance. Further, the Trust may terminate this Agreement immediately by issuing a written notice of termination to the Professional, if the Professional violates the law or engages in fraud, theft, or embezzlement.

D. **Termination For Non-appropriation.** The Trust is obligated only to pay periodic payments under this Agreement as may lawfully be made from funds budgeted and appropriated for that purpose during the Trust's then current budget year. Should the Trust, or the Lake Havasu Unified School District #1, fail to budget, appropriate or otherwise make available funds to pay periodic payments under this Agreement following the then current budget year, this Agreement shall be deemed terminated at the end of the then current budget year. This provision shall take precedence over and shall not be limited in any way by any other provision of this Agreement for all purposes.

II. The Professional's Post-Termination Obligations:

A. If this Agreement is terminated, the Professional will discontinue performance of services on the date of termination and deliver to the Trust completed or partially completed information, reports, and documentation, which, if performance had been completed, would have been furnished to the Trust under this Agreement.

B. The Professional shall at the Trust's option provide transitional services for a period of six months for a fee not to exceed an amount equal to the customary monthly fee due under the Agreement for a three-month period.

C. The Professional will convert any data generated during this Agreement into a format that can be transferred to the Trust for its use without the need to obtain a software license from the Professional.

D. The Professional shall provide any original records to the Trust and shall keep copies of all records generated during this Agreement at its own cost.

E. In no event shall the Professional cause or by omission allow to occur an event that would jeopardize the Trust's reinsurance.

F. The Professional shall cooperate fully with any audit of the services provided under this Agreement and shall do so without compensation for the twelve-month period beginning the day that services are last provided hereunder.

III. Scope of Services to Be Provided by the Professional:

1. AHG shall, during the term of this Agreement, perform at least the following services on an on-going basis:

A. Keep and maintain, at AHG's sole expense, an "800" or similar toll-free telephone number through which beneficiaries may reach AHG, at a minimum, during the hours of 8:00 a.m. through and including 5:00 p.m. Arizona time Monday through Friday and via answering machine, answering service or similar arrangement for after-hours, weekends and holidays recognized by AHG.

B. Use its best efforts to assist Trust beneficiaries in utilizing providers who are "in-network" as such term is defined in Trust's plan document.

C. As regards elective and/or planned in-patient hospitalizations, including Skilled Nursing Facilities (SNF's), AHG will, upon being contacted (telephonically or via facsimile) by physicians, hospitals, beneficiaries or others whose purpose is to initiate a request for authorization for inpatient hospitalization, review the medical necessity and appropriateness of proposed method and duration of the involved care to assure conformance with applicable provisions of the Plan Document and applicable industry standards. Where the proposed care appears to be medically necessary and/or of a duration that AHG believes to be appropriate, AHG shall pre-certify such treatment and immediately so notify the beneficiary and third-party claims administrator designated by the Trust. Where the proposed care appears not to be medically necessary or is of a method or duration which AHG believes to be inappropriate, AHG shall deny such pre-certification and immediately so notify the beneficiary and third-party claims administrator designated by the Trust.

D. As regards emergency in-patient hospitalizations AHG will, upon being contacted (telephonically or via facsimile) by physicians, hospitals, beneficiaries or others whose purpose is to initiate a request for authorization for inpatient hospitalization, conduct a retrospective review of the medical necessity and appropriateness of the method and duration of the involved care to assure conformance with applicable provisions of the Plan Document and applicable industry standards. Where the involved care appears to have been medically necessary and/or of a nature or duration that AHG believes to have been appropriate, AHG shall certify such treatment and immediately so notify the beneficiary and third party claims administrator designated by the Trust. Where the involved care appears not to have been medically necessary or was of a method or duration that AHG believes to have been inappropriate, AHG shall deny such certification and immediately so notify the beneficiary and third party claims administrator designated by the Trust.

E. As regards outpatient surgery or diagnostic testing where the physician's fee or any one or combination of the physician's fee, an individual test or combination of tests is expected to exceed any dollar thresholds established in the Plan Document or Summary Plan Description of the Trust, AHG will, upon being contacted (telephonically or via facsimile) by physicians, hospitals, SNF's, beneficiaries or others whose purpose is to initiate a request for authorization for outpatient surgery or diagnostic testing as described in this paragraph, review the medical necessity and appropriateness of the surgery or testing to assure conformance with applicable provisions of the Plan Document and applicable industry standards. Where the proposed surgery or testing appears to be medically necessary and/or appropriate, AHG shall pre-certify such surgery or testing and immediately so notify the beneficiary and third-party claims administrator designated by the Trust. Where the surgery or testing appears not to be medically necessary or appropriate, AHG shall deny such pre-certification and immediately so notify the beneficiary and third-party claims administrator designated by the Trust.

F. As regards Cardiac Rehabilitation, Advanced Imaging, Durable Medical Equipment/Prosthetics over $500 and Inpatient Maternity beyond 48 hours for a vaginal delivery and 96 hours for a caesarean section, AHG will, upon being contacted (telephonically or via facsimile) by physicians, hospitals, SNF's, beneficiaries or others whose purpose is to initiate a request for authorization for such services/supplies as described in this paragraph, review the medical necessity and appropriateness of the services or supplies to assure conformance with applicable provisions of the Plan Document and applicable industry standards. Where the proposed services/supplies appear to be medically necessary and/or appropriate, AHG shall pre-certify such services/supplies and immediately so notify the beneficiary and third-party claims administrator designated by the

Trust. Where the services/supplies appear not to be medically necessary or appropriate, AHG shall deny such pre-certification and immediately so notify the beneficiary and third-party claims administrator designated by the Trust.

G. As regards Second Surgical Opinions, AHG will assist beneficiaries in initiating and completing second surgical opinions which may be required as a result of denials of pre-certification or certifications as described under paragraphs 1(C-G) preceding or which may be requested by the beneficiary. Where such second surgical opinions are sought or required, AHG shall notify the beneficiary and third-party claims administrator designated by the Trust of such requirement so that the second surgical opinion can be accomplished without deductible, coinsurance or co-pay expense to the beneficiary in accordance with the summary plan description approved by the Trust.

H. Keep and maintain electronic, handwritten and/or similar records of all contacts from physicians, hospitals, SNF's, out-patient facilities, beneficiaries or others seeking pre-certification, certification and retrospective reviews, as well as associated determinations made by AHG for possible later review by the Trust.

I. Provide to the Trust, on a quarterly basis, and within fifteen (15) calendar days from the last day of the quarter for which the reports are being produced, detailed reports showing all activities and results achieved related to pre-certification, certification and related activity for the Trust.

J. Otherwise cooperate with the Trust and associated vendors in endeavors directed at ensuring smooth operation of the partially self-funded plan of benefits envisioned here and as may be amended in future periods.

K. Where first requested by the third party claims administrator designated by the Trust, and approved by the Trust's consultant/broker, AHG will perform case management services on cases known or expected to result in substantial or prolonged courses of treatment. Services envisioned under this section include but are not limited to assisting in the arrangement of access to care in specialty centers including, without limitation, trauma centers, transplant facilities, long term care, transitional care and similar institutions, facilities and/or providers.

L. Where first requested by the third party claims administrator designated by the Trust, and approved by the Trust's consultant/broker, AHG will perform independent medical review services on cases for which this service was not otherwise activated through the certification and/or pre-certification processes. Services anticipated to fall under this paragraph include, but are not limited to, assisting in determining the appropriateness

and medical necessity of proposed or previously given care in accordance with the summary plan description approved by the Trust.

M. Where first requested by the third party claims administrator designated by the Trust, and approved by the Trust's consultant/broker, AHG will prospectively negotiate discounts for services with providers and/or review bills for services already provided and negotiate discounts for same.

N. Perform such other related duties as may be agreed to by the Professional and the Trust.

O. Use those efforts which a skilled, competent, experienced and prudent organization would use to perform and complete the requirements of this Agreement in a timely fashion.

2. **Confidentiality.** Except to the degree required for AHG to conduct business, including coordination with the Trust's consultant/broker, insurer(s), reinsurer(s), third party claims administrator and other authorized agent(s) of the Trust, and/or as otherwise required by law, AHG agrees to keep confidential any information it receives in the course of performing services under this agreement, to the extent that such information identifies a particular beneficiary and describes the physical, emotional or mental condition of such beneficiary; provided, however, that AHG may retain and use for its database and statistical purposes any information that AHG obtains concerning costs charged, procedures used or treatments employed in treating any beneficiary so long as the information retained does not disclose the identity of the beneficiary or Trust.

3. **Non-Interference with Physician/Patient Relationship.** Nothing contained in this Agreement shall be construed to interfere with the physician/patient relationship. The Trust and AHG agree that AHG has not been retained to diagnose or treat individual beneficiaries. The decision to provide treatment remains with the physician and patient. The decision whether to pay for such treatment remains with the Trust.

4. **Liabilities & Obligations.** The Trust and AHG agree that AHG shall have no responsibility or obligation to take action, legal or otherwise, against a beneficiary, hospital, physician or other party to enforce plan provisions or services of the Trust. AHG shall have no responsibility, risk or liability for funding of the Trust's plan of benefits or in the event of failure of the Trust's plan of benefits.

IV. Compensation:

A. For the services included herein, the Professional shall receive as compensation only those amounts as set forth in the fee schedule attached

hereto as Exhibit "A" and incorporated herein by reference (the "Fee Schedule").

B. Subject to the rate agreements set forth in Exhibit "A", the Professional may deliver a request for a fee increase to the Trust no less than 150 calendar days prior to the end of the then current Term. If the Professional and the Trust have not reached an agreement on the requested fee increase before the 90th day prior to the end of the then current Term, this Agreement may be terminated at the end of the then current Term, at the option of the Professional.

V. Expenses:

A. Unless set forth in the Fee Schedule, each party shall be solely responsible for its own expenses including, without limitation, the hourly rates, salaries, benefits, and other things of value which arise from employment of such party's employees; any costs incurred for travel, meals, lodging, telephone, fax or other electronic or other means of communication; costs of compiling and formatting information, and any and all direct and indirect costs associated with or arising from the completion of the services contemplated under the terms of this Agreement.

B. The parties further acknowledge and agree that the Trust shall be solely responsible for its share of any charges related to actuary, auditor, attorney and any other professional or ancillary service providers separately retained by the Trust in order to review Trust operations or options as may from time to time be identified by the Trust.

VI. Taxes: The Professional shall have full and exclusive liability for and shall pay and hold the Trust harmless from any and all of the Professional's taxes, assessments, or governmental charges in connection with all or part of the services provided by the Professional hereunder, other than insurance premium taxes due as a result of any insurance and/or reinsurance placed on behalf of the Trust. The Professional is not responsible for assessments or governmental charges incurred by the Trust. The Professional shall complete and provide to the Trust an Internal Revenue Form W9 (Request for Taxpayer Identification Number and Certification) for the purpose of the Trust's Internal Revenue Service 1099 Form reporting.

VII. Ownership of Documents, Records and Work Product:

A. All documents, records, information, and work product of any kind related to the Trust and/or which result from this Agreement shall become property of and belong to the Trust and may be used as the Trust deems appropriate.

B. At all times during the term of this Agreement, the Trust or its appointed representative(s) shall, as authorized by the Trust, have access to the

documents, records, files, and information of the Trust maintained by the Professional and to work product of the Professional that is related to the Trust and/or which results from this Agreement. Such access shall occur during normal business hours upon not less than twenty-four (24) hours advance notice to the Professional.

C. The Trust, for itself and on behalf of the Trust, recognizes that AHG is able to meet its obligations under this Agreement only because it has developed and maintains a unique information system (the "databases") which identifies prospective and retrospective evaluation methods for various medical services and unique methods for processing, utilizing and delivering such information and performing its services hereunder. The Trust further recognizes that the sources and content of the databases and the nature and constituents of these methods are essential to AHG and its business. In recognition of these issues, the Trust hereby agrees to maintain in strict confidence, and refrain from unauthorized use, all information concerning these business elements, unless otherwise released to do so by AHG or required by applicable law or regulation.

VIII. Compliance with Laws; Non-Discrimination; No Kick-Back or Conflict of Interest Certification:

A. **Compliance with Laws.** The Professional and its partners, directors, officers, employees, and agents shall at all times comply with all applicable federal, state and local laws, statutes, ordinances, rules, regulations, codes, standards, and restrictions and all orders and decrees of bodies or tribunals having jurisdiction or authority, which may in any manner affect the provision of services under this Agreement (collectively, "**Laws**").

B. **Non-Discrimination.** The Professional shall not illegally discriminate on the basis of race, color, religion, gender, age, national origin, political affiliation, or disability in any contacts with the public with regard to work to be performed under this Agreement nor in regard to employment opportunities nor in the procurement of materials, equipment, leases, or subcontractors.

C. **No Kick-Back or Conflict of Interest Certification.** The Professional warrants that it has not employed, retained, or paid any person to solicit or secure this Agreement upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, and that no Trustee of the Trust has any interest, financially or otherwise in the Professional firm. The Professional further warrants that the Professional shall not receive any compensation, payment, or other item of more than nominal or insignificant economic value for the services provided to the Trust by the Professional under this Agreement, other than the compensation set forth in Section IV of this Agreement; provided, however, that this warranty does not prohibit any of the Professional's board members, directors, officers, employees, agents,

or representatives from accepting things such as food or refreshment of insignificant value on infrequent occasions, given that such items are customarily provided. For breach or violation of these warranties, the Trust shall have the right to terminate this Agreement without liability, or, at the Trust's discretion, to deduct from the consideration to be paid to the Professional hereunder the full amount of any such commission, percentage, brokerage, contingent fee, or other prohibited item of economic value received. The Professional further warrants that neither it nor its board members, directors, officers, or employees now have a conflict of interest in the performance of the Professional's obligations under this Agreement and that the Professional further agrees for itself, its board members, directors , officers, and employees, that it will not contract for nor accept employment for the performance of any work or services with any individuals, businesses, or governmental entities where such a contract would create a conflict of interest in the performance of its obligations under this Agreement.

D. **Certification.** The Professional shall, upon executing this agreement, and upon request of the Trust, provide a written attestation that it has no conflicts of interest as provided under A.R.S. § 38-511 and, further, that it remains in compliance with Section VIII (C) of this Agreement, such attestation attached here as Exhibit "B" and incorporated herein by reference.

IX. Licenses, Approvals and Permits: The Professional shall and agrees to obtain, pay for, and maintain throughout the term of this Agreement all licenses, approvals, and permits necessary for the Professional to perform its services under this Agreement.

X. Insurance: Throughout the term of this Agreement, the Professional, at the Professional's sole expense, shall purchase and maintain, from and with an insurance company or companies duly licensed and authorized to do business in Arizona and possessing a current A.M. Best Inc. Rating of A– or higher, insurance policies and endorsements, which are on policies and forms acceptable to the Trust and which meet or exceed the minimum insurance coverage requirements set forth below:

A. **Commercial General Liability ("CGL") Insurance.** CGL insurance, written on a claims occurred basis, with an unimpaired limit of not less than one million dollars ($1,000,000) for each occurrence, a one million dollar ($1,000,000) unimpaired products/completed operations aggregate, and a one million dollar ($1,000,000) unimpaired general aggregate limit.

B. **Automobile Liability.** Commercial/business automobile liability insurance with a combined single limit for bodily injury and property damage of not less then one million dollars ($1,000,000) each occurrence with respect to any owned, hired, and non-owned vehicles assigned to or used in the performance of the Professional's work or services under this Agreement.

C. **Professional Liability.** Professional Liability insurance covering acts, errors, mistakes, and omissions arising out of the work or services performed

by the Professional or any person employed by the Professional, with an unimpaired limit of not less than one million dollars ($1,000,000) for each claim or occurrence and as an aggregate.

D. **Workers' Compensation.** Workers' Compensation insurance as statutorily required by applicable federal and/or state statutes.

E. **Fidelity Bond.** If the Professional is authorized to hold client money under this Agreement, it shall provide the Trust a fidelity bond protecting against theft of client money by employees of the Professional in an amount not less than one million dollars ($1,000,000).

F. **Claims Made Policies.** In the event any insurance policy(ies) required by this Agreement is/are written on a "claims made" basis, the Professional shall insure that coverage shall extend for two years past completion and acceptance of the Professional's work or services under this Agreement and shall provide the Trust with evidence of that continued coverage by submittal of an annual certificates of insurance.

G. **Primary Coverage; Deductibles/Retentions.** The Professional's insurance shall be primary insurance with respect to the Trust, and any insurance or self-insurance maintained by the Trust shall not contribute to it. The insurance policies may provide coverage that contain deductibles or self-insured retentions. Such deductibles and/or self-insured retentions shall not be applicable with respect to the coverage provided to the Trust under such policies. The Professional shall be solely responsible for deductibles and/or self-insured retentions.

H. **Claim Reporting and Warranty Requirements.** Any failure to comply with the claim reporting provisions of the insurance policies or any breach of any insurance policy warranty shall not affect coverage afforded under the insurance policies to protect the Trust.

I. **Certificates of Insurance/Policies/Endorsements.** Within ten (10) working days after the first day of the commencement of the term of this Agreement, the Professional shall furnish the Trust with certificates of insurance or formal endorsements issued by the Professional's insurer(s), as verification that policies providing the required coverages, conditions, and limits required under this Agreement are in full force and effect. The Trust reserves the right to request and receive from the Professional within ten (10) working days of any such request, certified copies of any or all of the insurance policies and/or endorsements required under this Agreement. The Trust shall not be obligated, however, to review same or to advise the Professional of any deficiencies in such policies and endorsements, and such receipt shall not relieve the Professional from, or be deemed a waiver of, the Trust's right to insist on strict fulfillment of the Professional's obligations under this Agreement.

J. **Expiration and Renewal of Policies.** If any of the above-described insurance policies and/or endorsements, expire during the term of this Agreement, the Professional shall forward (or cause to be forwarded) renewal certificates or formal endorsements to the Trust within fifteen (15) calendar days prior to the expiration date, which renewal certificates shall set forth all the information required in the original certificates. Failure to maintain required insurance policies in full force and effect may, at the sole discretion of the Trust, constitute a material breach of this Agreement.

K. **Survival.** The provisions of this Section shall survive the termination of this Agreement.

XI. Indemnification:

A. Each party agrees to defend, indemnify (to the extent permissible under Arizona law) or hold harmless the other party, its employees, its member employees, agents, affiliates or affiliated entities and their employees, agents or affiliates from and against any and all claims, liabilities, damages, debts, demands, actions, causes of action, and judgments, and all costs and expenses related thereto, including attorney's fees for any and all injury, liability or damage resulting from a breach of this Agreement, or because of the actions or inactions, by the indemnifying party when such injury, liability or damage is not in whole or in part the result of the breach of this Agreement, or an action or inaction, by the party seeking indemnification, its employees, agents, affiliates or any affiliate member or its employees, agents or affiliates.

B. In the event any claim, liability, damage or cause of action is the result of both parties' acts or omissions (including those of their employees, agents or affiliates) the amount of responsibility shall be apportioned and each party shall indemnify the other to the extent of their portion of such liability.

XII. Business Associate Agreement: Professional agrees to sign the HIPAA Business Associate Agreement attached hereto as Exhibit "C".

XIII. No Waiver: No inadvertent or incidental waiver of any term, condition or provision included in this Agreement by either or both the Professional or the Trust shall constitute a breach of this Agreement or justify or authorize a repetition or on-going breach or waiver of that or any other term, condition or provision of this Agreement. In addition, no waiver of any breach of any of the terms, conditions, or provisions included in this Agreement shall be construed as a waiver of any succeeding breach of the same or other terms, conditions, or provisions of this Agreement.

XIV. Amendment: This Agreement may only be amended in writing upon mutual agreement of the Professional and the Trust.

XV. Entire Agreement: This Agreement, including any amendments hereto, constitutes the entire agreement and understanding between the Trust and the Professional with respect to, and supersedes, any and all prior agreements, understandings, negotiations, and representations regarding, the subject matter of this Agreement.

XVI. Partial Invalidity; Severability: If any term, condition or provision of this Agreement or the application thereof to any person or circumstance shall, at any time during the term of this Agreement, or to any extent, be deemed by a court of competent jurisdiction to be invalid or unenforceable, the remainder of this Agreement, or the application of such term, condition or provision to persons or circumstances other than those to which this Agreement is found to be invalid or unenforceable shall not be affected thereby and each remaining term, condition or provision of this Agreement shall remain valid and enforceable to the fullest extent provided by law.

XVII. Independent Contractor Status: This Agreement does not create an employee/employer relationship between the parties. Rather, it is understood and agreed that the Professional at all times shall be deemed an independent contractor of the Trust and not an employee of the Trust for any or all purposes, including but not limited to the application of the Americans with Disability Act, Fair Labor Standards Act, minimum wage and overtime payments, Federal Insurance Contribution Act, the Social Security Act, the Federal Unemployment Tax Act, the provisions of the Internal Revenue Code, any applicable revenue and taxation law, the Arizona Workers Compensation law, and the Arizona unemployment insurance law, and that employees of the Professional shall in no event be deemed to be employees of the Trust. Subject to the parameters of this Agreement, the Professional will retain sole and absolute discretion in the judgment of the manner and means of carrying out the Professional's activities and responsibilities hereunder. The Professional agrees it is a separate and independent enterprise from the Trust, it has a full opportunity to find other business, it has made its own investment in its business and it will utilize a high level of skill necessary to perform the work, including all services required to be performed by the Professional hereunder. This Agreement shall not be construed as creating any joint employment relationship between the Professional and the Trust and the Trust will not be liable for any obligation incurred by the Professional, including but not limited to unpaid minimum wages, overtime premiums, withholdings of taxes for the Professional and/or the Professional's employees and/or the withholding and payment of Social Security, unemployment payments, and any other withholdings or payments required by Laws including estimated taxes (if applicable) for the Professional or its employees. No agency relationship, except as expressly provided herein, shall exist between the parties as a result of the execution of this Agreement.

XVIII. Construction; Section Headings: Whenever the context of this Agreement requires, the singular shall include the plural, and the masculine, neutral or feminine shall include each of the other. This Agreement is the result of negotiations between the Trust and the Professional and shall not be construed for or against the Trust or the Professional as a consequence of its role or the role of its attorney in the preparation or drafting of this

Agreement or any amendments hereto. The Section Headings contained in this Agreement are for the convenience and reference of the Trust and the Professional and are not intended to define or limit the meaning or scope of any provision of this Agreement.

XIX. Choice of Law: This Agreement is made and to be performed in the State of Arizona and shall be construed, enforced, and governed by the internal, substantive laws of the State of Arizona without regard to conflict of law principals.

XX. Venue: The venue for any lawsuit arising between the parties under this Agreement shall be the Superior Court in Maricopa County, Arizona.

XXI. Inurement; Assignment: Except as provided in this Agreement to the contrary, all of the terms, covenants and conditions of this Agreement shall be binding upon, and shall inure to the benefit of, each party and the successors and assigns of each party. The Professional shall not assign its rights, duties, or obligations under this Agreement without the prior written consent of the Trust.

XXII. Voluntary Agreement; Legal Advice: Each party warrants that it has read and understands this Agreement and knowingly, willingly, and voluntarily entered into and agreed to all terms contained in this Agreement. Each party further acknowledges that, prior to signing this Agreement, he, she, or it has consulted with and been advised by legal counsel concerning the terms of this Agreement and the legal consequences of entering into this Agreement, or has voluntarily elected not to do so.

XXIII. Counterpart Signatures: This Agreement may be executed in any number of counterparts, each of which shall be deemed a duplicate original and all of which when taken together shall constitute one and the same document. Counterparts are effective and binding when this Agreement has been executed by all the parties.

XXIV. Notices: All notices required or permitted to be given under this Agreement shall be in writing and shall be given by facsimile, personal delivery, deposit with an overnight express delivery service, such as Federal Express, or deposit in the United States Mail, certified or registered mail, return receipt requested, postage prepaid, addressed to the applicable address set forth below, or such other addresses as hereafter may be designated by prior notice, in writing. Notices pursuant to this Agreement shall be sent to:

For the Trust:

Chairperson
Lake Havasu Schools Employee Benefit Trust
c/o Erin P. Collins & Associates, Inc.
1115 Stockton Hill Road, Suite 101
Kingman, Arizona 86401
Facsimile No.: 877.866.5732

Copy to:

JONES, SKELTON & HOCHULI, P.L.C.
Attn: Michael E. Hensley, Esq.
40 North Central Avenue, Suite 2700
Phoenix, Arizona 85004
Facsimile No.: 602.200.7832

For the Professional:
American Health Group
2152 South Vineyard, #103
Mesa, Arizona 85210
Facsimile No. 480.894.8105

Notices under this Section shall be deemed complete and effective on the date delivered, if the notice is given by facsimile, personal delivery or overnight express delivery service, or four (4) working days after the date of deposit in the Mail, if the notice is sent through the United States Mail.

XXV. Signatures: By their signatures set forth below, the Professional and the Trust agree to and accept the terms, conditions and provisions of this Agreement.

The Professional	**Trust**
American Health Group	Lake Havasu Schools Employee Benefit Trust
By: Raymond Jennings, President	By: Marcia Cox, Chairperson
Date: 10/10/18	Date:

Reviewed and approved as to form by counsel for the Trust.

Date: 10/14/18

JONES, SKELTON & HOCHULI, P.L.C.
By: Michael E. Hensley

EXHIBIT "A"

ANY EXPENSE NOT SET FORTH ON THE FOLLOWING FEE SCHEDULE OR IN AN AMOUNT NOT CUSTOMARILY SUBMITTED BY PROFESSIONAL SHALL REQUIRE THE SIGNATURE OF THE CHAIRMAN OF THE TRUST BEFORE REIMBURSEMENT WILL BE MADE BY THE TRUST.

1. For the services included in this agreement during the period November 01, 2018 through and including June 30, 2019, AHG shall be compensated at the following rates:

A.	Services included under section III(1)(A-J) of this Agreement:	$2.00 per employee per month
B.	Case Management per section III(1)(K) of this Agreement:	$125.00 per hour per case
C.	Independent Medical Review Per section III(1)(L) of this Agreement:	$165.00 per case
D.	Hospital Bill Audit/Negotiation Per section III(1)(M) of this Agreement:	20% of savings, not to exceed $25,000 for hospitals and $7,500 for non-hospital providers

All amounts due AHG under Section 1(A) shall be calculated by the Third Party Administrator retained by the Trust and remitted to AHG no later than the fifteenth (15th) day of each calendar month or the first business day immediately thereafter. Amounts due AHG under Section 1(B-D) shall be remitted after AHG sends an invoice to the consultant/broker for review and approval, but no later than thirty (30) days after receipt.

2. AHG's sole compensation from the Trust shall be the fees included under this Exhibit A, Section 1 preceding.

EXHIBIT "B"

ATTESTATION

By my signature below, I do attest and warrant on behalf of the Professional, as follows:

1. Neither the Professional nor its board members, directors, officers, or employees, now have or will have, during the term of this Agreement, a conflict of interest in the performance of the Professional's obligations under this Agreement and that the Professional further agrees for itself, its board members, directors, officers and employees, that it will not contract for nor accept employment for the performance of any work or services with any individuals, businesses, or governmental entities where such a contract would create a conflict of interest in the performance of its obligations under this Agreement as Conflict of Interest is defined under the provisions of A.R.S. § 38-511.

2. The Professional warrants that it has not employed, retained, or paid any person to solicit or secure this Agreement upon an agreement or understanding for a commission, percentage, brokerage or contingent fee, and that no member of the Trust Board has any interest, financially or otherwise in the Professional. The Professional further warrants that the Professional shall not receive any compensation, payment, or other item of more than nominal or insignificant economic value for the services provided to the Trust by the Professional under this Agreement, other than the compensation set forth in Section 3 of this Agreement; provided, however, that this warranty does not prohibit any of the Professional's board members, directors, officers, employees, agents, or representatives from accepting things such as food or refreshment of insignificant value on infrequent occasions, given that such items are customarily provided.

American Health Group

By: _____

By: Raymond Jennings, President

Date: 10/10/18

EXHIBIT "C"

BUSINESS ASSOCIATE AGREEMENT
HIPAA PRIVACY AND SECURITY RULES

This Business Associate Agreement (the "Agreement"), is entered into by and between Lake Havasu Schools Employee Benefit Trust, a self-funded health plan, ("Covered Entity" or "Plan") and American Health Group, a Business Associate ("BA" or "Business Associate") of the Covered Entity. This Agreement supplements and is made a part of the Agreement for Utilization Review Services ("Underlying Agreement") entered into between BA and Covered Entity and is effective the 1st day of November 2018 (the "Effective Date") and will remain in effect unless and until the Underlying Agreement is terminated.

RECITALS:

WHEREAS, pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 2024 (Aug. 21, 1996) ("HIPAA"), and the HITECH Act of American Recovery and Reinvestment Act of 2009, the Office of the Secretary of the Department of Health and Human Services has issued regulations governing the Standards for Privacy, Security and Breach Notification of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 ("Privacy Rule", "Security", "Breach Notification" Rules); and

WHEREAS, the HIPAA Rules provide, among other things, that a Covered Entity is permitted to disclose Protected Health Information to a Business Associate and allow the Business Associate to obtain, receive, and create Protected Health Information on the Covered Entity's behalf, only if the Covered Entity obtains satisfactory assurances in the form of a written contract, that the Business Associate will appropriately safeguard the Protected Health Information; and

WHEREAS, the Office of the Secretary of the Department of Health and Human Services has issued regulations requiring certain transmissions of electronic data, for vendors where such electronic data is exchanged, be conducted in specified standardized formats at 45 CFR Parts 160 and 162 ("Electronic Transactions Rule"); and

WHEREAS, Covered Entity and Business Associate desire to determine the terms under which they shall comply with the Privacy Rule and the Electronic Transactions Rule for the Business Associates to which this applies;

NOW THEREFORE, the Covered Entity and Business Associate agree as follows:

1. GENERAL HIPAA COMPLIANCE PROVISIONS

1.1. HIPAA Definitions. Except as otherwise provided in this Agreement, all capitalized terms contained in this Agreement shall have the meanings set forth in the Privacy Rule.

1.1.1. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

1.1.2. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean American Health Group.

1.1.3. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Lake Havasu Schools Employee Benefit Trust. Business associate provides utilization review services on behalf of various Covered Entities.

1.1.4. HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

1.1.5. "Protected Health Information" ("PHI") shall have the same meaning as the term "Protected Health Information" in the Security and Privacy Rules, limited to the information received by BA from, or on behalf of the covered Entities.

1.1.6. "Electronic Protected Health Information" ("ePHI") shall have the same meaning as the term "Electronic Protected Health Information" in 45 C.F.R. §160.103.

1.2. HIPAA Readiness. Business Associate agrees that it will be fully compliant with the requirements of the HIPAA Rules by the compliance dates established under the HIPAA Rules, and Electronic Transactions Rule, if applicable, and will provide the Plan with written certification of such compliance on or before such compliance date[s].

1.3. Changes in Law. Business Associate agrees that it will comply with any changes in HIPAA and the HIPAA Rules, and the Electronic Transactions Rule, if applicable, by the compliance date established for any such changes and will provide the Plan with written certification of such compliance. If, due to such a change, either or both of the parties are no longer required to treat Protected Health Information in the manner provided for in this Agreement, the parties shall renegotiate this Agreement, subject to the requirements of Section 6. Any such renegotiation shall occur as soon as practicable following the occurrence of the change.

1.4. Nature of Relationship. The parties acknowledge that:

1.4.1. The Parties to this Agreement are the Covered Entity and the Business Associate.

1.4.2. To the extent that the Plan is required to take any action, or that Business Associate is required to communicate with the Plan, such action shall in fact be taken by, and such communication shall be made to, the Trust Consultant of the Covered Entity.

2. TREATMENT OF PROTECTED HEALTH INFORMATION

2.1. Permitted Uses and Disclosures of Protected Health Information.

2.1.1. Uses and Disclosures on Behalf of the Plan. Business Associate may use PHI in its possession to perform the services set forth in the Underlying Agreement.

2.1.2. Other Permitted Uses and Disclosures. In addition to the uses and disclosures set forth in Section 2.1.1, Business Associate may use or disclose Protected Health Information under Subpart E, the HIPAA Privacy Rule, of 45 CFR Part 164, to comply with the requirements of Subpart E that apply to the Covered Entity in the performance of the Agreement obligations received from, or created or received on behalf of, the Plan under the following circumstances:

2.1.2.1. Use of Protected Health Information for Management, Administration, and Legal Responsibilities. Business Associate is permitted to use Protected Health Information if necessary for the proper management and administration of Business Associate or to carry out legal responsibilities of Business Associate.

2.1.2.2. Disclosure of Protected Health Information for Management, Administration, and Legal Responsibilities. Business Associate is permitted to disclose Protected Health Information if necessary for the proper management and administration of Business Associate, or to carry out legal responsibilities of Business Associate, provided that the disclosure is required by law, or Business Associate obtains reasonable assurances from the person to whom the Protected Health Information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, the person will use appropriate safeguards to prevent use or disclosure of the information, and the person will notify Business Associate immediately of any instance of which it is aware in which the confidentiality of the Protected Health Information has been breached.

2.1.2.3. Data Aggregation Services. Business Associate is also permitted to use or disclose Protected Health Information to provide data aggregation services, as that term is defined by 45 CFR 164.501, relating to the health care operations of the Covered Entity.

2.1.3. Further Uses Prohibited. Except as provided in Section 2.1.1 and Section 2.1.2. Business Associate is prohibited from further using or disclosing any information received from the Covered Entity, or from any other Business Associate of the Covered Entity, for any commercial purposes of Business Associate, including, for example, "data mining."

2.2. Minimum Necessary. Business Associate agrees to make uses and disclosures and requests for Protected Health Information consistent with the Covered Entity's minimum necessary policies and procedures.

2.3. Prohibited, Unlawful, or Unauthorized Use and Disclosure of Protected Health Information. Business Associate shall not use or further disclose any Protected Health Information received from, or created or received on behalf of, the Plan, in a manner that would violate the requirements of the Privacy Rule, if done by the Covered Entity.

2.4. Required Safeguards. Business Associate shall use all appropriate safeguards, and comply with Subpart C, the HIPAA Security Rule, of 45 CFR Part 164 with respect to Electronic Protected Health Information to prevent use or disclosure of Protected Health Information received from, or created or received on behalf of, the Covered Entity other than as provided for in this Agreement or as required by law. These safeguards will include, but not be limited to:

2.4.1. Employee /Contractor Education on HIPAA

2.4.1.1. Create a training plan that includes HIPAA and internal policies and procedures pertaining to HIPAA;

2.4.1.2. Provide training to all employees, contractors and subcontractors on HIPAA and how the regulations help to prevent the improper use or disclosure of Protected Health Information;

2.4.1.3. Document training completion and testing outcomes. Retain training records; and

2.4.1.4. Update and repeat training on a regular (annual) basis

2.4.2. Administrative Safeguards

2.4.2.1. Adopt policies and procedures regarding the safeguarding of Protected Health Information, including a Risk Analysis; and

2.4.2.2. Enforce those policies and procedures, including sanctions for anyone found not in compliance.

2.4.3. Technical and Physical Safeguards

2.4.3.1. Implement appropriate technical safeguards to protect Protected Health Information, including access controls, authentication and transmission security; and

2.4.3.2. Implement appropriate physical safeguards to protect Protected Health Information, including workstation security and device and media controls.

2.5. Mitigation of Improper Uses or Disclosures. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.6. Reporting of Unauthorized Uses and Disclosures. Business Associate shall promptly report in writing to the Covered Entity any use or disclosure of Protected Health Information or a security incident not provided for under this Agreement as required at 45 CFR 164.410, of which Business Associate becomes aware, but in no event later than 5 business days of first learning of any such use or disclosure. Business Associate agrees that if any of its employees, agents, subcontractors, and representatives use or disclose Protected Health Information received from, or created or received on behalf of, the Covered Entity, or any derivative De-identified Information in a manner not provided for in this Agreement, Business Associate shall ensure that such employees, agents, subcontractors, and representatives shall receive training on Business Associate's procedures for compliance with the HIPAA Rules, or shall be sanctioned or prevented from accessing any Protected Health Information Business Associate receives from, or creates or receives on behalf of, the Plan. Continued use of Protected Health Information in a manner contrary to the terms of this agreement shall constitute a material breach of this Agreement.

2.7. Access to Protected Health Information. Within 10 days of a request by the Covered Entity on behalf of an individual, Business Associate agrees to make available to the Covered Entity per 45 CFR 164.524 (or, at the direction of the Covered Entity, the Plan participant) any relevant Protected Health Information in either paper or electronic format received from, or created or received on behalf of, the Plan in accordance with the Privacy Rule. If Business Associate receives, directly or indirectly, a request from an individual requesting Protected Health Information, Business Associate shall notify the Plan in writing promptly of such individual's request no later than 5 business days of receiving such a request. Business Associate shall not give any individual access to Protected Health Information unless such access is approved by the Plan.

2.8. Amendment of Protected Health Information. Within 10 days of a request by the Covered Entity, Business Associate agrees to make available to the Covered Entity any relevant Protected Health Information per 45 CFR 164.526 received from, or created or received on behalf of, the Plan so the Plan may fulfill its obligations to amend such Protected Health Information pursuant to the Privacy Rule. At the direction of the Plan, Business Associate shall incorporate any amendments to Protected Health Information into any and all Protected Health Information Business Associate maintains. If Business Associate receives, directly or indirectly, a request from an individual requesting an amendment of Protected Health Information, Business Associate shall notify the Plan in writing promptly of such individual's request no later than 5 business days of receiving such a request. Business Associate shall not amend any Protected Health Information at the request of an individual unless directed by the Plan. The Plan shall have full discretion to determine whether the requested amendment shall occur.

2.9. Accounting of Disclosures. Business Associate shall maintain an accounting of disclosures of Protected Health Information it receives from, or creates or receives on behalf of, the Covered Entity in accordance with the Privacy Rule. Within 10 days of a request by the Covered Entity, Business Associate shall make available to the Covered Entity, or, at the direction of the Covered Entity, the Plan participant, the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528. If Business Associate receives, directly or indirectly, a request from an individual requesting an accounting of disclosures of Protected Health Information, Business Associate shall notify the Covered Entity in writing promptly of such individual's request no later than 5 business days of receiving such a request. Business Associate shall not provide such an accounting at the request of an individual unless directed by the Covered Entity. The Covered Entity shall have full discretion to determine whether the requested accounting shall occur.

2.10. Restrictions and Confidential Communications. Business Associate shall, upon notice from the Covered Entity in accordance with Section 4.4, accommodate any restriction per 45 CFR 164.522 to the use or disclosure of Protected Health Information and any request for confidential communications to which the Plan has agreed in accordance with the Privacy Rule.

2.11. Subcontractors. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, Business Associate shall ensure that any of its agents, including any subcontractor, to whom it provides Protected Health Information received from, or created, received, maintained or transmitted on behalf of, the Plan agree to all of the same restrictions, conditions and requirements contained in this Agreement or the HIPAA Rules that apply to Business Associate with respect to such information. Business Associate shall not assign any of its rights or obligations under this Agreement without the prior written consent of the Covered Entity. Business Associate shall provide the Covered Entity, for its approval a copy of any agreement with any agent or subcontractor to whom Business Associate provides Protected Health Information received from, or created or received on behalf of, the Covered Entity, prior to its execution.

2.12. Audit.

2.12.1. Audit by Secretary of Health and Human Services. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received on behalf of, the Covered Entity, available to the Secretary of Health and Human Services upon request for purposes of determining the Covered Entity's compliance with the HIPAA Rules.

2.12.2. Audit by the Covered Entity. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received on behalf of, the Covered Entity, available to the Covered Entity, within 14 business days of the Covered Entity's request for the purposes of monitoring Business Associate's compliance with this Agreement, the HIPAA Rules, and other applicable law.

3. STANDARD ELECTRONIC TRANSACTIONS.

The following section applies if this Business Associate will engage in standardized transactions.

3.1. The parties agree that Business Associate shall, on behalf of the Covered Entity, transmit data for transactions that are required to be conducted in standardized format under the Electronic Transactions Rule.

3.2. Business Associate shall comply with the Electronic Transactions Rule for all transactions conducted on behalf of the Covered Entity that are required to be in standardized format.

3.3. Business Associate shall ensure that any of its subcontractors to whom it delegates any of its duties under its contract with the Plan, agrees to conduct and agrees to require its agents or subcontractors to comply with the Electronic Transactions Rule for all transactions conducted on behalf of the Covered Entity that are required to be in standardized format.

4. OBLIGATIONS OF COVERED ENTITY

4.1. Notice of Privacy Practices. The Covered Entity shall provide Business Associate with the notice of privacy practices that the plan produces in accordance with 45 CFR 164.520, as well as any changes to such notice.

4.2. Revocation of Permission. The Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by any individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses and disclosures.

4.3. Notice of Restrictions. The Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that the Covered Entity has agreed to in accordance with 45 CFR § 164.522.

4.4. Notice of Restrictions and Confidential Communications. The Covered Entity shall notify Business Associate of any restriction on the use or disclosure of Protected Health Information and any request for confidential communications to which, in accordance with the HIPAA Rules, the Covered Entity has agreed.

4.5. Permissible Requests by the Covered Entity. Except as provided in Section 2.1, the Covered Entity shall not request that Business Associate use or disclose Protected Health Information in any manner that would not be permissible under the HIPAA Rules if done by the Covered Entity.

5. LIABILITY

5.1. Indemnification. Business Associate shall be solely responsible for, and shall indemnify and hold the Covered Entity harmless from any and all claims, damages, or causes of action (including the Covered Entity's reasonable attorneys' fees) arising out of the acts or omissions of Business Associate or Business Associate's employees, agents, and subcontractors, and Business Associate will pay all losses, costs, liabilities, and expenses agreed to in settlement of, or in compromise of, or finally awarded the Plan in connection with such claims or actions. The Covered Entity shall notify Business Associate promptly of any action or claims threatened against or received by the Covered Entity and provide Business Associate with such cooperation, information, and assistance as Business Associate shall reasonably request in connection therewith. This Section 5.1 shall survive the termination of this Agreement.

5.2. Insurance Coverage. Business Associate agrees that it will purchase, if available and at its own expense, an insurance policy that will insure against any violations of the Privacy Rule by Business Associate or its employees, agents, subcontractors, and representatives with respect to Protected Health Information it receives from, or creates or receives on behalf of, the Covered Entity. Such insurance policy will be effective no later than the Effective Date of this Agreement.

6. AMENDMENT AND TERMINATION

6.1. Term. The term of this Agreement shall be effective as the Effective Date and shall terminate at the termination of the Underlying Agreement or on the date the Covered Entity terminates for cause as authorized in 6.2.

6.2. Termination for Violation of Agreement. If the, Covered Entity, in its sole discretion, determines that Business Associate has violated a material term of this Agreement with respect to Protected Health Information it receives from, or creates or receives on behalf of, Covered Entity, this Agreement may be terminated by the Plan effective upon Business Associate's receipt of written notice from the Covered Entity, provided that Business Associate shall continue to comply with Section 6.4 after termination of this Agreement.

6.3. Termination of Underlying Agreement. This Agreement shall terminate upon the termination of the Underlying Agreement, provided that Business Associate shall continue to comply with Section 6.4 hereof after termination of this Agreement.

6.4. Additional Obligations of Business Associate Upon termination.

Upon termination of this Agreement for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

1. Retain only that protected health information which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;

2. Return to covered entity [or, if agreed to by covered entity, destroy] the remaining protected health information that the business associate still maintains in any form;

3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as business associate retains the protected health information;

4. Not use or disclose the protected health information retained by business associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at in Section 2 above, which applied prior to termination;

5. Return to covered entity [or, if agreed to by covered entity, destroy the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities. and

6. The business associate will transmit the protected health information to another business associate of the covered entity at termination, and/or could add terms regarding a business associate's obligations to obtain or ensure the destruction of protected health information created, received, or maintained by subcontractors.

7. Survival. The obligations of business associate under this Section 6.4 shall survive the termination of this Agreement.

6.5. Amendment to Comply with Law. The Parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments, The Parties agree to take such action as is necessary to comply with the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. Upon either Party's request, the other Party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement

7. MISCELLANEOUS PROVISIONS

7.1. Third-Party Beneficiary. No individual or entity is intended to be a third-party beneficiary to this Agreement or the Underlying Agreement, if separate.

7.2. Severability. If any term or other provision of this Agreement is determined to be invalid, illegal or incapable of being enforced by any rule or law, or public policy, all other conditions and provisions of this Agreement shall nevertheless remain in full force and effect so long as the economic or legal substance of the transactions contemplated hereby is not affected in any manner materially adverse to any party. Upon such determination that any term or other provision is invalid, illegal or incapable of being enforced, the parties hereto shall negotiate in good faith to modify this Agreement so as to affect the original intent of the parties as closely as possible in an acceptable manner to the end that transactions contemplated hereby are fulfilled to the extent possible. If any

provisions of this Agreement shall be held by a court of competent jurisdiction to be no longer required by the Privacy Rule, the parties shall exercise their best efforts to determine whether such provision shall be retained, replaced, or modified.

7.3. Procedures. The parties shall comply with procedures mutually agreed upon by the parties to facilitate compliance with HIPAA Rules, including procedures for employee sanctions and procedures designed to mitigate the harmful effects of any improper use or disclosure of the Plan's Protected Health Information.

7.4. Regulatory Reference. A reference in this Agreement to a section of the HIPAA Rules meant the section as in effect, or as amended.

7.5. Choice of Law. This Agreement shall be governed by, and construed in accordance with, the laws of the State of Arizona except to the extent federal law applies. The parties hereby submit to the jurisdiction of the courts located in the State of Arizona including any appellate court thereof.

7.6. Headings. The headings and subheadings of the Agreement have been inserted for convenience of reference only and shall not affect the construction of the provisions of the Agreement.

7.7. Cooperation. The parties shall agree to cooperate and to comply with procedures mutually agreed upon to facilitate compliance with the Privacy Rule, including procedures designed to mitigate the harmful effects of any improper use or disclosure of the Plan's Protected Health Information.

7.8. Notice. Other than notices specifically required by law, Notice under this agreement shall be given in the manner and to those persons or entities that are to be provided notice in the Underlying Agreement.

7.9. Survival. The obligations of the Business Associate under this Section shall survive the termination of this Agreement.

IN WITNESS WHEREOF, the Parties have caused this BA Agreement to be signed and delivered by their duly authorized representatives, as of the BA Agreement Effective Date.

BUSINESS ASSOCIATE:	**COVERED ENTITY:**
American Health Group, Inc.	**Lake Havasu Schools Employee Benefit Trust**
By: R. Jennings	By: _____
Print Name: Raymond Jennings	Print Name: _____

Print Title: President

Print Title: _____

Reviewed and approved as to form by counsel for the Trust:

Michael E. Hensley
Attorney for Trust

Date: 10/10/18

GDK CPA, LLC

90 Acoma Blvd S, Suite 100 • Lake Havasu City, AZ 86403
Office: (928) 680-1994 • Fax: (928) 680-2933
Email: mike@gdkcpa.com • Website: www.gdkcpa.com

June 19, 2018

To Management
Lake Havasu Unified School District #1
Lake Havasu City, Arizona 86403

We are pleased to confirm our understanding of the services we are to provide to Lake Havasu Unified School District #1(Employee Benefit Trust) for the year ending June 30, 2019, commencing July 1, 2018.

We will perform a compilation engagement to the financial statements of Lake Havasu Unified School District #1(Employee Benefit Trust), which comprise the monthly statement of net assets and the statement of activities, monthly beginning July 1, 2018.

Our Responsibilities

The objective of our engagement is to apply accounting and financial reporting expertise to assist you in the presentation of financial statements without undertaking to obtain or provide any assurance that there are no material modifications that should be made to the financial statements in order for them to be in accordance with accounting principles generally accepted in the United States of America.

We will conduct our compilation engagement in accordance with the Statements on Standards for Accounting and Review Services (SSARS) promulgated by the Accounting and Review Services Committee of the AICPA and comply with the AICPA's *Code of Professional Conduct,* including the ethical principles of integrity, objectivity, professional competence, and due care.

We are not required to, and will not, verify the accuracy or completeness of the information you will provide to us for the engagement or otherwise gather evidence for the purpose of expressing an opinion or a conclusion. Accordingly, we will not express an opinion or a conclusion nor provide any assurance on the financial statements.

Our engagement cannot be relied upon to identify or disclose any financial statement misstatements, including those caused by fraud or error, or to identify or disclose any wrongdoing within the entity or noncompliance with laws and regulations.

Your Responsibilities

The engagement to be performed is conducted on the basis that you acknowledge and understand that our role is to assist you in the presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America. You have the following overall responsibilities that are fundamental to our undertaking the engagement in accordance with SSARS:

1. The selection of accounting principles generally accepted in the United States of America as the financial reporting framework to be applied in the preparation of the financial statements.
2. The preparation and fair presentation of financial statements in accordance with accounting principles generally accepted in the United States of America and the inclusion of all informative disclosures that are appropriate for accounting principles generally accepted in the United States of America, if applicable.
3. The design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the financial statements.
4. The prevention of fraud and detection of fraud.
5. To ensure that the Organization complies with the laws and regulations applicable to its activities.
6. The accuracy and completeness of the records, documents, explanations, and other information, including significant judgments, you provide us for the engagement.
7. To provide us with:
    a. Access to all information of which you are aware is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, and other matters.
    b. Additional information that we may request from you for the purpose of the compilation engagement.
    c. Unrestricted access to persons within the Organization of whom we determine necessary to make inquiries.

Our Report

As part of our engagement, we will issue a report that will state that we did not audit, or review the financial statements and that, accordingly, we do not express an opinion, a conclusion, nor provide any assurance on them. If, for any reason, we are unable to complete the compilation of your financial statements, we will not issue a report on such statements as a result of this engagement.

You agree to include our accountant's compilation report in any document containing financial statements that indicates that we have performed a compilation on such financial statements and, prior to the inclusion of the report, to ask our permission to do so.

Other Relevant Information

Michael E. Bonney is the engagement partner and is responsible for supervising the engagement and signing the report or authorizing another individual to sign it.

Our fees for these compilation services will be $300.00 per month. which includes attending the required 5-6 meetings held during the school year.

You agree to hold us harmless and to release, indemnify, and defend us from any liability or costs, including attorney's fees, resulting from management's knowing misrepresentation to us.

We appreciate the opportunity to be of service to you and believe this letter accurately summarizes the significant terms of our engagement. If you have any questions, please let us know. If you acknowledge and agree with the terms of our engagement as described in this letter, please sign the enclosed copy and return it to us.

Sincerely,

Michael E. Bonney

Partner

Acknowledged:

_____

Name and Title

Participating Group Addendum

Participating Group Name: Lake Havasu Schools Employee Benefit Trust

Participating Group Address: 2200 Havasupai Blvd.

Lake Havasu City, AZ 86403

Contact Person:

Participating Group Addendum Effective Date: January 1, 2019

Participating Group Addendum End Date: December 31, 2021

Participating Group represents that the Plan is not governed by ERISA.

This Addendum ("**Participating Group Addendum**") supplements the Amended and Restated Coalition Master Prescription Benefit Services Agreement effective January 1, 2019 ("**Master Agreement**"), as amended, between CaremarkPCS Health, L.L.C., a Delaware limited liability company ("**CVS/caremark**"), and National CooperativeRx, a Wisconsin Cooperative ("**NCRx**"), on its own behalf and on behalf of the Participating Group. All capitalized terms used in this Participating Group Addendum shall have the meaning set forth in the Master Agreement.

1. The undersigned Participating Group ("**Participating Group**") is, and shall remain, a cooperative member of NCRx during the Term. Participating Group has reviewed the Master Agreement and desires that CVS/caremark provide to it the products and services described in the Master Agreement on the terms and conditions set forth in the Master Agreement, as amended from time to time, and this Participating Group Addendum. By signing this Participating Group Addendum, Participating Group agrees to the terms and conditions of the Master Agreement, including the Exhibits attached thereto and any subsequent amendments to the Master Agreement which may be entered into between NCRx and CVS/caremark, and this Participating Group Addendum.

2. CVS/caremark agrees to provide services to the undersigned Participating Group under the same terms and conditions set forth in the Master Agreement, including any amendments or other applicable written agreements which may be entered in writing between NCRx and CVS/caremark during the Term, as applicable. This Participating Group Addendum shall terminate automatically upon termination of the Master Agreement, except as otherwise set forth in Section 6.10 of the Master Agreement, consistent with the terms of the Master Agreement.

3. Participating Group elects the pricing options and optional services as further described in the Master Agreement, as reflected in the PDD documents approved by Participating Group:

Retail Network (Select one):

☒ **Retail - National Network**
☐ **Retail - CareChoice Network**
☐ **Advanced Choice Network**

Formularies (Select those that apply):

- ☐ Aligned CVS/caremark Performance Drug List – Standard Control
- ☒ Aligned CVS/caremark Performance Drug List – Standard Control with PA Option
- ☐ Aligned CVS/caremark Performance Drug List – Standard Formulary Opt Out
- ☐ Advanced Control Formulary (Includes Advanced Control Specialty Formulary)
- ☒ Advanced Control Specialty Formulary
- ☐ Value Formulary (Incentivized)
- ☐ Value Formulary (Closed)

Rebates

- ☒ Traditional
- ☐ POS Rebates
- ☐ Reinvested Rebates

Specialty Medications (Select those that apply):
Note: Advanced Control Specialty Formulary is not offered with the PDPD Program.)
Specialty pricing will be included in a Specialty Drug List – See applicable Attachment 1 to Exhibit A (Traditional Rebates) or Attachment 2 to Exhibit A (Reinvested Rebates) in Master Agreement.

- ☐ Open Specialty Arrangement
- ☒ Exclusive Specialty Arrangement
- ☐ Open Specialty Arrangement with PDPD Program
- ☐ Exclusive Specialty Arrangement with PDPD Program

Select only one of the following 90-day network options, if any:

Maintenance Choice Program

- ☐ Maintenance Choice Program – Mandatory/Incentivized Option available to Plan Participants
- ☐ Maintenance Choice Program – Voluntary Option available to Plan Participants
- ☐ Maintenance Choice Program – Opt-Out Option available to Plan Participants
- ☒ **Extended Day Supply (EDS) - 90**

If elected, select one of the following optional services (if eligible) as further described in the Master Agreement:
Generic Step Therapy Program

- ☐ High Performance Generic Step Therapy
- ☐ Traditional Generic Step Therapy

4. Market Check. Participating Group delegates the authority to negotiate the market check pricing terms applicable to Participating Group, if any, to NCRx. Once the revised pricing terms are agreed upon by NCRx and CVS/caremark, NCRx shall advise Participating Group of the revised pricing in advance of the effective date of such revised pricing.

5. This Participating Group Addendum, together with the Master Agreement constitutes the entire agreement between the parties with respect to the subject matter herein and supersedes all prior understandings, agreements, contracts or arrangements between the parties, whether oral or written.

LAKE HAVASU SCHOOLS EMPLOYEE BENEFIT TRUST

By: _____

Name: _____

Title: _____

Date: _____

AUTHENTICATION

NCRx signs below to certify that this Participating Group Addendum is entered into under and in accordance with the provisions of the Master Agreement, and is approved by it in form and substance. No amendments or other modifications to this Participating Group Addendum are effective until NCRx has reviewed such modifications and approved them in a written amendment to this Participating Group Addendum.

NATIONAL COOPERATIVERX

By: 

Name: Josh Bindl

Title: CEO

Amended and Restated
COALITION MASTER PRESCRIPTION BENEFIT SERVICES AGREEMENT

This Amended and Restated Coalition Master Prescription Benefit Services Agreement (the "**Agreement**"), is effective as of January 1, 2019 (the "**Effective Date**"), between CaremarkPCS Health, L.L.C., a Delaware limited liability company ("**CVS/caremark**" or **"Caremark")** and National CooperativeRx, a Wisconsin cooperative, ("NCRx"), on its own behalf and on behalf of the Participating Groups (as hereinafter defined).

NCRx arranges on behalf of its Participating Groups, for CVS/caremark to provide certain prescription benefit management, disease management and specialty pharmacy services with respect to the Participating Group's health benefit plan(s);

Each Participating Group has established a health benefit plan(s) for its Plan Participants (as hereinafter defined) and hereby retains CVS/caremark to provide certain prescription benefit management, disease management and specialty pharmacy services with respect to the Participating Group's health benefit plan(s); and

CVS/caremark agrees to provide such Services (as hereinafter defined) pursuant to the terms and conditions of this Agreement.

Now, therefore, in consideration of the mutual promises set forth herein, the parties hereto agree as follows:

1. Definitions. Capitalized terms in this Agreement and the Exhibits shall have the meaning provided in this Section 1.

1.1 **"AWP"** means the "**average wholesale price**" for a standard package size of a prescription drug from the most current pricing information provided to CVS/caremark by Medi-Span Prescription Pricing Guide (with supplements), or following one hundred eighty (180) days advance notice to NCRx, any other nationally available reporting service of pharmaceutical prices as utilized by CVS/caremark as a pricing source for prescription drug pricing. The standard package size applicable to a mail service pharmacy shall mean the actual 11-digit NDC of the package size used to fulfill the quantity dispensed. The standard package size applicable to a Participating Pharmacy shall be the actual 11-digit NDC of the package size dispensed from a Participating Pharmacy as reported by such Participating Pharmacy to CVS/caremark. AWP files will be updated no less than weekly to reflect current published pricing.

1.2 **"Brand Drug"** shall mean any drug, as identified by CVS/caremark, using the Medi-Span Master Drug Database (Medi-Span) indicators, and their associated files, or indicators provided by another nationally available reporting service of pharmaceutical drug information per Section 2.13 of this Agreement that adjudicates at the brand drug Cost Share logic consistent with the Plan, and shall include any drug not determined to be a Generic Drug consistent with Section 1.10.

1.3 **"Claims"** means those Covered Drug claims processed through CVS/caremark's on-line claims adjudication system or otherwise transmitted or processed in accordance with the terms of this Agreement in connection with a Plan.

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

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

1.6 **"Covered Drug"** means a drug or supply which, under applicable law, requires a prescription and

which is covered under the formulary adopted by the Plan pursuant to Section 2.6 of this Agreement.

1.7 **"Dispensing Fee"** means the amount charged to Participating Groups to reimburse Participating Pharmacies to dispense a prescription drug.

1.8 **"Drug Interchange"** means any substitution initiated by CVS/caremark of a Covered Drug for a clinically comparable Covered Drug that is not a preferred Brand Drug. Drug Interchange shall not include any substitution initiated by CVS/caremark that is (i) due to a Drug Utilization Review; (ii) due to Plan Participant safety reasons; (iii) due to market unavailability of the originally prescribed drug; (iv) a substitution of a Generic Drug for a Brand Drug; or (v) due to the originally prescribed drug not being a Covered Drug.

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

1.10 **"Generic Drug"** means a drug that is one or more of the following: (i) a single and/or multi-source generic prescription drug (non-brand) determined in accordance with the drug classification requirements set forth in Section 2.13 of this Agreement; (ii) consistent with the requirements in Section 2.13, a drug, whether identified by its chemical, proprietary, or non-proprietary name that has a multisource code field in Medi-Span of "Y" (generic); (iii) a drug where the Multisource Code is "O" and there is a DAW code of 3,4,5,6, or 9; (iv) multi-source Brand Drugs that adjudicate at MAC; (v) Brand Drugs that are treated as "house" generic drugs (DAW5) by the dispensing pharmacy; and (vi) Single Source Generic Drugs (as defined in Section 1.28).

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

1.12 **"Limited Distribution Drug"** means a Covered Drug that is (i) used to treat conditions affecting only a small number of patients with special requirements; (ii) distributed by a limited number of specialty pharmacy providers as determined by exclusive or preferred vendor arrangements with the pharmaceutical manufacturer; and (iii) may require specific clinical expertise by the dispensing pharmacy or require the discussion and completion of Risk Evaluation Mitigation Strategy (REMS) documents by both the patient and dispensing pharmacy.

1.13 **"Losses"** means all legal claims, liabilities, demands, damages, losses, costs or expenses of any kind, including, without limitation, reasonable attorneys' fees and expenses.

1.14 **"Maximum Allowable Cost"** or **"MAC"** means the unit price that has been established by CVS/caremark for a multi-source drug (i.e., a drug with more than two sources) included on the MAC drug list applicable to Participating Groups, which list may be amended from time to time by CVS/caremark in maintaining its generic pricing program. The MAC list applicable to Participating Groups is not the same as the MAC list published by the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration, or "HCFA MAC"). A copy of such MAC drug list shall be provided to NCRx and Participating Group prior to execution of this Agreement and thereafter upon NCRx and Participating Group's reasonable request. The drugs on the MAC list applicable to Participating Groups are the same for all Participating Groups and for Claims processed at retail or mail.

1.15 **"Paid Claim"** means all Claims made by eligible Plan Participants that result in a payment to Participating Pharmacies or Plan Participants or Plan Participant Cost Shares. (Does not include reversals and adjustments.) Each prescription transmission that results in payment shall be calculated separately as a Paid Claim.

1.16 **"Participating Group"** means a cooperative member of NCRx that has entered into a Participating Group Addendum, as defined in Section 6.7 of this Agreement and as set forth in Exhibit F, with CVS/caremark, pursuant to the terms and conditions of this Agreement, which has been authenticated under this Agreement by NCRx, and which thereafter may be modified from time to time, consistent with the terms and conditions of this Agreement.

1.17 **"Participating Pharmacy"** means a retail pharmacy that participates in a retail network established by CVS/caremark.

1.18 "**PDL**", which is CVS/caremark's formulary and includes the CVS/caremark Performance Drug List and the Prescribing Guide**,** and is a ranking of Covered Drugs into preferred, non-preferred tiers, as created, maintained and amended by CVS/caremark from time to time, which: (a) has been approved by CVS/caremark's pharmacy and therapeutics committee; and (b) represents the formulary that CVS/caremark recommends that its clients adopt as the Plan formulary. The term PDL shall not include a Custom PDL, as defined in Section 2.6A(b) of the Agreement.

1.19 **"Plan"** means the health benefit plan(s) sponsored by a Participating Group that includes the prescription drug benefit.

1.20 **"PDD"** or **"Plan Design Document"** means various documents or forms, including implementation forms, clinical management forms, clinical utilization or other documents, prepared by CVS/caremark and approved by Participating Group, as may be modified by Participating Group from time to time in accordance with Section 6.3 of this Agreement, which documents in detail the relevant parts of the Plan for prescription drug benefits and clinical programs adopted by Participating Group and which are used by CVS/caremark to provide Services under this Agreement.

1.21 **"Plan Participant" or "Member"** means each individual identified by Participating Group to be eligible for prescription drug benefits under the Plan, as set forth in Participating Group's eligibility file or otherwise communicated by Participating Group in a format acceptable to CVS/caremark.

1.22 **"PPACA"** means the Patient Protection and Affordable Care Act, as amended and the regulations promulgated thereunder.

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

1.24 **"Prescribing Guide"** means the CVS/caremark Prescribing Guide, as modified and published from time to time, which has been approved by CVS/caremark's pharmacy and therapeutics committee.

1.25 **"Protected Health Information"** or **"PHI"** shall have the meaning set forth in Exhibit B to this Agreement.

1.26 **"Rebates"** means the formulary rebates, including base and market share rebates, Manufacturer Administrative Fees (as defined in 8.4 of this Agreement), and inflation price protection payments collected by CVS/caremark in its capacity as a group purchasing organization for the Plan from various pharmaceutical companies, aggregators or other third parties that are attributable to the utilization of Covered Drugs by Plan Participants. The term Rebates shall not include the fees, compensation, and concurrent or retrospective discounts associated with the purchase price of products described in this Agreement that are attributable to or based on products purchased by CVS/caremark affiliated dispensing pharmacies, which belong exclusively to CVS/caremark or its affiliates CVS/caremark acknowledges and agrees that neither it nor its affiliates shall enter into any agreement with a pharmaceutical manufacturer for manufacturer payments with the impact to reduce or otherwise circumvent monies received from pharmaceutical manufacturers as being considered Rebates.

1.27 **"Services"** means the prescription drugs and supplies and all related products and services as provided by CVS/caremark pursuant to this Agreement.

1.28 **"Single Source Generics" (SSGs)** are defined as sole source or authorized generics, or select generics which may have limited availability, or competition.

1.29 **"Specialty Drugs"** means certain pharmaceuticals, biotech or biological drugs, that are Covered Drugs and that are used by CVS/caremark, that are used in the management of chronic or genetic disease, including but not limited to, injectable, infused, or oral medications, or products that otherwise require special handling, including without limitation those listed in Attachment 1 to Exhibit A. Attachment 1 to Exhibit A may be amended by CVS/caremark from time to time provided that any additions must be consistent with this definition and either: (i) existing drugs that have changes mandated by the FDA and/or manufacturer in distribution, administration or other requirements; (ii) have demonstrated need of special handling, distribution, administration,

monitoring or patient education and counseling; or (iii) have been reviewed and approved by NCRx.

1.30 **"Term"** shall be as defined in Section 9.1 of this Agreement.

1.31 **"Usual and Customary"** or **"U&C"** means a Participating Pharmacy's usual selling price for a prescription drug.

2. CVS/caremark Services. CVS/caremark shall provide the Services in a manner consistent with the PDD, and the terms of this Agreement, and NCRx and Participating Group hereby authorize CVS/caremark to provide the Services in such manner.

2.1 **Claims Processing.**

(a) On-Line Claims Processing. CVS/caremark will perform Claims processing Services for products dispensed by Participating Pharmacies and CVS/caremark's mail and specialty pharmacies. CVS/caremark will perform standard Drug Utilization Review Services, as described in Section 2.8 of this Agreement, for each Claim submitted by Participating Pharmacies, and CVS/caremark's mail and specialty pharmacies.

(b) Submitted Paper Claims. To the extent authorized by the PDD, CVS/caremark will process Claims submitted by Plan Participants directly to CVS/caremark consistent with CVS/caremark's standard procedures and for the fees set forth in Exhibit A.

2.2 **Mail Service Pharmacy**. CVS/caremark's mail service pharmacies shall provide the following products and Services:

(a) Dispense new or refill prescriptions following receipt from a Plan Participant and/or Prescriber of (i) a prescription and a completed order or refill order; and (ii) any applicable Cost Share;
(b) Fill prescriptions subject to the professional judgment of the dispensing pharmacist, good pharmacy practices in accordance with local community standards, and product labeling guidelines;
(c) Ship all drugs to Plan Participants via United States postal service or other appropriate carriers consistent with CVS/caremark's standard policies to the address provided by Participating Group and/or the Plan Participant. In the event non-standard shipping is requested by Participating Group and/or Plan Participant, additional charges may apply;
(d) CVS/caremark agrees that mail order unit costs charged to Participating Groups, prior to Cost Sharing, Dispensing Fees, and sales taxes, will be no greater than those at retail on the date dispensed with the exception of U&C Claims.

2.3 **Retail Pharmacy Network**. CVS/caremark contracts with Participating Pharmacies, which are independent contractors, to provide prescription drugs and related products and services with respect to the Plan. CVS/caremark shall:

(a) Require Participating Pharmacies to service Plan Participants during their normal business hours, in all applicable geographic areas;
(b) Include in its standard retail pharmacy network agreement that Participating Pharmacies must comply with CVS/caremark's terms and conditions applicable to participation in the retail pharmacy network in effect as may be amended from time to time;
(c) Provide information to Participating Pharmacies concerning drug interaction, safety edits, and generic substitution and therapeutic intervention programs;
(d) Direct Participating Pharmacies to collect all applicable Cost Shares or the lowest of Cost Share, U&C, MAC plus the Dispensing Fee, or discounted ingredient cost plus the Dispensing

Fee from Plan Participants;

(e) Provide and maintain toll free telephone access for Participating Pharmacies to address Claim submission and clinical Drug Utilization Review issues;

(f) Maintain a database of Participating Pharmacies so that Plan Participants and Participating Group may locate a Participating Pharmacy using CVS/caremark's Web site maintained consistent with Section 2.10(a) of this Agreement;

(g) Be solely responsible for payment to the Participating Pharmacies for prescriptions dispensed (exclusive of Cost Shares), provided that the foregoing shall not release NCRx or Participating Group from any payment obligation to CVS/caremark; and

(h) Conduct Participating Pharmacy audits as follows:

(i) CVS/caremark shall conduct weekly on-site and off-site audits of certain Participating Pharmacies as selected by CVS/caremark to help verify such Participating Pharmacies' compliance with their respective retail pharmacy network agreements with CVS/caremark ("**Periodic Audits**"). CVS/caremark shall have the sole right to audit Participating Pharmacies. Such audits shall include a daily review of Claims greater than one thousand dollars ($1,000). Additionally, NCRx or its designee, may request an on-site and/or off-site audit of Participating Pharmacies and CVS/caremark will take such request into consideration when scheduling audits; and

(ii) To the extent CVS/caremark determines, as the result of its Periodic Audits, that amounts have not been billed in accordance with CVS/caremark's retail pharmacy network agreements ("**Audit Discrepancies**"), CVS/caremark shall make reasonable attempts to reconcile such Audit Discrepancies. CVS/caremark shall provide one hundred percent (100%) of all recovered Audit Discrepancies to Participating Group. In the event an Audit Discrepancy has a financial impact to Participating Group, CVS/caremark shall reconcile Participating Group's invoice, or credit Participating Group, based upon such recovered Audit Discrepancy. CVS/caremark shall notify Participating Group of any Audit Discrepancy that has impacted Participating Group's financial obligation to CVS/caremark by greater than one thousand dollars ($1,000) that CVS/caremark determines to be reasonably uncollectible by CVS/caremark. Participating Group acknowledges and agrees that CVS/caremark may, but is not required to, initiate any collection action to collect any Audit Discrepancies. In the event CVS/caremark does initiate a collection action against a Participating Pharmacy for any Audit Discrepancy, CVS/caremark may offset any reasonable costs, including reasonable attorneys' fees and expenses, arising from any such action, with such expenses allocated among CVS/caremark's affected or impacted clients on a prorated basis against the amount of the recovery. CVS/caremark's obligation to conduct Periodic Audits and to attempt collection and reconciliation, as described, shall be CVS/caremark's sole obligation with respect to remedying Audit Discrepancies.

2.4 **Implementation.**

(a) In consultation with Participating Group, CVS/caremark shall develop a mutually agreeable implementation project plan prior to the Effective Date, or prior to the implementation of any new group or Plan during the Term.

(b) Participating Group or Participating Group's designee shall provide to CVS/caremark prior to the Effective Date, or prior to the implementation of any new group or Plan during the Term: (i) the initial eligibility test data and the initial full eligibility data; (ii) the governing Plan documents, a summary plan description, and an executed PDD; and (iii) a refill file (if available) in a format acceptable to CVS/caremark. Any delays by Participating Group or its designee in providing this information may reasonably delay the implementation of Services

by CVS/caremark.

(c) Subject to timely receipt of a refill file or prescription, CVS/caremark will begin filling prescriptions through its mail service pharmacies as of the Effective Date.

(d) CVS/caremark will make available implementation information to Plan Participants which may include the following materials: (i) introductory cover letter; (ii) standard identification cards for use within the retail network which shall include CVS/caremark's name and toll free number; (iii) a standard client benefit brochure; (iv) mail service order form; (v) paper Claim reimbursement form, if applicable; and (vi) PDL brochure, if applicable. At Participating Group's expense and election, CVS/caremark shall prepare envelopes for mailing such information to Plan Participants. CVS/caremark will use Plan Participant address information provided as part of the Eligibility Information submitted in accordance with Section 2.5. If Participating Group implements a Custom PDL, the parties will mutually agree on any costs associated with printing and distributing a Custom PDL brochure.

(e) Any reprints or customization of any communication materials requested by Participating Group shall be at Participating Group's expense. Notwithstanding the foregoing, replacement cards will be at no cost to Participating Group should the issuance of the replacement card be required as a result of an error on the card on the part of CVS/caremark.

2.5 **Eligibility Data**. Participating Group, or Participating Group's designee, at Participating Group's sole expense, will provide CVS/caremark all information concerning its Plan and Plan Participants needed to perform the Services, including any updates thereto ("**Eligibility Information**"). This Eligibility Information must be complete and accurate, provided timely, and in a mutually agreeable format and media. Participating Group acknowledges and agrees that CVS/caremark will not use Social Security Numbers on Plan Participants' identification cards and will instead use alternate identification numbers assigned and provided by Participating Group. Participating Group acknowledges that CVS/caremark, NCRx, Plan Participant's Prescriber or Participating Pharmacy shall be able to rely on the Eligibility Information provided by Participating Group.

2.6 **Formulary Management.**

A. **CVS/caremark Standard Formulary**. For Participating Groups that are electing the standard CVS/caremark PDL formulary the following terms apply:

(a) As designated in each Participating Group's Participating Group Addendum, Participating Group hereby adopts, as part of the Plan design and as Participating Group's formulary, either: standard CVS/caremark Performance Drug List – Standard Control, or the CVS/caremark Performance Drug List – Standard Control with prior authorization ("PA") Option, or CVS/caremark Performance Drug List - Standard Formulary Opt Out. The CVS/caremark Performance Drug List – Standard Control and the CVS/caremark Performance Drug List - Standard Control with PA Option and the CVS/caremark Performance Drug List - Standard Formulary Opt Out are collectively referred to herein as the PDL and Prescribing Guide, except as expressly noted. Participating Groups adopting the CVS/caremark Performance Drug List – Standard Control and Prescribing Guide, shall receive the minimum Rebate guarantees identified in Exhibit A of this Agreement as "CVS/caremark Performance Drug List – Standard Control" and "CVS/caremark Performance Drug List – Standard Control with PA Option" Participating Groups adopting the CVS/caremark Performance Drug List - Standard Formulary Opt Out and Prescribing Guide, shall receive the minimum Rebate guarantees identified in Exhibit A of this Agreement as "CVS/caremark Performance Drug List - Standard Formulary Opt Out. The parties acknowledge that Plan Participant and Prescriber materials prepared by CVS/caremark that list drugs excluded from the CVS/caremark PDL and Prescribing Guide may be labeled as "Formulary Exclusions" or

"Formulary Drug Removals."

(b) During the term of the agreement, NCRx may establish a custom formulary option ("Custom PDL"). Rebate guarantees associated with the Custom PDL will be negotiated in good faith.

(c) Changes made by CVS/caremark to the PDL, may be based upon, among other things, the introduction of new products, customer safety, clinical appropriateness, efficacy, cost effectiveness, changes in availability of products, new clinical information and other considerations, changes in the pharmaceutical industry or its practices, introduction of new Generic Drugs, new legislation and regulations. CVS/caremark shall use best efforts to provide NCRx with thirty (30) days' notice prior to the addition, or movement within tiers of a drug on the PDL, which may include but not be limited to, movement of a drug from a preferred to a non-preferred tier, or vice versa. The parties acknowledge that CVS/caremark may elect to add to the PDL new drugs to the market, or line-extensions of certain drugs. In the event safety concerns, regulatory actions or other events outside of CVS/caremark's control require CVS/caremark to remove a drug sooner, CVS/caremark shall notify NCRx of the removal of a drug from the PDL within five (5) business days.

(d) With regards to any drugs CVS/caremark may not identify as a Covered Drug, or remove from the PDL, CVS/caremark may make PDL decisions based upon, among other things, new products, customer safety, clinical appropriateness, efficacy, cost effectiveness, changes in availability of products, new clinical information and other considerations, changes in the pharmaceutical industry, introduction of new Generic Drugs, new legislation and regulations. CVS/caremark agrees, however, that (i) drugs shall be removed from the PDL only once per calendar year; (ii) to provide such notice of the drugs being removed from the PDL on or around August 1 of each calendar year. In the event of a removal of a drug from the PDL, CVS/caremark agrees to provide targeted communications to Plan Participants prior to the date of drug removal; and (iv) to provide a detailed disruption analysis at least ninety (90) days in advance of any removal from the PDL.

(e) CVS/caremark may implement Drug Interchange program(s), which has been approved by CVS/caremark's pharmacy and therapeutics committee for selected prescriptions under which CVS/caremark's mail service pharmacy shall contact Prescribers, as appropriate, to obtain approval for the Drug Interchange. In accordance with its standard policies, CVS/caremark shall credit Participating Group or Plan Participant, as appropriate, for any mail prescription returned to CVS/caremark upon rejection by the Plan Participant of the Drug Interchange. Participating Group and NCRx acknowledge that the adoption of therapeutic interventions may result in an increase of Rebates payable by pharmaceutical manufacturers pursuant to their agreements with CVS/caremark. CVS/caremark will not engage in any practice that results in the conversion of a lower discounted ingredient cost drug products to higher ingredient cost drug products or increases Cost Share without the prior written consent of NCRx or Participating Group. The parties agree that CVS/caremark's compliance with the terms of the settlement agreement entered during 2008 by, among others, CVS/caremark Rx, L.L.C. and certain states of the United States, effective March 1, 2009, shall satisfy this requirement.

(f) NCRx, Participating Group and CVS/caremark acknowledge that the Prescriber shall have final authority over the drug prescribed to a Plan Participant, regardless of benefit coverage.

(g) CVS/caremark may implement Drug Interchange programs, as approved by its pharmacy and therapeutics committee, for Participating Pharmacies to promote the use of the PDL by encouraging Participating Pharmacies to: (i) identify appropriate opportunities for converting a prescription for a non-preferred Covered Drug to a clinically comparable preferred Brand Drug or Generic Drug, and (ii) contact the Plan Participant and the Prescriber to request that the prescription be changed to a clinically comparable preferred Brand Drug or Generic Drug.

B. **CVS/caremark's Advanced Control Formulary**. For Participating Groups that are electing CVS/caremark's Advanced Control Formulary the following terms apply.

a) Participating Group hereby adopts, as part of the Plan design and as Participating Group's formulary, CVS/caremark PDL, or Advanced Control Formulary, as in effect from time to time.

b) Changes made by CVS/caremark to PDL, may be based upon, among other things, the introduction of new products, customer safety, clinical appropriateness, efficacy, cost effectiveness, changes in availability of products, new clinical information and other considerations, changes in the pharmaceutical industry or its practices, introduction of new Generic Drugs, new legislation and regulations. CVS/caremark shall provide quarterly updates to NCRx regarding any additions, removals or movement within the tiers of the Advanced Control Formulary. CVS/caremark shall use best efforts to provide Participating Group with thirty (30) days' notice prior to the addition, removal or movement within tiers of a drug on the PDL, which may include but not limited to, movement of a drug from a preferred to a non-preferred tier, or vice versa. The parties acknowledge that CVS/caremark may elect to add to the PDL new drugs to the market, or line-extensions of certain drugs after CVS/caremark's P&T Committee has evaluated such drug and recommends such drug should be added to the Advanced Control Formulary. In the event safety concerns, regulatory action, or other events outside of CVS/caremark's control require CVS/caremark to remove a drug sooner, CVS/caremark shall notify NCRx of the removal of a drug from the PDL within five (5) business days.

c) With regards to any drugs CVS/caremark may not identify as a Covered Drug, or remove from the PDL, CVS/caremark may make such decisions based upon, among other things, new products, customer safety, clinical appropriateness, efficacy, cost effectiveness, changes in availability of products, new clinical information and other considerations, changes in the pharmaceutical industry, introduction of new Generic Drugs, new legislation and regulations. Participating Group acknowledges and agrees, however, that CVS/caremark (i) may remove or add drugs from or to the Advanced Control Formulary drugs from time to time; and (ii) to provide Participating Group quarterly notification of any changes to the Advanced Control Formulary. In the event of a removal of a drug from the PDL CVS/caremark agrees to provide targeted communications to Plan Participants prior to the date of removal.

d) CVS/caremark may implement Drug Interchange program(s), which has been approved by CVS/caremark's pharmacy and therapeutics committee for selected prescriptions, under which CVS/caremark's mail service pharmacy shall contact Prescribers, as appropriate, to obtain approval for the Drug Interchange. In accordance with its standard policies, CVS/caremark shall credit Participating Group or Plan Participant, as appropriate, for any mail prescription returned to CVS/caremark upon rejection by the Plan Participant of the Drug Interchange. Participating Group and NCRx acknowledge that the adoption of therapeutic interventions may result in an increase of Rebates payable by pharmaceutical manufacturers pursuant to their agreements with CVS/caremark.

e) Participating Group and NCRx acknowledge that the Prescriber shall have final authority over the drug prescribed to a Plan Participant, regardless of benefit coverage.

f) CVS/caremark to provide a detailed disruption analysis at least thirty (30) days in advance of any removal from the PDL.

[Include (h) below and replace (B) above with the following when ADVANCED CONTROL FORMULARY FOR SPECIALTY ONLY is elected by a Participating Group. The standard formulary would be applicable for non-specialty products and the following subsection shall be added.]

h) Advanced Control Formulary for Specialty Drugs: Participating Group hereby adopts, as part of the Plan design and as Participating Group's formulary, CVS/caremark's Advanced Control Formulary for Specialty Drugs, as in effect from time to time. CVS/caremark's Advanced Control

Formulary for Specialty Drugs ("Advanced Specialty Formulary"), is specific to Specialty Drugs and the process, as described below, shall be different than CVS/caremark's PDL.

i) Changes made by CVS/caremark to Advanced Specialty Formulary, may be based upon, among other things, the introduction of new products, customer safety, clinical appropriateness, efficacy, cost effectiveness, changes in availability of products, new clinical information and other considerations, changes in the pharmaceutical industry or its practices, introduction of new Specialty Drugs, new legislation and regulations. CVS/caremark may provide quarterly updates to Participating Group regarding any additions, removals or movement within the tiers of the Advanced Control Formulary and use best efforts to provide Participating Group with thirty (30) days, notice prior to the addition, removal or movement within tiers of a drug on the PDL, which may include but not limited to, movement of a drug from a preferred to a non-preferred tier, or vice versa. The parties acknowledge that CVS/caremark may elect to add to the Advanced Specialty Formulary new drugs to the market, or line-extensions of certain drugs after CVS/caremark's P&T Committee has evaluated such Specialty Drug and recommends such drug should be added to the Advanced Specialty Formulary. In the event safety concerns, regulatory action or other events outside of CVS/caremark's control require CVS/caremark to remove a drug sooner, CVS/caremark shall notify Participating Group of the removal of a drug from the Advanced Specialty Formulary within five (5) business days.

ii) With regards to any Specialty Drug CVS/caremark may not identify as a Covered Drug, or remove from the Advanced Specialty Formulary, CVS/caremark may make such decisions based upon, among other things, new products, customer safety, clinical appropriateness, efficacy, cost effectiveness, changes in availability of products, new clinical information and other considerations, changes in the pharmaceutical industry, introduction of new Specialty Drugs, new legislation and regulations. Participating Group acknowledges and agrees, however, that CVS/caremark (i) may remove or add drugs from or to the Advanced Specialty Formulary any Specialty Drug, from time to time; and (ii) will provide Participating Group quarterly notification of any changes to the Advanced Control Formulary. In the event of a removal of a drug from the Advanced Specialty Formulary, CVS/caremark agrees to provide targeted communications to Plan Participants prior to the date of removal.

iii) Participating Group acknowledges the Prescriber shall have final authority over the drug prescribed to a Plan Participant, regardless of benefit coverage.

iv) CVS/caremark to provide a detailed disruption analysis at least thirty (30) days in advance of any removal from the PDL.

(C) Value Formulary. For Participating Groups that are electing the Value Formulary ("VBF Program") the following terms apply:

(i) upon election of the VBF Program, Participating Group adopts, as part of its Plan design and as Participating Group's formulary, the Value Based Formulary. The Value Based Formulary is a restrictive formulary that addresses all disease states and drug classes. Participating Group acknowledges and agrees that under the Highly Managed most major drug classes shall only include Generic Drugs and only select drug classes may include Brand Drugs when clinically necessary. Participating Group further acknowledges and agrees that CVS/caremark reserves the right to modify the Value Based Formulary from time to time with advance written notification to NCRx and Participating Group;

(ii) Participating Group directs CVS/caremark to implement, as CVS/caremark determines necessary, certain prior authorizations or step therapy edits to appropriately promote Generic Drug alternatives under the Value Based Formulary;

(iii) CVS/caremark shall communicate with Plan Participants and prescribing physicians regarding the Value Based Formulary. Such communications may include, but not be limited to:

(1) pre-implementation letters to Plan Participants targeting Brand Drugs that are no longer covered by the Value Based Formulary, or may require a Generic Drug to be tried prior to the Brand Drug,

(2) post-implementation letters sent to impacted Plan Participants alerting them to any Value Based Formulary changes, or

(3) notification letters to prescribers identifying the drugs available on the Value Based Formulary;

(iv) the Value Based Formulary may be a change to Participating Group's existing Plan design. Participating Group is responsible for its Plan's compliance with all applicable laws and regulations, for making any appropriate notifications to Plan Participants concerning the VBF Program and for making any appropriate changes to the Plan's Plan design documents to reflect participation in the VBF Program; (v) If Participating Group does not adopt all of the requirements of the VBF Program or otherwise qualify for the VBF Program, then CVS/caremark reserves the right to modify the minimum Rebate guarantees applicable under this Agreement. With the implementation of the VBF Program, and due to the emphasis on dispensing Generic Drugs, the minimum Rebate guarantees applicable to Participating Group electing to participate in the VBF Program shall be as designated in the pricing table located in Exhibit A.

2.7 **Generic Substitution Program.**

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

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

2.8 **Drug Utilization Review ("DUR") Services.**

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

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

2.9 **Plan Participant Services**. CVS/caremark shall operate toll-free customer service lines twenty-four (24) hours a day, seven (7) days a week for the purpose of responding to inquiries from Plan Participants. CVS/caremark shall also provide telephonic emergency pharmacist Services twenty-four (24) hours a day, seven (7) days a week.

2.10 **Communication Materials**. In addition to materials provided under Section 2.4(d), CVS/caremark shall produce and provide the following communication materials:

(a) CVS/caremark will provide an Internet Web site where Plan Participants can access information with respect to Plan specific drug information, the PDL or Custom PDL, Cost Shares, Participating Pharmacy listings and prescriptions.
(b) CVS/caremark may provide communications to Plan Participants and/or Participating Group regarding drug recalls or withdrawals. NCRx and Participating Group acknowledge that NCRx or Participating Group shall look solely to pharmaceutical companies and not to CVS/caremark for any refunds or reimbursements associated with such drug recalls or withdrawals.
(c) CVS/caremark may also communicate to Plan Participants about health-related products or services that would be offered on behalf of Participating Group through CVS/caremark as a value-added item or service that is not part of the Plan benefit.
(d) CVS/caremark shall not send non-emergency, standard form communication materials to Plan Participants without NCRx's prior approval.

2.11 **Reports, Claims Data and SSAE 16**. CVS/caremark shall provide reports and detailed Claims data to Participating Group and NCRx as follows:

(a) CVS/caremark shall prepare and provide Participating Group with CVS/caremark's standard management and utilization reports.
(b) At NCRx or Participating Group's request and expense, CVS/caremark may prepare and provide non-standard management and utilization reports and ad hoc reports within an agreed-upon time and format, at CVS/caremark's prevailing rate.
(c) With the issuance of each Claims invoice, CVS/caremark shall provide Participating Group with up to two (2) sets of complete Claims data in CVS/caremark's standard format at no additional charge. At Participating Group's expense, request and direction, CVS/caremark may provide detailed electronic Claims files or Claim detail reports to Participating Group's designated third party service provider subject to such third party's execution of CVS/caremark's standard confidentiality agreement. At no additional charge, CVS/caremark shall provide, and Participating Group authorizes, CVS/caremark to provide NCRx, on a bi-weekly basis, with one (1) set of complete Claims data for all Participating Groups in CVS/caremark's standard format at no additional charge and, on a monthly basis, one (1) eligibility file for all Participating Groups in CVS/caremark's standard format. Except as otherwise set forth in Section 10 of this Agreement, Participating Group shall not release or provide any Claims data including pricing and other Confidential Information, to a third party.
(d) If requested, CVS/caremark shall provide Participating Group with a copy of its most recent SSAE 16 (SOC 1) report, or a copy of the successor to such report, in accordance with the terms and conditions of such report.

2.12 **Plan Enhancements for Non-Covered Drugs.** If elected by Participating Group, CVS/caremark may provide to Plan Participants filling prescriptions at Participating Pharmacies discounts on prescription drugs that are not Covered Drugs. Claims that process with such discounts are excluded from any and all commitments CVS/caremark may have to Participating Group under this Agreement, including those relating to pricing, rates, or Rebates. Participating Group acknowledges that CVS/caremark will retain Rebates, if any, and charge Plan Participant fees that may be part of a Plan Participant's prescription price for Claims processed through this program to assist CVS/caremark in funding this program.

2.13 **Drug Classification**. CVS/caremark shall use Medi-Span Master Drug Database (Medi-Span) indicators, and their associated files, or indicators provided by another nationally available reporting service of pharmaceutical drug information in helping to determine the classification of drugs (*e.g*., prescription vs. over the counter, brand vs. generic, single-source vs. multi-source) for purposes of this Agreement. As of the Effective Date, CVS/caremark uses Medi-Span Prescription Pricing Guide (with supplements) for determining all client AWP. Upon request, CVS/caremark shall disclose to NCRx within a reasonable period the service used to determine the classification of a drug.

2.14 **Specialty Pharmacy**. CVS/caremark's specialty pharmacies shall provide specialty pharmacy products and Services as follows:

(a) Dispense new or refill prescription orders for Specialty Drugs upon receipt from a Plan Participant of (i) a prescription and a completed order or refill order form; and (ii) the applicable Cost Share;
(b) Fill prescriptions for Specialty Drugs subject to the professional judgment of the dispensing pharmacist, good pharmacy practices in accordance with local community standards, and product labeling and guidelines;
(c) Ship Specialty Drugs to Plan Participants via the United States postal service or other appropriate carriers consistent with CVS/caremark's standard policies to the address provided by Participating Group and/or Plan Participant. In the event non-standard shipping is requested by Participating Group and/or Plan Participant, additional charges may apply; and
(d) Bill Participating Group's medical benefits provider when appropriate, and pursuant to instructions from Participating Group's medical benefits provider.

2.15 **Government Agency Submitted Claims**. Participating Group acknowledges that government agencies, or their agents may seek eligibility or similar data from CVS/caremark regarding Plan Participants. Additionally, government agencies, or their agents, may submit to CVS/caremark claims for reimbursement for prescription drug benefits provided by such government agencies, or their agents, to Plan Participants ("**Government Claims**"). Participating Group authorizes CVS/caremark to provide such data as requested by government agencies or their agents and further authorizes CVS/caremark to process such Government Claims. Participating Group acknowledges that CVS/caremark may advance payment for Government Claims on behalf of Participating Group. Participating Group will reimburse CVS/caremark, in accordance with Participating Group's payment obligations under this Agreement, for all amounts advanced by CVS/caremark for payment of Government Claims. Participating Group acknowledges that Government Claims submitted by or on behalf of a state Medicaid agency shall be paid if submitted within three (3) years from the original date of fill unless a longer period is required by applicable law. In addition, Government Claims submitted by or on behalf of a state Medicaid agency may not be denied on the basis of the format of the Government Claim or failure to present proper documentation at the point-of-sale. Participating Group shall also reimburse CVS/caremark for any adjustments or reconciliations to previously processed Government Claims that may be payable to government

agencies in accordance with applicable laws and regulations. The administrative fee for processing Government Claims will be invoiced at the paper submitted Claim rate stated in Exhibit A or as otherwise agreed in writing by CVS/caremark and Participating Group. CVS/caremark reserves the right to (i) to terminate these Services upon ninety (90) days prior notice to Participating Group; or (ii) to delegate these Services to a third party claims processor.

2.16 **Clinical Programs.**

(a) CVS/caremark shall provide the clinical programs identified in the PDD and elected by Participating Group for the fees set forth in Exhibit A.

(b) As identified in the PDD, Participating Group may authorize CVS/caremark to perform Services or programs (collectively referred to herein as "**Additional Health-Related Service**s") that include Prescriber education programs, health research, compliance and persistency, and health education or management programs for Plan Participants. If elected by Participating Group, CVS/caremark shall provide such Additional Health-Related Services in accordance with applicable law, including HIPAA. Participating Group, NCRx and CVS/caremark acknowledge and agree that: (i) although the Additional Health-Related Services may be of benefit to Participating Group and its Plan Participants, CVS/caremark will not charge Participating Group for the performance of such Additional Health-Related Services; (ii) the performance of such Additional Health-Related Services may utilize PHI; (iii) the performance and scope of such Additional Health-Related Services shall be determined by CVS/caremark, and CVS/caremark shall have no obligation to perform Additional Health-Related Services; and (iv) CVS/caremark may contract with, and pursue and retain for its own account compensation or fees received from, pharmaceutical companies for the funding and provision of such Additional Health-Related Services. Participating Group may discontinue one (1) or more Additional Health-Related Services upon sixty (60) days prior written notice to CVS/caremark and upon an amendment to the PDD.

(c) The pricing provided in Exhibit A is not contingent upon Participating Group participation in any proposed clinical programs, except as set forth in Exhibit A. Participating Groups are not required to elect the clinical programs set forth in Exhibit A.

2.17 **Debit Card Program**. Participating Group hereby authorizes and directs CVS/caremark to disclose data, upon the request of Participating Group, to a third party vendor for the purposes of administering debit card program payments under a flexible spending account or other consumer directed health plan subject to such third party's execution of CVS/caremark's standard confidentiality agreement. CVS/caremark may provide such data, as requested by the third party for this purpose, until such time as Participating Group advises CVS/caremark otherwise in writing.

2.18 **Performance Guarantees**. CVS/caremark agrees to perform in accordance with the performance standards described in Exhibit D. Unless otherwise stated, all performance standards shall be measured across CVS/caremark's book of business based on CVS/caremark's standard calculation methodology and shall exclude Specialty Drugs and related specialty services.

2.19 **Appeals.** If elected by Participating Group, CVS/caremark shall conduct appeals for the fees set forth in Exhibit A in accordance with the terms and conditions described in Exhibit E.

2.20 **ExtraCare Health Discount Card. [Optional but ONLY for Maintenance Choice (mandatory or incentivized) or a limited network offering]** If elected by Participating Group, CVS/caremark shall provide Plan Participants with an ExtraCare Health discount card ("**ExtraCare Card**"). The ExtraCare Card provides the ability to earn rewards for purchases at CVS/pharmacy store or online at CVS.com and to receive a 20% discount on all CVS-branded health care-related items at

CVS/pharmacy stores; provided that no rewards or discounts are available for the purchase of certain items such as prescription drugs (including Cost Shares).

Participating Group has either mailed or authorized CVS/caremark on its behalf to mail a letter to all Plan Participants reflecting that the ExtraCare Card is being provided as a health plan benefit. Participating Group further acknowledges that it is offering the ExtraCare Card to the Plan Participants as a value-added item or service under HIPAA.

2.21 **Medicare Retiree Drug Subsidy**. If elected by Participating Group, CVS/caremark shall provide the Medicare Retiree Drug Subsidy Services in accordance with the terms and conditions described in Exhibit G.

2.22 **Preventative Care Drug Program**. If elected by Participating Group, CVS/caremark shall administer Participating Group's preventive care drug program for its high deductible health plan in accordance with the terms and conditions described in Exhibit H.

2.23 **Vaccine Services**. Should any Participating Group elect for CVS/caremark to provide vaccine administration services, CVS/caremark shall do so in accordance with the terms and conditions described in Exhibit I.

2.24 **Personnel.** CVS/caremark will provide dedicated account management support (including pre-sale support), implementation, enrollment and other ongoing Services for NCRx and each Participating Group in accordance with the terms of this Agreement and each applicable Participating Group Addendum and meet the requirements of minimum dedicated personnel as shown on Exhibit J (CVS/caremark Dedicated Personnel).

2.25 **Maintenance Choice Program**.

(a) (Applicable to Participating Group(s) governed by ERISA) - If elected by Participating Group(s) that are governed by ERISA, Participating Group acknowledges and agrees that Participating Group(s) may elect CVS/caremark's Maintenance Choice Program and that CVS/caremark shall provide such Maintenance Choice Program to Participating Group's eligible Plan(s) in accordance with the terms and conditions described in Exhibit K. Participating Group acknowledges and agrees that Participating Group's Plan(s) participating in the Maintenance Choice program may not participate in the CVS/caremark Retail-90 Network program.

(b) (Applicable to Participating Group(s) NOT governed by ERISA) - If elected by Participating Group(s) that are NOT governed by ERISA, Participating Group acknowledges and agrees that eligible Participating Group(s) may elect CVS/caremark's Maintenance Choice Program and that CVS/caremark shall provide such Maintenance Choice Program to Participating Group's eligible Plan(s) in accordance with the terms and conditions described in the "**Maintenance Choice Letter Agreement**" to be executed by such non-ERISA Participating Group. Participating Group acknowledges and agrees that Participating Group's Plan(s) participating in the Maintenance Choice program may not participate in the CVS/caremark Retail-90 Network program.

3. **Maintenance of Records.** CVS/caremark shall maintain records with respect to the processing, payment, and denial of Claims by CVS/caremark and shall retain such records for a period of up to ten (10) years after the transaction occurred or as otherwise required by applicable law.

4. **Use of Deidentified Data.** Claims, as well as Eligibility Information which is deidentified in accordance with HIPAA and other applicable law, and which is not identifiable on a Participating Group or Plan Participant basis, may be used, disclosed, reproduced, adapted or sold by CVS/caremark. Such deidentified data may be provided to nationally recognized data integration firms to support appropriate administration of CVS/caremark's drug management programs. This benchmarking data enables CVS/caremark to compare against other drug population sets and improve programs and Services for clients.

5. **Audit Rights.**

5.1 **Claims Audits**.

NCRx shall have the right, using an independent third party, subject to the approval of CVS/caremark (not to be unreasonably withheld), to audit the books and records of CVS/caremark and its PBM affiliates to assure the accuracy of the fees, charges, Rebates, credits and benefit design provided for under each Participating Group Agreement entered into under this Agreement, and to assure the compliance of CVS/caremark and its affiliates with their other obligations to each Participating Group and to NCRx. Each Contract Year may only be audited by NCRx one (1) time. Such audit shall be limited to the prior Contract Year and will consist of an audit of CVS/caremark data that directly relates to Participating Group Claims billings (including fees, charges, credits and administration of Participating Group's benefit design) during the Term of this Agreement, and NCRx shall have the right to perform audits pursuant to this Section 5.1 up to two (2) years following expiration of the Term or termination of this Agreement. As a part of the Claims audit NCRx shall not be entitled to audit: (i) documents that CVS/caremark is barred from disclosing by applicable Law or pursuant to an obligation of confidentiality to a third party; and (ii) agreements with vendors, pharmaceutical manufacturers, or distributors, Participating Pharmacies or other providers of products or services to CVS/caremark. Any mutually agreed upon third party auditor engaged by NCRx shall execute CVS/caremark's standard confidentiality agreement prior to conducting a Claims audit ensuring that all information reviewed during such audit and all details will be treated as confidential and will not be revealed in any manner or form by or to any third party. The scope and procedures of the Claims audit shall be in accordance with the procedures set forth in Exhibit C.

5.2 **Rebate Audits.**

(a) NCRx, through a mutually agreeable independent third party retained by NCRx, may conduct a Rebate audit for prior Contract Years. Such audit shall be limited to a review of up to ten (10) pharmaceutical company contracts directly related to NCRx's Rebates as selected by NCRx. Each Contract Year may only be audited by NCRx one (1) time and will be started within three (3) years of the Contract Year to be audited. Audits may include multiple years, but shall be no more frequently than annually. CVS/caremark will provide additional contracts, at NCRx's or their auditor's request, if the 10 provided do not represent 80% of the Rebates provided for the time period being audited. Such review of pharmaceutical company contracts may include formulary and Rebate provisions to the extent permitted by such contracts and shall be limited to information necessary for validating the accuracy of the Rebate amounts remitted to NCRx by CVS/caremark. NCRx shall have the right to perform audits pursuant to this Section 5.2 up to two (2) years following expiration of the Term or termination of this Agreement. The scope and procedures of the Rebate audit shall be in accordance with the procedures set forth in Exhibit C.

(b) Any mutually agreed upon third party auditor engaged by NCRx shall execute CVS/caremark's form confidentiality agreement prior to conducting a Rebate audit ensuring that all information reviewed during such audit and all details and terms of any pharmaceutical company contract reviewed will be treated as confidential and will not be revealed in any manner or form by or to any third party, including Participating Groups.

6. Obligations of Participating Groups and/or NCRx.

6.1 **Plan Participant Authorizations**. Participating Group represents and warrants that it has obtained from Plan Participants all consents and/or authorizations required, if any, for CVS/caremark to perform the Services and for the use and disclosure of information, including PHI, as permitted under this Agreement.

6.2 **Control of Plan**. Participating Group will represent on its Participating Group Addendum whether the Plan is governed by ERISA. Unless otherwise stated in this Agreement, Participating Group and/or Plan administrator retain the sole and absolute authority to design, amend, terminate or modify, in whole or in part, all or any portion of the Plan, including the sole authority to control and administer the Plan and any assets of the Plan. Participating Group and/or Plan administrator shall also have complete discretionary, binding and final authority to construe the terms of the Plan, to interpret ambiguous Plan language, to make factual determinations regarding the payment of Claims or provision of benefits, to review denied Claims and to resolve complaints by Plan Participants. CVS/caremark agrees to be a fiduciary solely for the purpose of initial Claim adjudication and appeals relating to the coverage of prescription drug benefits, as further described in Exhibit E. CVS/caremark and Participating Group acknowledge and agree that, except with respect to its fiduciary obligations as specifically delegated and accepted by CVS/caremark pursuant to this Agreement, CVS/caremark shall not be (i) the administrator of the Plan for any purpose; (ii) a named fiduciary with respect to the Plan for purposes of ERISA or any applicable state law; (iii) delegated discretionary authority or responsibility, or exercise discretionary authority or control, with respect to the Plan or its administration; or (iv) deemed a fiduciary with respect to the Plan for purposes of ERISA or any applicable state law.

6.3 **PDD**.

(a) Participating Group represents and warrants that the PDD accurately reflects the applicable terms of the Plan for purposes of this Agreement.
(b) Plan design changes will be implemented by CVS/caremark within thirty (30) calendar days of receipt of notice from Participating Group, and will be implemented at no cost; provided, however, that complex changes (e.g. implementing add on plans, revised information technology systems, restructured plan designs, etc.) and any such changes that are to take effect between November 1 and February 1 of any year shall require at least sixty (60) calendar days prior notice. In the event that Participating Group requests that a Plan design change be implemented prior to the expiration of the applicable thirty (30) or sixty (60) calendar day period, CVS/caremark shall make reasonable efforts to implement the requested Plan design change by the requested date, however, CVS/caremark shall not be held responsible if it is unable to implement the requested Plan design change prior to the expiration of the applicable thirty (30) or sixty (60) calendar day period. Participating Group agrees that it is responsible for Losses resulting from: (i) any failure to implement Plan design changes which are not communicated in a written format acceptable to CVS/caremark; or (ii) CVS/caremark's implementation of Participating Group's verbal or written direction regarding exception or overrides to the PDD. Participating Group shall notify Plan Participants of any Plan design changes prior to the effective date of any such changes as required by PPACA or other

applicable law.

6.4 **Government Programs**. To the extent required by applicable law or contractual commitment, Participating Group agrees to fully and accurately disclose and report to Medicare, Medicaid or other government health care programs any discount or rebate or other credit received by Participating Group under this Agreement, whether reflected in the fees for the products and Services or otherwise provided hereunder, as discounts against the price of the drugs under all applicable state or federal programs that provide reimbursement to Participating Group for products or Services provided by CVS/caremark. It is the intention of the parties, that for purposes of the Federal Anti-kickback Statute, any discount, rebate or other Participating Group credit, shall constitute and be treated as discount against the price of drugs within the meaning of 42 U.S.C. §1320a 7b(b)(3)(A).

6.5 **Plan Participant Cost Share.** CVS/caremark may, but shall not be obligated to, dispense a prescription even if the prescription is not accompanied by the Cost Share. CVS/caremark will credit any amount submitted by Plan Participant in excess of the Plan Participant's Cost Share. Participating Group has a debit limit of $100 per cardholder, which may be increased or decreased by Participating Group at its discretion. Effective January 1, 2019, for Claims processed thereafter, CVS/caremark will not hold NCRx or Participating Group responsible for uncollected Cost Shares. Shipping of prescriptions submitted without the appropriate Cost Share may be delayed and these delayed shipments shall not be included in the measurement of any applicable performance guarantees.

6.6 **NCRx's/Participating Group's Obligation.** NCRx and Participating Group acknowledge CVS/caremark shall not be held responsible for fulfilling an obligation under this Agreement if NCRx, Participating Group or such parties' designee fails to provide CVS/caremark with accurate, timely and complete information that must be provided to CVS/caremark under the terms of this Agreement required to perform such obligation. CVS/caremark shall fulfill the obligation once the information has been provided to CVS/caremark and incorporated consistent with the terms of the Agreement.

6.7 **Participating Group Addendum.** NCRx shall be responsible for ensuring that each Participating Group executes an Addendum to this Agreement, in the form attached hereto as Exhibit F (the "**Participating Group Addendum**"), prior to CVS/caremark providing Services to such Participating Group. A Participating Group is required to execute a Participating Group Addendum as set forth in Exhibit F. In the event that Participating Group terminates its cooperative membership with NCRx, CVS/caremark shall revise the pricing of the terminating Participating Group's Addendum to reflect the Participating Group's population, for the remaining term of the Participating Group's agreement with CVS/caremark. On reasonable notice of such termination, CVS/caremark will not provide NCRx pricing to a Participating Group which terminates its membership in NCRx. If a Participating Group does not sign a renewal Participating Group Addendum extending the term of the Participating Group's Participating Group Addendum through December 31, 2021 ("Renewal Addendum"), within ninety (90) days following the Participating Group's receipt of a Renewal Addendum, then CVS/caremark reserves the right to provide the Participating Group, at any time during the remainder of the Term, the pricing and Rebates contained in Amendment No. 7 to the January 1, 2014 Master Agreement, that would otherwise apply to such Participating Group during calendar year 2018. Notwithstanding the foregoing, if a Participating Group signs a Renewal Addendum more than ninety (90) days following the Participating Group's receipt of a Renewal Addendum, then CVS/caremark shall provide the Participating Group, effective the first day of the first calendar quarter following the date on which the Participating Group signed the Renewal Addendum, the pricing and Rebates (with Rebates

payable in accordance with Section 3.1 of Exhibit A of this Agreement) in Amendment No. 7 to the January 1, 2014 Master Agreement, dated January 1, 2018, that are applicable to the Participating Group.

6.8 **Promote Purposes of Agreement.** Subject to the terms and conditions of this Agreement, NCRx will promote CVS/caremark as its exclusive vendor for Services to potential Participating Groups except (i) if CVS/caremark declines to bid on a potential Participating Group, (ii) as agreed in good faith between CVS/caremark and NCRx if NCRx believes CVS/caremark would not be able to adequately implement or service that potential Participating Group, or iii) if CVS/caremark directly and materially impact NCRx's ability to grow their business. NCRx shall use its best efforts to identify potential Participating Groups who would benefit from the Services provided by CVS/caremark and to market such Services to such potential Participating Groups. NCRx will diligently and to the best of its ability, perform duties and services customarily necessary and appropriate to assist Participating Groups with entering into a Participating Group Addendum with CVS/caremark to provide Services for Participating Groups and otherwise to facilitate the relationship between CVS/caremark and Participating Groups. CVS/caremark acknowledges and agrees that certain NCRx cooperative members who are themselves coalitions of employers will promote CVS/caremark to their respective coalition members as their recommended pharmacy benefit manager. If NCRx provides notice of termination of this Agreement, neither party will have any obligation to promote this Agreement in its final six (6) months.

6.9 **Disclosure to Participants.** NCRx will disclose to Participating Groups any and all matters related to this Agreement that are required by law to be disclosed, including but not limited to, information regarding fees payable to NCRx.

6.10 **Potential Participating Groups**. NCRx shall provide to CVS/caremark notice of any potential Participating Group which requires the provision of Services by submitting information to CVS/caremark in a form and content mutually agreed. CVS/caremark shall not be obligated to provide Services to a potential Participating Group until such time as the potential Participating Group and a duly authorized officer of CVS/caremark have executed a Participating Group Addendum, in form and substance acceptable to CVS/caremark and NCRx, for the provision of the Services by CVS/caremark. CVS/caremark reserves the right to decline a potential Participating Group if it determines in good faith that such potential Participating Group fails to meet financial criteria established for Participating Groups by CVS/caremark and after consultation with NCRx prior to declining a potential Participating Group. NCRx shall use its best efforts to facilitate the execution of a Participating Group Addendum and the implementation of Services for each such potential Participating Group. In the event a Participating Group signs a Participating Group Addendum less than twelve (12) months prior to expiration of the Term, the Participating Group shall be allowed to continue to receive the Services under this Agreement for a full twelve (12) month period of time provided the Participating Group remains a cooperative member of NCRx. Under all other circumstances, the termination of the Participating Group Addendum will coincide with the termination of the Agreement, unless mutually agreed upon by Participating Group, NCRx and CVS/caremark in the Participating Group Addendum.

7. Invoicing and Payment.

7.1 **Invoicing**. CVS/caremark shall invoice Participating Group in accordance with the terms set forth in Exhibit A according to the following schedule:

(a) Claims. CVS/caremark shall issue Participating Group an invoice for prescription Claims two (2) times monthly.

(a) Service Fees. CVS/caremark shall issue Participating Group an invoice for all other Services one (1) time monthly.

7.2 **Payment**. Participating Group shall pay CVS/caremark for the Services in accordance with the terms set forth in Exhibit A. Participating Group shall pay CVS/caremark all invoiced amounts for Claims and service fees within five (5) business days after Participating Group receives an invoice from CVS/caremark except for those amounts that are disputed in good faith, provided CVS/caremark is notified of the dispute and Participating Group has provided a detailed description justifying the dispute. CVS/caremark and Participating Group agree to actively work to resolve any dispute as outlined herein. Other than as stated above, Participating Group shall have no right to offset disputed amounts or amounts due or allegedly due from CVS/caremark from such payment, except as previously approved in writing by CVS/caremark. Any sales, use or other tax or assessment, including any surcharge or similar fee imposed under any applicable law on any health care provider, pharmaceutical supplier, Plan Participant, Claim(s) paid, service, supply or product provided under this Agreement, will be the sole responsibility of Participating Group and may be added to the invoice, unless (a) Participating Group is exempt from a certain tax or assessment and (b) Participating Group has provided sufficient evidence of such exemption in a timely manner to CVS/caremark pursuant to Section 13.9 of this Agreement.

7.3 **Late Payments**. Payments not received in accordance with Section 7.2 shall bear a service fee of one percent (1%) per month (or, if less, the highest rate allowed by law) from the due date until paid in full by Participating Group.

8. Pharmaceutical Contracts and Rebates.

8.1 **Participating Group Authorization.** NCRx and Participating Group authorize CVS/caremark to contract with pharmaceutical companies for Rebates as a group purchasing organization for the applicable Plan.

8.2 **Remittance of Rebates.** CVS/caremark will remit to NCRx, on behalf of Participating Group's, and NCRx will distribute the Rebates received by CVS/caremark with respect to Participating Group's Claims during the prior calendar quarter pursuant to Exhibit A. Rebates are guaranteed for the Term of the Agreement as well as any extension of this Agreement. NCRx and Participating Group each acknowledge and agree that it shall not have a right to interest on, or the time value of, any Rebate payments received by CVS/caremark or monies payable under this Agreement. Upon termination of this Agreement or upon NCRx and Participating Group's breach of this Agreement, CVS/caremark may use Rebates to set off amounts due from Participating Group or may reasonably delay remittance of Rebates to allow for final adjustments. Such right of set off or delay shall be in addition to CVS/caremark's other rights set forth in this Agreement, including, without limitation, Section 9.4.

8.3 **Rebate Limitations**. NCRx and Participating Group waive, release and forever discharge CVS/caremark from any Losses arising from a pharmaceutical company's (i) failure to pay Rebates; (ii) breach of an agreement related to Rebates; or (iii) negligence or misconduct affecting Rebates. NCRx and Participating Group acknowledge and agree that CVS/caremark will make commercially reasonable efforts to collect any Rebates from a pharmaceutical company, and may, but shall not be required to, initiate a collection action to collect any Rebates from a pharmaceutical company. In the event CVS/caremark does initiate collection action against a pharmaceutical company to collect Rebates, CVS/caremark may offset any reasonable costs, including reasonable attorneys' fees and expenses, arising from any such action. Such expenses will be allocated among CVS/caremark's affected or impacted clients on a prorated basis against the amount of the Rebate

recovery), arising from any such Rebate recovery action.

8.4 **Disclosure of Manufacturer Fees.** In accordance with Section 8.1 of this Agreement, CVS/caremark or its affiliates may hold contracts with pharmaceutical companies relating to products covered under this Agreement. In connection with such contracts, CVS/caremark or its affiliates may have a financial relationship with such pharmaceutical companies and may receive fees or other compensation from pharmaceutical companies for services rendered and property provided to pharmaceutical companies based on NCRx's utilization. These fees are defined as Rebates. In addition, CVS/caremark or its affiliates may receive concurrent or retrospective discounts from pharmaceutical companies which are attributable to or based on products purchased by CVS/caremark affiliated dispensing pharmacies. Other than Manufacturer Administrative Fees described above, the term "Rebates" shall not include any fees, compensation, and concurrent or retrospective discounts associated with the purchase price of products described in this Agreement, which belong exclusively to CVS/caremark or its affiliates.

8.5 **Non-Interference.** NCRx and Participating Group agree that during the Term of this Agreement, NCRx and Participating Group will not directly or indirectly negotiate, contract, or agree with any pharmaceutical company, or any other third party, for the purpose of obtaining Rebates or other discounts related to the drug utilization of Plan Participants, including, but not limited to the use of over the counter products. NCRx and Participating Group represents and warrants that, as of the Effective Date, it does not have any direct or indirect agreements, arrangements and/or contracts with any pharmaceutical company or other third party related to any Rebates or discounts. NCRx and Participating Group acknowledge and agree that a breach of this Section 8.5 shall be deemed a material breach of this Agreement.

8.6 **Rebate Reports.** Rebate reports listing detailed rebate utilization and calculations will be provided to NCRx and Participating Group.

9. Term and Termination.

9.1 **Term.** The term of this Agreement shall commence on the Effective Date and expire on December 31, 2021, subject to earlier termination as hereinafter set forth ("**Term**"). CVS/caremark shall provide NCRx with a renewal proposal at least one hundred eighty (180) days prior to the end of the Term.

9.2 **Termination.**

(a) **Termination Rights**.

i. CVS/caremark, Participating Group or NCRx may terminate its respective Agreement upon sixty (60) days prior written notice to the other party in the event of a material breach of this Agreement by the other party (other than a payment default, which is addressed in subsection (iii) which is not cured within sixty (60) days of notice thereof including, without limitation, any material breach described in Sections 8.5, 10 or 13.2.

ii. Participating Group may terminate their Participating Group Addendum upon a material breach by CVS/caremark of Exhibit B (Business Associate Obligations) of this Agreement if CVS/caremark does not cure the breach or if a cure is not possible, end the violation, within thirty (30) business days of receipt of written notice by CVS/caremark of such breach.

iii. If Participating Group fails to make any payment required under this Agreement and fails to cure such failure within seven (7) days of CVS/caremark providing written notice of such default to Participating Group, CVS/caremark may terminate the

Participating Group Addendum.

iv. NCRx may terminate this Agreement after December 31, 2019, without cause and without penalty, upon at least ninety (90) days prior written notice to CVS/caremark.

v. If the Agreement is terminated by NCRx under Section 9.2(a)i. or Section 9.2(a)(iv), all Participating Group Addendums shall automatically terminate.

vi. Participating Group may terminate, without penalty the Participating Group Addendum on ninety (90) days' written notice to CVS/caremark following a sale of all, or substantially all, of the assets of Participating Group or CVS/caremark

(b) **Effect of Early Termination**.

i. If the Participating Group Addendum is terminated as a result of a breach by Participating Group, in addition to any other remedy available in law or equity to CVS/caremark:

a. CVS/caremark shall retain 100% of any and all Rebates that have not been remitted to NCRx on behalf of Participating Group as of the date of such breach. The pursuit or award of damages shall not constitute a penalty or liquidated damages, and shall in no event preclude the right of CVS/caremark to any remedy available at law or equity.

b. In the event Participating Group also terminates its cooperative membership with NCRx, Participating Group shall pay NCRx a termination fee of $5.00 per Plan Participant, based on the total number of Plan Participants on the day prior to the effective date of the termination notice to NCRx, which amount shall not constitute a penalty or liquidated damages. Participating Group agrees that NCRx may request that CVS/caremark bill this fee during any termination notice period.

9.3 **Termination for Change in Law.**

(a) Subject to Section 9.3(b), either party may terminate this Agreement upon thirty (30) days prior written notice to the other party if, as a result of any Change in Law, as defined herein, the rights or obligations of the terminating party under this Agreement would be materially adversely affected. For purposes of this Section 9.3, the term "**Change in Law**" means any (i) applicable federal or state law or regulation enacted after the Effective Date, or any change in any existing applicable federal or state law or regulation; (ii) change in judicial or administrative interpretation of any applicable federal or state law or regulation; or (iii) change in the enforcement of any applicable federal or state law or regulation, in each case occurring after the date CVS/caremark begins providing Services or the Effective Date, whichever is earlier.

(b) Prior to any termination pursuant to Section 9.3(a), the parties agree to use prompt, good faith efforts to renegotiate the terms of this Agreement. If the parties successfully conclude such negotiations prior to the termination date, this Agreement shall not terminate and shall be amended to reflect the negotiated terms. In the event the parties are unable to successfully conclude such negotiations, this Agreement shall terminate as provided above. However, in the event that the parties are unable to successfully conclude such negotiations prior to the termination date, upon written notice to CVS/caremark twenty (20) days prior to termination of this Agreement, NCRx may elect to continue to receive Services pursuant to the revised terms and conditions proposed by CVS/caremark in order to comply with any Change in Law, for a period to be mutually agreed by the parties, but not less than ninety (90) calendar days if requested by NCRx.

(c) State Fiduciary Laws. CVS/caremark shall not be obligated at any time to provide Services to NCRx and/or Participating Groups, or, if applicable, Plan Participants, if NCRx and/or Participating Groups or, if applicable, Plan Participants are located in a state requiring a

prescription benefit manager to be a fiduciary to NCRx and/or Participating Groups or a Plan Participant, in any capacity, contrary to the terms and conditions specifically identified in this Agreement. In the event any state law or regulation requires CVS/caremark to be a fiduciary to NCRx and/or Participating Group or a Plan Participant contrary to the terms and conditions identified in this Agreement, CVS/caremark may elect not to provide Services to the impacted Participating Group(s) and/or Plan Participants upon thirty (30) days prior written notice to NCRx and/or Participating Group.

9.4 **Additional Remedies.**

(a) Suspension of Performance. In the event: (i) Participating Group is five business (5) days in arrears on its payment obligations under this Agreement and the Participating Group Addendum, as applicable, and Participating Group fails to cure such arrearage within two (2) business days of CVS/caremark notifying NCRx and Participating Group's designated day to day contacts of such outstanding amount; (ii) Participating Group fails to provide a deposit pursuant to Section 9.4(b) upon CVS/caremark's request; (iii) Participating Group makes an assignment for the benefit of creditors; (iv) Participating Group is the subject of a voluntary or involuntary petition for bankruptcy, or is adjudged insolvent or bankrupt; or (v) a receiver or trustee is appointed for any portion of Participating Group's rights or property, CVS/caremark may immediately, and without penalty or any liability for any Participating Group Losses, suspend performance of Services hereunder to such Participating Group until such time as any of the aforementioned conditions cease to exist. Notwithstanding anything in this Section 9.4 to the contrary, Participating Group acknowledges and agrees that CVS/caremark may suspend performance of Services to the Participating Group in the last two (2) months of the Term if Participating Group is two (2) business days in arrears on its payment obligations and Participating Group fails to cure such arrearage within two (2) business days of CVS/caremark notifying Participating Group's designated day to day contact of such outstanding amount. Suspension of performance under this Section 9.4(a) of the Agreement by CVS/caremark shall not constitute termination of this Agreement. CVS/caremark shall notify NCRx prior to suspending performance on or terminating a Participating Group's Addendum.

(b) Financial Responsibility. If at any time during this Agreement, Participating Group fails to comply with the payment terms, as set forth in Section 7.2 of this Agreement, on three (3) or more occasions within a four (4) month period, then CVS/caremark may request information, reasonable assurances, or both, from such Participating Group as to its financial responsibility (including a deposit in an amount equal to two (2) billing cycles based upon the average of the last three (3) months of billing history). If CVS/caremark requires Participating Group to provide a deposit, Participating Group will provide such deposit within ten (10) business days of CVS/caremark's request. If Participating Group gives CVS/caremark a deposit, CVS/caremark may apply the deposit to past due balances and shall return the remaining deposit, if any, after the termination of the Participating Group Addendum and the payment of all amounts payable to CVS/caremark hereunder. Any deposit provided by a Participating Group shall be paid from the general assets of Participating Group and not from assets of the Plan. Such deposit shall not be considered Plan assets for purposes of ERISA.

(c) In the event that CVS/caremark terminates this Agreement due to a material breach of this Agreement by NCRx or Participating Group, including without limitation, Sections 8.5 (Non-Interference), 10 (Confidentiality) and 13.2 (Exclusivity), CVS/caremark shall have no further obligation following the date of such material breach to pay the Participating Group, as applicable, any Rebates, or other amount that may be payable by CVS/caremark to Participating Group.

(d) The exercise by a party of any of its rights under Section 9 will not preclude such party from

seeking any other remedy available under this Agreement or at law or equity.

9.5 **Obligations Upon Termination.**

(a) Upon termination of this Agreement consistent with its terms, CVS/caremark shall, at NCRx or Participating Group's request, provide mutually agreed upon post-termination services at the rates set forth in Section 2.3 (Additional Services) of Exhibit A.
(b) Upon termination of this Agreement for any reason, CVS/caremark shall comply with the terms and conditions of Exhibit B regarding PHI.
(c) Upon termination of this Agreement for any reason, CVS/caremark will, at Participating Group's request, transition Claims files and/or history to Participating Group's new prescription benefit manager or any other third party that is scrubbed of CVS/caremark's Confidential Information.

10. Confidential and Proprietary Information.

10.1 **Confidential Information**. The term "**Confidential Information**" includes, but is not limited to, this Agreement or any information of any of NCRx, Participating Group or CVS/caremark (whether oral, written, electronic, visual or fixed in any tangible medium of expression) relating to another party's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers, contractors, costs and pricing data, trade secrets, know-how, processes, plans, designs and other information of or relating to either party's business. Confidential Information does not include PHI, the use and disclosure of which is governed by Section 12 of this Agreement.

10.2 **Confidentiality Obligations**.

(a) CVS/caremark, NCRx and Participating Group shall not disclose or make use of Confidential Information of the other parties except as permitted under this Agreement without the prior written consent of the owner of the Confidential Information, which consent may be conditioned upon the execution of a confidentiality agreement. Additionally, each party may disclose Confidential Information of the other parties only to its employees, agents, consultants, or authorized representatives who have a need to know the Confidential Information in order to accomplish the purpose of this Agreement and who (i) have been informed of the confidential and proprietary nature of the Confidential Information; and (ii) with respect to agents, consultants or authorized representatives, have agreed in writing not to disclose it to others and to treat it in accordance with the requirements of this Section. CVS/caremark, NCRx and Participating Group, as applicable, shall be responsible to the other parties for any breach of this Agreement by its respective employees, agents, consultants, or authorized representatives.
(b) Authorization to Release Data to NCRx's and Participating Group's Designated Third Party Service Providers. NCRx and Participating Group hereby authorizes CVS/caremark to disclose Confidential Information and other data, including Claims, utilization, eligibility, and cost data to NCRx or Participating Group's designated health benefit plan(s), consultants, auditors and third party service provider(s) (each, including with respect to Participating Group NCRx, a "Participating Group Service Provider") so that such Participating Group Service Provider may provide services to Participating Group with regard to such Confidential Information and data. NCRx and Participating Group each acknowledges that any such disclosure shall be subject to either the execution of a separate confidentiality agreement by CVS/caremark and Participating Group Service Provider or with respect to disclosures to NCRx, Section 10 of the Agreement, which shall govern the disclosure and use of such Confidential Information as between CVS/caremark and Participating Group Service

Provider. NCRx and Participating Group each authorizes CVS/caremark to provide Confidential Information to such Participating Group Service Provider for whatever time periods CVS/caremark holds the Confidential Information and other data or until NCRx or Participating Group revokes this authorization in writing. NCRx and Participating Group each acknowledges and agrees that to the extent any data disclosed to a Participating Group Service Provider includes Plan Participant information, including PHI, such Plan Participant information shall be disclosed by CVS/caremark on behalf of Participating Group and subject to the Business Associate Agreement between Participating Group and Participating Group Services Provider. Participating Group acknowledges that Participating Group Services Provider is not a downstream business associate of CVS/caremark for any purpose in connection with any such disclosure of data or Confidential Information. NCRx and Participating Group agrees that CVS/caremark and its subsidiaries and affiliates, and each of their respective officers, directors, employees and agents, will have no liability arising, in whole or in part, from: (i) the release of Confidential Information or PHI by CVS/caremark to a Participating Group Service Provider pursuant to NCRx or Participating Group's direction; or (ii) the use or subsequent release of Confidential Information or PHI by Participating Group Service Provider, NCRx or Participating Group.

10.3 **Permitted Disclosure of Confidential Information**. The foregoing shall not apply to such Confidential Information to the extent: (i) the information is or becomes generally available or known to the public through no fault of the receiving party; (ii) the information was already known by or available to the receiving party prior to the disclosure by the other party on a non-confidential basis; (iii) the information is subsequently disclosed to the receiving party by a third party who is not under any obligation of confidentiality to the disclosing party; (iv) the information has already been or is hereafter independently acquired or developed by the receiving party without violating any confidentiality agreement or other similar obligation; or (v) the information is required to be disclosed pursuant to a non-appealable court order. Except in accordance with the requirements of this Section 10.3 or as necessary to fulfill the purpose of Section 13.16, no party nor its employees, agents, consultants, or authorized representatives may disclose, or permit to be disclosed, Confidential Information of the other party as an expert witness in any proceeding, or in response to a request for information by oral questions, interrogatories, document requests, subpoena, civil investigative demand, formal or informal investigation by any government agency, judicial process or otherwise. If a party, or any of its respective employees, agents, consultants, or authorized representatives, is requested to disclose the Confidential Information of another party for any of the reasons described in the preceding sentence such party shall give prompt prior written notice to the disclosing party to allow the disclosing party to seek an appropriate protective order or modification of any requested disclosure. The receiving party agrees to cooperate with the disclosing party in any action by the disclosing party to obtain a protective order or other appropriate remedy. If the receiving party is ultimately legally compelled to disclose such Confidential Information, the receiving party shall disclose the minimum required pursuant to the court order or other legal compulsion.

10.4 **Remedies**. Any unauthorized disclosure or use of Confidential Information would cause CVS/caremark, NCRx or Participating Group immediate and irreparable injury or loss that may not be adequately compensated with money damages. Accordingly, if a party fails to comply with this Section 10, the other parties shall be entitled to specific performance including immediate issuance of a temporary restraining order or preliminary injunction enforcing this Agreement, and to judgment for Losses caused by the breach, and to any other remedies provided by law or in equity.

11. <u>Indemnification</u>.

11.1 **CVS/caremark Indemnification.** Subject to Section 13.6(b), CVS/caremark shall defend, indemnify and hold harmless NCRx, Participating Group, their respective subsidiaries and affiliates and each of their respective officers, directors, and employees (the "**Participating Group Parties**") from and against any and all Losses incurred by any Participating Group Parties arising out of or relating to CVS/caremark's negligent acts or omissions or breach of its obligations or warranties set forth in this Agreement, except to the extent such Losses are caused by the negligent acts or omissions or willful misconduct of any Participating Group Parties or breach of this Agreement by NCRx or Participating Group.

11.2 **NCRx and/or Participating Group Indemnification**.

(a) **Participating Group Indemnification**. Subject to Section 13.6(b), Participating Group shall defend, indemnify and hold harmless CVS/caremark, its subsidiaries and affiliates and each of their respective officers, directors, and employees (the "**CVS/caremark Parties**") from and against any and all Losses incurred by any CVS/caremark Parties arising out of or relating to (i) Participating Group's negligent acts or omissions or breach of its obligations or warranties set forth in this Agreement, except to the extent such Losses are caused by the negligent acts or omissions or willful misconduct of any CVS/caremark Parties or breach of this Agreement by CVS/caremark; (ii) any legal defects in the design of the Plan; or (iii) any deficiencies in the PDD approved by Participating Group.

(b) **NCRx Indemnification**. Subject to Section 13.6(b), NCRx shall defend, indemnify and hold harmless CVS/caremark, its subsidiaries and affiliates and each of their respective officers, directors, and employees (the "**CVS/caremark Parties**") from and against any and all Losses incurred by any CVS/caremark Parties arising out of or relating to (i) NCRx's negligent acts or omissions or breach of its obligations or warranties set forth in this Agreement, except to the extent such Losses are caused by the negligent acts or omissions or willful misconduct of any CVS/caremark Parties or breach of this Agreement by CVS/caremark.

11.3 **Notice of Claim.** Subject to the requirements of Section 13.16, the party seeking indemnification shall notify the other party in writing within thirty (30) days of the assertion of any legal claim or the commencement of any action or proceeding for which indemnity may be sought under this Agreement. Failure to notify the other party shall not result in the waiver of indemnity rights with respect to such legal claim, suit, action or proceeding unless such failure materially prejudices the ability of the indemnifying party to defend such legal claim, suit, action or proceeding. The parties shall cooperate with each other in the defense and settlement of any such legal claim, action or proceeding.

12. **Business Associate Relationship.** The parties acknowledge and agree that CVS/caremark is a Business Associate, as defined under HIPAA, of the Plan in connection with the provision of certain Services, and is a health care provider and Covered Entity, and not a Business Associate of Participating Group, under HIPAA in connection with its provision of certain other Services. To the extent CVS/caremark acts as a Business Associate of the Plan, and in accordance with HIPAA, CVS/caremark shall adhere to the applicable requirements established for Business Associates as set forth in Exhibit B. In compliance with applicable law, including HIPAA, CVS/caremark may share Plan Participant information, including PHI, as appropriate for the treatment, payment and health care operations of other health care providers (which may or may not be affiliated with CVS/caremark) or Plans.

13. **Miscellaneous Provisions.**

13.1 **Assignment**. No party may assign this Agreement without the prior written consent of the other parties, provided such consent will not be unreasonably withheld. However, CVS/caremark may assign this Agreement or delegate the duties to be performed under this Agreement without the consent of NCRx or Participating Group to any of its subsidiaries or affiliates at any time, or as part of a sale of all, or substantially all, of the assets to which this Agreement pertains.

13.2 **Exclusivity**. Subject to Section 6.8 and as otherwise mutually agreed, CVS/caremark shall be the exclusive provider to NCRx, Participating Groups and such Participating Group's Plan(s) of each of the Services described in this Agreement during the Term. Notwithstanding the foregoing, this Section shall not be construed to prohibit Participating Group from including pharmacy coverage under a managed care, HMO or similar comprehensive medical/prescription benefit plan. NCRx and Participating Groups acknowledge and agree that they will not provide, directly or indirectly, or engage any prescription benefit manager or other third party, to provide to Participating Groups or such Participating Group's Plan(s) any service that is similar to one of the Services provided by CVS/caremark, including without limitation, retail pharmacy network contracting, pharmacy Claims processing, mail and specialty pharmacy Services, and formulary and Rebate administration Services. NCRx and Participating Group acknowledge and agree that a breach of this Section 13.2 shall be deemed a material breach of this Agreement and shall entitle CVS/caremark to modify pricing terms pursuant to Section 13.3 of this Agreement. If NCRx provides notice of termination consistent with the terms of this Agreement, NCRx may negotiate, contract, or agree with any third party for the purpose of obtaining Services that will commence following the termination date of this Agreement, which action shall not constitute a violation of Section 8.5.

13.3 **Pricing Assumptions.** In addition to any pricing assumptions set forth in any pricing implementation or similar document that is executed by NCRx and/or Participating Group:

(a) Upon thirty (30) days prior written notice to NCRx, CVS/caremark reserves the right to modify or amend the financial provisions in this Agreement in a manner designed to equitably account for the impact of the events identified below. Such notice will include CVS/caremark's explanation, rationale and detailed analysis of the manner in which the modification accounts for the impact of the event:

1. Material change in the scope of services to be performed by CVS/caremark including, but not limited to: retail networks, mail service, formulary management or rebate administration, customer care services, or specialty pharmacy services;
2. Material change in total membership or Claims volume;
3. Material change in proportion of members or Claims attributed to Medicare Part D programs, Health Exchanges, or consumer driven high deductible plans, regardless of total membership or claims volume;
4. Modification of Participating Group's benefit design, including changes to the Plan's 90 days' supply incentives, retail network composition, formulary program selection, PDL alignment, clinical programs, utilization management, or step therapy edits;
5. Any government imposed or industry-wide change, including any prohibition or restriction on CVS/caremark's ability to receive rebates or discounts from pharmaceutical manufacturers; changes to methodology, availability, or publication of AWP; changes to tax laws; or a changes in CMS guidelines for government regulated programs, if applicable;
6. NCRx's and/or Participating Group's failure to implement, maintain, or satisfy the terms and conditions as described in the Agreement and/or the Pricing Commitment Document.

13.4 **Compliance with Law**. Each party shall comply with the provisions of all applicable laws relating to the performance of its obligations under this Agreement. Each party is responsible for obtaining its own legal advice concerning its compliance with applicable laws.

13.5 **Force Majeure**. Except for payment obligations, no party shall be liable for failure or delay of performance arising from an act of God or other events beyond the reasonable control of such party, such as the acts of a regulatory agency, fires, floods, pandemics, explosions, strikes, labor stoppages, and acts of terrorism, war or rebellion.

13.6 **Limitation of Liability**.

(a) Except as otherwise expressly set forth in this Agreement, the parties make no additional representations or warranties, including without limitation, warranties of merchantability or fitness for a particular purpose.
(b) In no event shall any party be liable to the other for any incidental, special, consequential, or punitive damages as a result of the performance or any default in the performance of their respective obligations under this Agreement.
(c) NCRx and Participating Group acknowledge that CVS/caremark does not establish AWP or other available industry pricing benchmark methodologies (e.g., "**Wholesale Acquisition Costs**" or "**WAC**"), and CVS/caremark shall have no liability to NCRx or Participating Group arising from the use of Medi-Span or any other nationally available reporting service.

13.7 **General.** Except as otherwise provided herein, this Agreement may not be amended except in a writing signed by both parties; provided, however, CVS/caremark may make changes to the Services from time to time provided such changes do not materially alter any of the provisions of this Agreement and may use Claims information to improve or recommend additional Services to Participating Group. If any provision of this Agreement is held to be invalid or unenforceable for any reason, such invalidity or unenforceability shall not affect the remainder of this Agreement, which shall remain in full force and effect and enforceable in accordance with its terms. This Agreement, including all documents referred to herein and attached hereto, constitutes the entire agreement of the parties with respect to the subject matter hereof and supersedes all prior oral or written representations, understanding and agreements between the parties with respect thereto. Any waiver of any breach of any provision of this Agreement shall not be a waiver of any subsequent breach of any provision of this Agreement. The terms and conditions of this Agreement are the result of an arm's length negotiations between the parties and each party has had the opportunity to obtain the advice of legal counsel regarding the negotiations and execution of this Agreement. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The section headings contained in this Agreement are solely for the purpose of reference, are not part of the agreement of the parties and shall not in any way affect the meaning or interpretation of this Agreement.

13.8 **Governing Law/Venue.** This Agreement shall be governed by, construed and enforced in accordance with the laws of the State of Wisconsin (without regard to its conflict of laws rules). Subject to Section 13.16, any suit brought hereunder, including any action to compel arbitration or to enforce any award or judgment reentered thereby, shall be brought in the state or federal courts sitting in Wisconsin the parties hereby waiving any legal claim or defense that such forum is not convenient or proper. Each party agrees that any such court shall have *in personam* jurisdiction over it and consents to service of process in any manner authorized by Wisconsin law.

13.9 **Notices**. Any notice given under this Agreement shall be given in writing, and sent by hand delivery, facsimile transmission (receipt confirmed), overnight courier that provides confirmation of delivery, or certified mail, return receipt requested, to the applicable party at its address set forth below:

If to CVS/caremark:

2211 Sanders Road, 10th Floor
Northbrook, Illinois 60062
Attn: Vice President and Senior Counsel, Healthcare Services
Fax No: (847) 559-4879

With a copy to:

9501 E. Shea Blvd.
Scottsdale, AZ 85260
Attn: Senior Vice President, Health Care Services
Fax No: (480) 314-8231

If to Participating Group:

Address of Participating Group as identified in Exhibit F, as applicable.

If to NCRx, including copies of Participating Group notices:

5510 Research Park Drive
Fitchburg, WI 53711
Attn: CEO
Fax No: (608) 204-9480

With a copy to:

Godfrey & Kahn, S.C.
Attn: Thomas Shorter
One East Main Street, Suite 500
P.O. Box 2719
Madison, Wisconsin 53701-2719
Fax No: (608) 257-0609

or to such other address or to the attention of such other person as either party may designate in writing pursuant to this Section 13.9. Written notices shall be deemed received on the date actually delivered to the other parties.

13.10 **Independent Contractors**. Nothing contained herein shall be deemed or construed by the parties hereto, or by any third party, as creating a relationship of employer and employee, principal and agent, or joint venture of the parties hereto; it being understood and agreed that no provision contained in this Agreement nor any acts of the parties hereto shall be deemed to place CVS/caremark in any relationship with NCRx or Participating Group other than as an independent contractor.

13.11 **Third Party Beneficiary.** This Agreement has been entered into solely for the benefit of NCRx

and CVS/caremark and is not intended to create any legal, equitable, or beneficial interest in any third party or to vest in any third party any interest as to enforcement or performance, including but not limited to, Participating Pharmacies or Plan Participants.

The Participating Group Addendum has been entered into solely for the benefit of Participating Group and CVS/caremark and is not intended to create any legal, equitable, or beneficial interest in any third party or to vest in any third party any interest as to enforcement or performance, including but not limited to, Participating Pharmacies or Plan Participants.

13.12 **Survival**. Sections 3 (Maintenance of Records), 4 (Use of Data), 6.1 (Plan Participant Authorizations), 6.2 (Control of Plan), 6.3(a) (PDD), 6.5 (Plan Participant Cost Share), 7.2 (Payment), 9.4 (Remedies), 9.5 (Obligations Upon Termination), 10 (Confidential and Proprietary Information), 11 (Indemnification), 13.6 (Limitation of Liability), 13.8 (Governing Law/Venue) 13.12 (Survival), 13.16 (Dispute Resolution), and Section 3.1 of Exhibit A, shall survive the termination or expiration of this Agreement.

13.13 **Use of Name**. Each party shall use the other parties' name, logo and trademark only in the manner specified by the other party in writing, or as expressly permitted by this Agreement.

13.14 **Third Party Recoveries**. CVS/caremark shall use reasonable commercial efforts to distribute among its clients recoveries received from third parties during the Term to the extent such recoveries may reasonably be allocated to CVS/caremark's clients based on the utilization of products by Plan Participants. CVS/caremark may offset its reasonable costs arising from collection and distribution of such recovery, including reasonable attorneys' fees and expenses. CVS/caremark shall have no obligation to initiate or participate in any legal proceeding seeking third party recoveries. Such expenses will be allocated among CVS/caremark's affected or impacted clients on a prorated basis against the amount of the recovery.

13.15 **Authority**. Each party represents and warrants that it has the necessary power and authority to enter into this Agreement and to consummate the transactions contemplated by this Agreement.

13.16 **Dispute Resolution.** In the event of a dispute between the parties and prior to commencing any litigation or other legal proceeding, each party shall, by giving written notice to the other party ("**Dispute Notice**"), request a meeting of authorized representatives of the parties for the purpose of resolving the dispute. The parties agree that, within ninety (90) days after issuance of the Dispute Notice, each party shall designate a representative to participate in dispute resolution discussions which will be held at a mutually acceptable time and place (or by telephone) for the purpose of resolving the dispute. Each party agrees to negotiate in good faith to resolve the dispute in a mutually acceptable manner. If despite the good faith efforts of the parties, the authorized representatives of the parties are unable to resolve the dispute within ninety (90) days after the issuance of the Dispute Notice, or if the parties fail to meet within such ninety (90) day period, either party may, by written notice to the other party, submit the dispute to binding arbitration in Cook County or Milwaukee County, Wisconsin, as mutually agreed by NCRx and CVS/caremark, in accordance with the commercial arbitration rules of the American Arbitration Association ("AAA"). Unless the parties agree otherwise in writing, the arbitration hearing shall be held within six (6) months of the filing of the Dispute Notice. Discovery shall be limited to one deposition unless otherwise agreed to by the parties and at the request of any party or at the discretion of the arbitrator, consistent with the expedited nature of the arbitration, the arbitrator may direct: (i) the production of documents and other information; and (ii) the identification of any witnesses to be called. The award shall be made promptly by the arbitrator and, unless otherwise agreed by the parties or specified by law, no later than 30 days from the date of closing the hearing, or, if oral

hearings have been waived, from the date of the AAA's transmittal of the final statements and proofs to the arbitrator. The foregoing shall not affect the right of either party to at any time seek appropriate equitable relief to enforce its rights under this Agreement. Notwithstanding any provision in this Agreement to the contrary, in no event, as a result of any such arbitration or otherwise, shall any party be liable to another party for payment of any incidental, special, consequential, or punitive, damages incurred by such other party.

13.17 **Market Check**. On an annual basis and at NCRx's reasonable request, NCRx or a mutually acceptable independent third party (with CVS/caremark's approval not to be unreasonably withheld) retained by NCRX, may conduct an annual market check any time prior to the end of the second quarter. NCRx, or their mutually acceptable independent third party, may review the financial terms of NCRx compared to financial offerings presented to similar employers in the marketplace. The parties agree for the purpose of this market check that the review will compare, among other things, the following factors to determine whether NCRx is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable clients of comparable size, inclusive of the program savings, the retail and mail pricing for Brand Drugs and Generic Drugs, pricing for Specialty Drugs, administrative fees, Rebates and guarantees; (ii) the services provided by CVS/caremark to such clients; and (ii) the plan design of such clients, which may include plan formulary, brand/generic utilization information and mail and retail utilization information, available to CVS/caremark. The market check analysis prepared by NCRx or its' representative (the "Report") will be submitted to CVS/caremark and provided that (i) NCRx has given CVS/Caremark thirty (30) days' advance notice and (ii) the Report requires no material changes to the pricing model or format, CVS/caremark will provide its comments on the Report to NCRx and its' representative within the (10) business days of receipt. In other circumstances, NCRx and CVS/caremark will agree on a response time to the Report in good faith. In the event that the market check demonstrates at least a 1% savings of gross plan costs (i.e., ingredient costs, plus dispensing and administrative fees, less Rebates), CVS/caremark and NCRx will renegotiate the pricing terms. If NCRx and CVS/caremark agree to revise the financial terms of this Agreement as a result of this market check review (i) the Agreement shall be amended and (ii) shall be effective January 1 of the Contract Year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the Contract Year as to which the revisions are to apply. A legal document must be signed by NCRx and returned to CVS/caremark 60 days prior to the pricing effective date.

13.18 CVS/caremark agrees that it will not directly solicit, entice or induce, any Participating Group to enter into a new, different, direct or other coalition agreement prior to the end of the then current term of the Participating Group's PGA. NCRx agrees that it will not enter into a new, direct agreement with any CVS/caremark client and/or Participating Group, prior to the end of the then current term of the client and/or Participating Group's agreement with CVS/caremark, unless agreed to by CVS/caremark. NCRx and CVS/caremark each acknowledges that the other may have pre-existing relationships with other clients outside of the Coalition and provide similar services to such clients as contemplated by this Agreement. NCRx and CVS/caremark each further acknowledges that NCRx or CVS/caremark may, either through such client relationships or on its own initiative, pursue new business opportunities that the other may choose to pursue and nothing contained herein shall prevent CVS/caremark from acting as prescription benefit management provider for such opportunities in the event NCRx, CVS/caremark, or CVS/caremark's existing clients choose to submit bids or pursue such opportunities. Nothing in this section is intended to limit the parties ability to compete in the marketplace.

14. **Exhibits.** The following Exhibits are hereby incorporated into and made a part of this Agreement:

Exhibit	Description
A, including any attachments or schedules to said Exhibit	Financial Terms, including Attachment 1 (Specialty Drug List)
B	Business Associate Obligations
C	Audit Procedures
D	Performance Guarantees
E	Appeals
F	Form of Participating Group Addendum
G	Medicare Part D Subsidy
H	Preventative Care Drugs
I	Vaccine Program Terms and Conditions
J	CVS/caremark Dedicated Personnel
K	Maintenance Choice Program

* * * * *

The parties hereto have caused this Prescription Benefit Services Agreement to be executed by their duly authorized representatives.

CAREMARKPCS HEALTH, L.L.C.

LEGAL REVIEW

By: Steven C. Schaper

Name (Print): Steven Schaper

Title: Group Head, Employer Sales

Date Signed: June 19, 2018

NATIONAL COOPERATIVERX

By: Josh Bindl

Name (Print): Josh Bindl

Title: CEO

Date Signed: June 14, 2018

Exhibit A
Financial Terms

1. Mail, Retail, Rebates and Specialty.

TRADITIONAL WITH REBATE OPTION

RETAIL	Traditional
NETWORK	National Network
BRAND	AWP -17.75%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -81.75% 01/01/2020 - 12/31/2020: AWP -82.25% 01/01/2021 - 12/31/2021: AWP -82.75% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -25.00%
DISPENSING FEE	Brand & Generic $0.50 per Claim

RETAIL	Traditional
NETWORK	National Less Walgreens (CareChoice) Network
BRAND	AWP -18.25%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -81.75% 01/01/2020 - 12/31/2020: AWP -82.25% 01/01/2021 - 12/31/2021: AWP -82.75% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -25.00%
DISPENSING FEE	Brand & Generic $0.45 per Claim

RETAIL	Traditional
NETWORK	Extended Days' Supply (EDS)-90
BRAND	AWP -21.00%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -81.75% 01/01/2020 - 12/31/2020: AWP -82.25% 01/01/2021 - 12/31/2021: AWP -82.75% (MAC & Non-MAC Combined)

NON-MAC GENERICS	AWP -25.00%
DISPENSING FEE	Brand & Generic $0.00 per Claim

RETAIL	**Traditional**
NETWORK	Advanced Choice
BRAND	AWP -18.75%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -81.75% 01/01/2020 - 12/31/2020: AWP -82.25% 01/01/2021 - 12/31/2021: AWP -82.75% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -25.00%
DISPENSING FEE	Brand & Generic $0.40 per Claim

MAIL/MAINTENANCE CHOICE	
BRAND	AWP -25.50%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -86.75% 01/01/2020 - 12/31/2020: AWP -87.00% 01/01/2021 - 12/31/2021: AWP -87.25% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -30.00%
DISPENSING FEE	Brand & Generic $0.00 per Claim

NCRx Rebate Guarantees
(per Claim)

CVS/caremark Performance Drug List – Standard Control

		Retail 30			Retail 90			Mail		
		2019	2020	2021	2019	2020	2021	2019	2020	2021
Standard Control	2TQ/3TNQ	$17.02	$18.83	$20.90	$42.55	$47.09	$52.24	$55.28	$61.09	$67.52
	3TQ	$18.91	$20.93	$23.22	$47.27	$52.32	$58.04	$61.42	$67.87	$75.03
		Retail 30			**Retail 90**			**Mail**		
		2019	2020	2021	2019	2020	2021	2019	2020	2021
HPGST	2TQ/3TNQ	$14.48	$16.02	$17.77	$36.19	$40.05	$44.44	$51.13	$56.51	$62.46
	3TQ	$16.08	$17.79	$19.74	$40.19	$44.48	$49.34	$61.74	$68.23	$75.42
		Retail 30			**Retail 90**			**Mail**		
		2019	2020	2021	2019	2020	2021	2019	2020	2021
TGST	2TQ/3TNQ	$14.04	$15.54	$17.24	$35.10	$38.84	$43.09	$49.59	$54.80	$60.58
	3TQ	$15.59	$17.26	$19.14	$38.98	$43.14	$47.86	$59.89	$66.19	$73.16
		Retail 30			**Retail 90**			**Mail**		
		2019	2020	2021	2019	2020	2021	2019	2020	2021
CVS/caremark Value Formulary	Incentivized	$8.52	$9.42	$10.46	$21.29	$23.56	$26.14	$27.63	$30.54	$33.75
	Closed	$9.45	$10.46	$11.61	$23.64	$26.16	$29.02	$30.70	$33.93	$37.51
		Retail 30			**Retail 90**			**Mail**		
		2019	2020	2021	2019	2020	2021	2019	2020	2021
CVS/caremark Advanced Control Formulary	3TQ	$21.88	$24.21	$26.86	$54.69	$60.53	$67.15	$66.61	$73.61	$81.37

CVS/caremark Performance Drug List – Standard Formulary Opt Out

		Retail 30			Retail 90			Mail		
		2019	2020	2021	2019	2020	2021	2019	2020	2021
Standard Formulary Opt Out	2TQ/3TNQ	$13.62	$15.07	$16.72	$34.04	$37.67	$41.79	$44.22	$48.87	$54.02
	3TQ	$15.14	$16.75	$18.58	$37.84	$41.88	$46.46	$49.13	$54.29	$60.02
		Retail 30			**Retail 90**			**Mail**		
		2019	2020	2021	2019	2020	2021	2019	2020	2021
HPGST	2TQ/3TNQ	$11.58	$12.82	$14.22	$28.95	$32.04	$35.55	$40.90	$45.20	$49.96
	3TQ	$12.87	$14.24	$15.80	$32.17	$35.60	$39.49	$49.39	$54.58	$60.33
		Retail 30			**Retail 90**			**Mail**		
		2019	2020	2021	2019	2020	2021	2019	2020	2021
TGST	2TQ/3TNQ	$11.23	$12.43	$13.79	$28.07	$31.06	$34.46	$39.68	$43.85	$48.47
	3TQ	$12.48	$13.81	$15.32	$31.19	$34.52	$38.30	$47.92	$52.95	$58.53

Specialty (applies to With Rebates Option and Reinvested Rebates Option)

Standard Control	SPDPD	CVS/caremark Advanced Control Specialty Formulary

		Standard Control			SPDPD			CVS/caremark Advanced Control Specialty Formulary		
		2019	2020	2021	2019	2020	2021	2019	2020	2021
Specialty - excludes Hepatitis C Claims	2TQ/3 TNQ	$532.97	$586.27	$644.90	$586.27	$644.90	$709.39	$642.14	$706.35	$776.99
	3TQ	$532.97	$586.27	$644.90	$586.27	$644.90	$709.39	$642.14	$706.35	$776.99
Specialty - Hepatitis C Claims only	2TQ/3 TNQ	$8,542.71	$8,798.99	$9,062.96	$9,396.98	$9,678.89	$9,969.26	$10,292.42	$10,601.19	$10,919.23
	3TQ	$8,542.71	$8,798.99	$9,062.96	$9,396.98	$9,678.89	$9,969.26	$10,292.42	$10,601.19	$10,919.23

REINVESTED OPTION[1]

RETAIL	Traditional
NETWORK	National Network
BRAND	Standard Control or Standard Control with PA Option Formulary 2TQ/3TNQ AWP -37.10% 3TQ AWP -39.10% Standard Formulary Opt Out 2TQ/3TNQ AWP -32.60% 3TQ AWP -34.60%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -81.75% 01/01/2020 - 12/31/2020: AWP -82.25% 01/01/2021 - 12/31/2021: AWP -82.75% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -25.00%
DISPENSING FEE	Brand & Generic $0.50 per Claim

RETAIL	Traditional
NETWORK	National Less Walgreens (CareChoice)

BRAND	Standard Control or Standard Control with PA Option Formulary 2TQ/3TNQ AWP -37.60% 3TQ AWP -39.60% Standard Formulary Opt Out 2TQ/3TNQ AWP -33.10% 3TQ AWP -35.10%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -81.75% 01/01/2020 - 12/31/2020: AWP -82.25% 01/01/2021 - 12/31/2021: AWP -82.75% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -25.00%
DISPENSING FEE	Brand & Generic $0.45 per Claim

RETAIL	Traditional
NETWORK	Extended Days' Supply (EDS)-90
BRAND	Standard Control or Standard Control with PA Option Formulary 2TQ/3TNQ AWP -40.35% 3TQ AWP -42.35% Standard Formulary Opt Out 2TQ/3TNQ AWP -35.85% 3TQ AWP -37.85%
GENERIC	Generic Effective Rate

	01/01/2019 - 12/31/2019: AWP -81.75% 01/01/2020 - 12/31/2020: AWP -82.25% 01/01/2021 - 12/31/2021: AWP -82.75% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -25.00%
DISPENSING FEE	Brand & Generic $0.00 per Claim

RETAIL	**Traditional**
NETWORK	Advanced Choice
BRAND	Standard Control or Standard Control with PA Option Formulary 2TQ/3TNQ AWP -38.10% 3TQ AWP -40.10% Standard Formulary Opt Out 2TQ/3TNQ AWP -33.60% 3TQ AWP -35.60%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -81.75% 01/01/2020 - 12/31/2020: AWP -82.25% 01/01/2021 - 12/31/2021: AWP -82.75% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -25.00%
DISPENSING FEE	Brand & Generic $0.40 per Claim

MAIL	
BRAND	Standard Control or Standard Control with PA Option Formulary 2TQ/3TNQ AWP -56.20%

	3TQ AWP -58.20% Standard Formulary Opt Out 2TQ/3TNQ AWP -50.20% 3TQ AWP -52.20%
GENERIC	Generic Effective Rate 01/01/2019 - 12/31/2019: AWP -86.75% 01/01/2020 - 12/31/2020: AWP -87.00% 01/01/2021 - 12/31/2021: AWP -87.25% (MAC & Non-MAC Combined)
NON-MAC GENERICS	AWP -30.00%
DISPENSING FEE	Brand & Generic $0.00 per Claim

SPECIALTY MEDICATIONS (applies to With Rebates Option and Reinvested Rebates Option)	
SPECIALTY AT CVS/CAREMARK SPECIALTY	See Specialty Drug Fee Schedule
SPECIALTY AT RETAIL	**Traditional** **Brands:** AWP-16.00% + $0.50 dispensing fee **Generics:** AWP-16.00% + $0.50 dispensing fee or MAC + $0.50 dispensing fee

ADMINISTRATIVE FEES	
ELECTRONIC CLAIM ADMINISTRATION FEE	$0.00 per Claim
MANUAL CLAIMS ADMINISTRATION FEE	$1.50 per Claim
POINT OF SALE REBATE FEE	$0.50 per Claim
NON-NETWORK CLIENT OWNED PHARMACY ADMINISTRATION FEE	$0.50 per Claim

GENERIC DISPENSING RATE (GDR) GUARANTEES	
RETAIL	01/01/2019 - 12/31/2019: 87.20% 01/01/2020 - 12/31/2020: 87.30% 01/01/2021 - 12/31/2021: 87.50%
MAIL	01/01/2019 - 12/31/2019: 86.40% 01/01/202N0 - 12/31/2020: 86.50% 01/01/2021 - 12/31/2021: 86.70%

[1] See Sections 1.b. and 3.1 for Rebate conditions.

a. Retail, Mail and Specialty Conditions. The AWP discount and dispensing fee pricing for retail, mail and specialty set forth above is contingent upon the following conditions:

1. CVS/caremark may exclude the following from mail and retail discount and dispensing fee guarantees:
   - Limited Distribution Drugs and exclusive distribution drugs;
   - Compound drug Claims;
   - 340B Claims; limited to those where the 340B price is charged to the Participating Group;
   - Paper or Member submitted Claims;
   - Coordination of Benefits (COB) or secondary payor Claims;
   - Vaccine and vaccine administration Claims if covered by Participating Group's Plan design, in those cases where the purchase price includes both the ingredient cost and the cost to administer the vaccine.
2. Retail network guarantees and Mail guarantees for Brand AWP Discounts and Brand and Generic Dispensing Fees are measured and reconciled by component.. Any dollar savings generated in excess of one retail or mail component may not be used to offset a short fall for any other retail component.
3. Generic AWP discounts shown in the pricing chart above for the networks at retail, excluding Maintenance Choice, are measured and calculated on a combined retail generic discount. Generic AWP discounts for Mail and Maintenance Choice are measured and calculated on a combined generic discount basis.
4. Participating Pharmacy rates may vary and the amount paid by CVS/caremark to the Participating Pharmacy may not be equal to the amount billed to Participating Group and CVS/caremark shall retain, and not be disclosed to any third party, including Participating Group or NCRx, any difference.
5. Participating Group acknowledges that Participating Pharmacies will collect from the Plan Participant at the point of sale the lowest of:
   - The applicable Cost Share,
   - The MAC + Dispensing Fee
   - The discounted price + Dispensing Fee; or
   - The Participating Pharmacy's Usual and Customary price or cash price.
   -
6. CVS/caremark's Generic Drug pricing program is monitored based on Participating Group's utilization, and pricing is adjusted to meet CVS/caremark's Participating Group commitments.
7. For compound drugs, CVS/caremark applies the NCPDP D.0 standard. For each compound drug, the submitting pharmacy shall provide the following: (a) compound indicator; (b) eleven-digit NDC, quantity, and submitted ingredient cost for each component in the recipe; (c) total quantity and total Usual & Customary price; and (d) level of effort value. CVS/caremark shall determine the appropriate ingredient cost, or NDC, for each component using the lower of (1) the AWP discount; (2) MAC; or (3) the submitted ingredient cost. The level of effort charge will be applied in addition to the appropriate dispensing fee.
8. The AWP discount and dispensing fee guarantees will be measured and reconciled across the entire NCRx, subject to the following exceptions:

   If a Participating Group (i) provides CVS/caremark with written notice on or before October 1 of a particular calendar year of such Participating Group's desire to have its pricing guarantees reconciled individually, (ii) has more than 5,000 Members as of the date on which Participating Group provides CVS/caremark such notice, CVS/caremark shall individually reconcile such Participating Group's retail, and mail discount and dispensing fee guarantees for the following calendar year.

   Specialty Overall MAC Effective Rate (MER) Guarantee.
   Applicable to Specialty Drugs on the MAC list dispensed by CVS/caremark specialty owned or affiliated pharmacies only. If a Participating Group (i) provides CVS/caremark with written notice the MER guarantee reconciled at the Participating Group level, and (ii) has more than 5,000 Members as of the date on which Participating Group provides CVS/caremark such notice, CVS/caremark shall individually reconcile the MER guarantee at the Participating Group level for the following calendar year.

9. For the exclusive specialty arrangement, CVS/caremark specialty pharmacies will be the exclusive provider of specialty pharmacy services with the exception of the HIV class. HIV medications can be dispensed through either the retail network or through a CVS/caremark specialty pharmacy. With the exception of the HIV class, and those Specialty Drugs that CVS/caremark's specialty pharmacies are unable to dispense, Claims for specialty products will not be processed through the retail network.

b. Rebate Guarantees. The Rebate guarantees set forth above are contingent upon the following conditions:

1. Pricing is based upon fully-funded Plan designs. For the reinvested rebates offer, in lieu of paying Participating Group Rebates, CVS/caremark has provided an improved Brand Drug AWP discount for mail pharmacy service, service and retail pharmacy service.
2. For the reinvested rebate offer, NCRx and CVS/caremark agree to renegotiate the AWP discount for mail service, and retail Claims if: 1) a generic version of a branded product is unexpectedly introduced in the market; or (2) a branded product is recalled or withdrawn from the market.
3. NCRx and Participating Groups agree that if a Participating Group elects the reinvested Rebate option on their Participating Group Addendum, or other CVS/caremark election form, Section 5.2 (Rebate Audits) of the Master Agreement shall not apply to said Participating Groups.
4. CVS/caremark may adjust the NCRx Rebate guarantees in an equitable manner if: (x) a generic version of a branded product is unexpectedly introduced in the market; or (y) a branded product is recalled or withdrawn from the market.
5. Rebate guarantees will be effective January 1, 2019 and will remain in effect until December 31, 2021. Rebate guarantees are contingent upon CVS/caremark's ability to collect Rebates under its Rebate contracts with pharmaceutical companies, either currently in existence or entered into after the date of this Agreement, is not materially adversely impacted by legislative, regulatory, or judicial action, and continued full pharmaceutical company participation. In the event these conditions are not met, CVS/caremark reserves the right to equitably adjust the Rebate guarantees. NCRx acknowledges that whether and to what extent pharmaceutical companies are willing to provide Rebates to NCRx may depend upon a variety of factors, including NCRx meeting criteria for Rebates and the extent of participation in CVS/caremark's formulary management programs, as well as CVS/caremark receiving sufficient information regarding each Claim for submission to pharmaceutical companies for Rebates.
6. Rebate guarantees assume the following formulary and step therapy options, allowing up to 90 days' supply at mail, and plan performance materially the same as the baseline data provided by, or relied upon by CVS/caremark, including information regarding Member enrollment and utilization of pharmacy services.

   CVS/caremark is providing a separate Rebate guarantee for the specialty brand Claims within the Hepatitis C therapeutic class based upon the currently available formulary products. In the event that new to market products in this therapeutic class are selected to replace existing formulary products, a Rebate adjustment may be warranted. Specialty Rebates apply to specialty Claims regardless of distribution channel. Rebate guarantees are paid quarterly for each component and reconciled annually in the aggregate. Rebate guarantees exclude the Claims noted below; however, CVS/caremark will pass to Participating Group 100% of the Rebates collected for those Claims in accordance with the Rebate terms described herein:

   - 340B Claims
   - New to market Biosimilar Claims
   - Lipid Disorders-PCSK9 Claims
   - Limited Distribution Specialty Drugs

   Formulary options:

   1. alignment with CVS/caremark Performance Drug List – Standard Control
   2. alignment with CVS/caremark Performance Drug List – Standard Control with PA option
   3. alignment with CVS/caremark Performance Drug List – Standard Formulary Opt Out
   4. alignment with CVS/caremark Advanced Control Formulary™ (("ACF") ACF Rebates are only applicable to Participating Groups who have adopted the ACF required 3 tier Plan design)
   5. alignment with CVS/caremark Value Formulary

Specialty options:

1. Specialty preferred plan design
2. Alignment with CVS/caremark Advance Control Specialty Formulary™ and are conditioned on (i) Participating Group adoption of CVS/caremark's specialty utilization management edits, including prior authorization and quantity edits; and (ii) Client implements and maintains a generics first plan design for specialty

UM options:

1. High Performance Generic Step Therapy (HPGST)
2. Traditional Generic Step Therapy (TGST)

7. Participating Groups must notify CVS/caremark with their selection of either the traditional Rebate option or the reinvested Rebate or the POS Rebate option no later than ninety (90) days before the beginning of the following Contract Year. For Participating Groups that join NCRx after January 1, 2019, they must make their election of either the traditional Rebate option, the reinvested Rebate option or the POS Rebate option prior to the effective date of their Participating Group Addendum. For Participating Groups who joined NCRx prior to January 1, 2019, the traditional Rebates provided in the pricing grid in Exhibit A shall apply as the default Rebate option unless a Participating Group signs a new Participating Group Addendum electing the reinvested Rebates option or the POS Rebate option.

8. Any Specialty Drug Rebates received will be provided to the Participating Group and NCRx, in accordance with Section 1, above.

c. Shipping fees and/or postage will not be increased if CVS/caremark's third party carrier increases its charges to CVS/caremark for shipping fees and/or postage costs and such charges due to increases in postage will not be passed on to NCRx and Participating Group**.**

d. General Conditions to Pricing. If elected by a Participating Group, the pricing above is contingent upon adopting the following program(s):

1. Generic Step Therapy Program. If elected by Participating Group, Participating Group acknowledges and agrees that, as a condition of the pricing, it adopts CVS/caremark's generic step therapy plans (hereinafter referred to as the "GSTP Program"), as amended from time to time by CVS/caremark, as part of its Plan design. Participating Group directs CVS/caremark to implement the coverage limitations, generic substitutions, step-therapies or prior authorizations for the therapeutic classes as identified in the PDD. Participating Group acknowledges and agrees that if it fails to adopt the GSTP Program conditions or otherwise qualify for the GSTP Program, then CVS/caremark reserves the right to modify the financial terms of this Exhibit A, including any financial guarantees. Participating Group shall be responsible for amending any applicable Plan documents, as it deems appropriate, to reflect the GSTP Program as part of its benefit.
2. Specialty Preferred Drug Plan Design Program ("SPDPD Program"). NCRx and Participating Group acknowledge and agree that, as a condition of the Specialty Preferred Drug Plan Design Program pricing set forth above, Participating Group adopts, as part of its Plan design, the Specialty Preferred Drug Plan Design Program (hereinafter referred to as the "SPDPD Program"), as amended from time to time by CVS/caremark and Participating Group will modify, as it deems necessary, any applicable Plan documents to reflect the SPDPD Program. Participating Group directs CVS/caremark to implement the step-therapies or prior authorizations identified in Participating Group's PDD, consistent with the SPDPD Program. NCRx and Participating Group acknowledge and agree that if Participating Group fails to adopt the SPDPD Program conditions, or otherwise qualify for the SPDPD Program, including drug utilization assumptions, then CVS/caremark reserves the right to modify the financial terms of the SPDPD Program applicable to a Participating Group.

e. Generic Dispensing Rate ("GDR") Guarantee.

1. Generic Dispensing Rate ("GDR") Guarantee. The GDR guarantee is measured and reconciled in the aggregate annually across the entire NCRx coalition. The GDR guarantee is based upon plan design, membership, and demographics as represented by Client, and changes to these aspects may materially affect CVS Health's ability to meet the GDR guarantees. In the event of a change to the Plan design, or the Plan's demographics, both parties agree to work in good faith to determine if the GDR guarantee(s) should be adjusted to account for such change, whether higher or lower, depending on the actual impact of such change. An example of this would be situations where generically available medications are excluded from the benefit, such as OTC equivalent strengths. If a brand does not lose patent protection when expected due to unforeseen circumstances, including but not limited to litigation, the parties acknowledge and agree an adjustment may need to be made to the GDR guarantees. Any potential amount owed will be determined based on the following formula: (Average Amount Paid per Multi-Source Brand Claim - Average Amount Paid per Generic Claim) multiplied by (GDR guarantee - GDR measured) multiplied by total Claims. The GDR guarantees will be measured and reconciled in the aggregate across the NCRx. Specialty Drugs, Compound Claims, Paper Claims, COB claims and Vaccines are not included in the GDR guarantee calculation. Penalties for a shortfall on the GDR guarantee will be paid on a dollar-for-dollar basis, with a maximum annual payment cap of $500,000 for mail and $500,000 for retail.

f. Retail Network.

1. CareChoice Network. If elected by Participating Group, Participating Group hereby selects the CVS/caremark CareChoice network, which is a national network that excludes Walgreens.. Implementation of this network requires evaluation of each Participating Group's Claims distribution and Plan design to determine eligibility. Implementation of the CareChoice Network requires a minimum 60 days' advance notice and may be limited by applicable law.
2. The CVS/caremark Advanced Choice Network is a national narrow network that was solicited to balance savings while eliminating network access redundancy and it includes most major chains and independent pharmacies. Implementation of this network requires evaluation of each Participating Group's claims distribution and plan design to determine eligibility. Implementation of the CVS/caremark Advanced Choice Network requires a minimum 60 days' advance notice and may be limited by applicable law.
3. Extended Days' Supply (EDS)-90 Network. The CVS/caremark Extended Days' Supply (EDS)-90 Network is a 90 day network comprised of many major chains and independent pharmacies providing the combination of member access and market competitive pricing. CVS/caremark EDS-90 network pricing is applicable for non-specialty Claims equal to or greater than Participating Group's qualified retail plan design limits, and filled by a participating CVS/caremark EDS-90 network pharmacy. Claims up to Participating Group's qualified retail days' supply plan design limits can be filled at any Participating Pharmacy. Claims greater than Participating Group's retail plan design limits shall only be filled by a CVS/caremark EDS-90 network pharmacy. Implementation of Maintenance Choice and/or a mandatory plan design may limit the implementation of this offering.

g. Miscellaneous.

1. The exclusive specialty offer includes the provision by CVS/caremark of nurse-based rare condition care management services for Engaged Members (defined below) with the following rare conditions pursuant to the CareTeam Choice program established by CVS/caremark, as may be amended by CVS/caremark from time to time: Crohn's Disease, Cystic Fibrosis, Gauchers Disease, Hemophilia, Lupus, Multiple Sclerosis, Rheumatoid Arthritis, and Ulcerative Colitis (the "CareTeam Choice Program"). Pursuant to the CareTeam Choice Program, Participating Group acknowledges that CVS/caremark will utilize those Specialty Drug Claims that are filled by CVS/caremark's specialty pharmacy to identify and outreach to Members that CVS/caremark determines are likely to have one of the above listed rare conditions (each an "Eligible Member"), and CVS/caremark may communicate with medical and other healthcare providers and any health plans providing benefits to Engaged Members. Participating Group acknowledges that the CareTeam Choice Program is intended solely to provide education of, and support to, Engaged Members in the diagnosis and treatment provided by their healthcare providers. "Engaged

Member" means an Eligible Member who elects to receive and receives CareTeam Choice Program services.

2. **High-Cost State Pricing**
   Notwithstanding anything in the Agreement to the contrary, based on higher cost of goods in certain regions, CVS/caremark reserves the right to adjust pricing for Participating Groups that join NCRx on or after January 1, 2019 that have high utilization in those regions. Examples of high cost regions include: State of Massachusetts, State of Hawaii, State of Alaska and Puerto Rico.
3. New to market Specialty drugs will be evaluated during the annual market check process and will be added to the fee schedule as appropriate.
4. "Alignment with CVS/caremark Performance Drug List – Standard Control" Rebate guarantees assume Participating Group adoption of the PDL and formulary exclusions or if Participating Group adopts the CVS/caremark prior authorization program related to the formulary exclusions.
5. "Alignment with CVS/caremark Performance Drug List – Standard Formulary Opt Out" Rebate guarantees assume Participating Group adoption of the PDL but not the adoption of the formulary exclusions or prior authorization program.
6. High-deductible health plan ("HDHP") business will receive the pricing and Rebate minimum amounts outlined in Section 1 of this Exhibit, subject to Section 1 b above.
7. CVS/caremark agrees to provide quarterly reporting and measurement of pricing guarantees within ninety (90) days of the end of each calendar quarter, with annual payment and reconciliation of any discrepancies within thirty (30) days of the reporting for the fourth calendar quarter thereafter. Aggregate Ingredient Cost, not including Dispensing Fees, prior to application of Plan specific Cost-Share will be the basis of the calculation.
8. Both the Aggregate Ingredient Cost and Aggregate AWP from the actual date of Claim adjudication will be used to measure the pricing guarantees.

2. **Clinical Programs and Services.** As consideration for the clinical Services and programs selected by Participating Group as described in the PDD and this Agreement, Participating Group shall pay to CVS/caremark the fees set forth below:

2.1 Core Clinical Services and Programs (available at no additional charge to Participating Group):

	Core Clinical Services and Programs		**Cost**
(a)	**Formulary Management (as described in Section 2.6 of the Agreement)**		No additional charge
(b)	**Safety Programs**		
	i.	POS Safety Review	No additional charge
	ii.	Retrospective Safety Review with Pharmacy Claims	No additional charge
	iii.	Safety and Monitoring Solution	No additional charge
	iv.	Physicians Profiling Report	No additional charge
	v.	POS Utilization Management - Dose Optimization - Quantity Limit - Step Therapy	No additional charge
(c)	**Savings Programs**		
	i.	Comprehensive Generics Solutions a. DAW Solution 1 and or 2 b. Value Drug Savings Tool c. DAW Penalty	No additional charge
	ii.	POS Preferred Product Messaging	No additional charge
	iii.	Generic Step Therapy (Prior Auth fee will apply)	No additional charge

(d)	**Pharmacy Advisor**		
	i.	Pharmacy Advisor Support: Adherence	No additional charge
	ii.	Pharmacy Advisor Support: Ready Fill at Mail(R)	No additional charge
	iii.	Pharmacy Advisor Support: Closing Gaps in Medication Therapy	No additional charge

2.2 Enhanced Clinical Programs and Services:

Enhanced Clinical Programs and Services Managing Bad Trend				**Fee**	**Guaranteed Return on Investment ("ROI")**
(a)		**Evidence Based Utilization**			
	i.	Enhanced Safety & Monitoring Solution Communications describing management protocols, Prescriber/pharmacy lock, and benefit coverage limits and the provision of toolkits to Prescribers:		\$0.04 PMPM **OR** \$0.06 per Claim	
		1.	Physician consultation	\$239/consultation	N/A
		2.	Referral to appropriate government agencies to conduct criminal investigations	\$80/hr investigator	N/A
	ii.	Prior Authorization (PA) In instances where a state regulation requires denial oversight by a physician the charges for Prior Authorization requests are as follows: 1. Internal CVS/caremark Physician: \$45 per request External Physician: \$55 per request		Level 1 - \$0.00/Request; Level 2 - \$30.00/Request[1] [1] Level 1 consists of a selected set of PA drugs. Level 2 includes any PA drugs not listed in Level 1.	N/A
	iii.	Appeals (as described in Exhibit E)		\$100 per review of benefit coverage \$500 per review of medical necessity	N/A
	iv.	External Review (as described in Exhibit E)		\$500 per IRO external review requested	N/A
	v.	Specialty Guideline Management (Specialty)		\$30.00 per review [applicable to Open Specialty Participating Groups.] No additional charge [applicable to Exclusive Specialty (Retail Lock) Participating Groups.]	N/A
	vi.	Drug Savings Review		\$0.30 PMPM **OR** \$0.50 per Claim	300% ROI over 1 year**
CVS/caremark guarantees that the gross savings realized from these Services over the Clinical Program Year of the					

Agreement for the Drug Savings Review Program shall be 300% of the expense to Participating Group for these Services over the Clinical Program Year. In the event CVS/caremark fails to meet the targeted savings, Participating Group shall be credited for any guaranteed savings short-fall following the end of the applicable Clinical Program Year, up to the amount of fees paid by Participating Group for the Drug Savings Review Program during the Clinical Program Year. "**Clinical Program Year**" means the twelve (12) month period commencing on the start date of the Drug Savings Review Program and each full consecutive twelve (12) month period thereafter that the Drug Savings Review Program is provided.				
(b)		Prescription Savings Guide	CVS/caremark will provide an annual report to Plan Participants with savings opportunities via electronic means or by mailing such report to Plan Participants. In the event CVS/caremark mails such annual report, Participating Group shall pay CVS/caremark $1.50 per annual report mailed to Plan Participants with savings opportunities of $50.00 or more.	N/A
(c)		Formulary Exceptions/Non-clinical requests (includes formulary exceptions, DAW, mandatory mail, Plan exclusions, and formulary edits for specific classes)	$30 per request	N/A
(d)		RxNavigator® License	Forty (40) licenses included, distributable to Participating Groups at the discretion of NCRx. Additional licenses available for $1,500.00 per license per user per year.	N/A

Enhanced Clinical Programs and Services Managing Good Trend			**Fee**	**Guaranteed Return on Investment ("ROI")**
(a)		Pharmacy Advisor		
	i.	Pharmacy Advisor Counseling at CVS/pharmacy Condition specific messaging plus: • Face-to-face interventions and messaging at CVS/pharmacy • Inbound pharmacist phone support for Plan Participants who utilize mail and other Participating Pharmacies	$0.20 PMPM	125% annual ROI*
	ii.	Pharmacy Advisor Counseling All Channels Condition specific messaging plus: • Face-to-face interventions and messaging at CVS/pharmacy • Outbound and inbound pharmacist phone support for Plan Participants who utilize mail and other Participating Pharmacies	$0.45 PMPM	125% annual ROI*

Participating Group may terminate the Pharmacy Advisor program by providing CVS/caremark at least sixty (60) days prior written notice.

The pricing described above for Pharmacy Advisor is based on the following conditions:

(i) In the event Participating Group desires to include additional lines of business, implement a portion of the Plan Participants, or reduces the Plan Participants participating in the Pharmacy Advisor program, CVS/caremark may revise pricing for the program;

(ii) Participating Group agrees to implement all of the current conditions in Pharmacy Advisor Counseling: Asthma/COPD, Breast Cancer, Depression, Diabetes, Cardiovascular conditions, and Osteoporosis; and

The above pricing reflects the current program and future program expansions may require an additional fee.

*CVS/caremark guarantees that the aggregate gross savings realized from the Pharmacy Advisor Counseling Program services over the Clinical Program Term shall be 125% of the aggregate fees paid by Participating Group for the Clinical Program Term, measured in aggregate across all NCRx Participating Groups. For the purpose of this guarantee, the term "Clinical Program Term" means the twelve (12) month period following implementation of the Pharmacy Advisor Counseling Program ("Counseling Program").

This ROI guarantee requires that: (1) a minimum of twenty thousand (20,000) Plan Participants, measured across all NCRx Participating Groups, be enrolled in the Counseling Program for the full Clinical Program Term, (2) Participating Group providing CVS/caremark with (a) the required prior year Plan Participant, Eligibility and Prescription data elements prior to calculation of the ROI if CVS/caremark was not Participating Group's PBM in the calendar year prior to Participating Group's implementation of the Counseling Program; and (b) sufficient and accurate eligibility information, which includes Plan Participant current telephone numbers and mailing addresses. If these conditions are met, CVS/caremark guarantees that the aggregate gross savings realized from the Counseling Program services over the Clinical Program Term shall be 125% of the aggregate fees paid by NCRx Participating Groups participating in the Counseling Program for the Clinical Program Term. Participating Groups not participating in the Counseling Program for the full Clinical Program Term shall be excluded from this ROI guarantee and their respective Plan Participants will not be considered for determination as to whether the minimum number (20,000) of participating Plan Participants has been met. Participating Groups that are new CVS/caremark clients may be included in the calculation of ROI if history for the prior year, including full eligibility details, full prescription details and member identifiers, is made available to CVS/caremark in an acceptable format. Data for all Plan Participants in the Participating Group during the year before joining CVS/caremark is required (not just for those that remain enrolled at the time Participating Group joined CVS/caremark).

The ROI savings calculation shall be determined as follows:
1. Medication Possession Ratio: If a Plan Participant's Medication Possession Ratio is equal to or greater than 80% (i.e., the member is "optimally adherent") then the associated savings, which may include productivity savings, for each Plan Participant who is optimally adherent will be credited to the ROI guarantee based on the condition-specific savings identified in current peer reviewed clinical literature; and
2. Gaps in therapy closure: For each gap in therapy closed, (i.e. a first fill of a recommended drug) CVS/caremark will include the associated savings in its ROI guarantee.

Participating Group acknowledges and agrees that the estimated health care savings described above in paragraph 1 and 2, reflect an estimate of the healthcare costs presumed to be avoided through the actions of CVS/caremark to improve medication adherence and close gaps in care associated with certain chronic conditions that typically have high levels of medical costs. This amount will be an estimate of the healthcare costs avoided by the Plan through the associated condition-specific savings identified in current peer reviewed clinical literature.

CVS/caremark reserves the right to revise the ROI in the event of changes to Plan design or Plan Participant population that materially impacts the effectiveness of the Pharmacy Advisor Counseling Program. Participating Group acknowledges it shall not be eligible to receive an ROI savings guarantee under any other program, which includes adherence or closing gaps in therapy, with the exception of Pharmacy Advisor Condition Alerts, during any period that Participating Group receives an ROI savings guarantee under the Pharmacy Advisor Counseling Program. In the event CVS/caremark fails to meet the ROI guarantee, CVS/caremark shall, within one-hundred fifty (150) days after the close of the Clinical Plan Term, credit Participating Group for its portion of any ROI short-fall following the end of the applicable Clinical Program Term. CVS/caremark's maximum obligation under the ROI shall be the amount of fees paid by Participating Group during the Clinical Program Term**.**

NOTE: Any program enhancements that are developed by CVS/caremark during the Term may be available to Participating Group for an additional fee.

NOTE: Any overachievement of guaranteed savings related to any clinical program will be applied to any underachievement of guaranteed savings.

NOTE: CVS/caremark reserves the right to adjust any ROI listed in this Section 2.2 if the total number of Plan Participants changes by 30% or more or if Participating Group implements certain Plan design or other program changes as designated by CVS/caremark (including but not limited to Maintenance Choice, the Generic Step Therapy Program, and prior authorization).

2.3 Additional Services:

Paper Submitted Claim (per processed Claim)	1.50/Claim
Card Re-issuance	$0.50/Card
Manual Eligibility Submission	$1.00/Manual Entry
Participating Group Specific Programming	$150.00/Hour

Post-Termination Services	
a. Claims History	$125.00 per month of history requested
b. Open Refills (one test and two post-transition production files)	$4,500.00
c. Open Refills (pre-transition production file)	$1,500.00
d. Pre-Authorizations (includes one test and up to two production files)	$3,500.00
e. Accumulators (includes one test and up to two production files).	$2,500.00

The fees, expenses or charges for clinical programs identified in this Exhibit A shall supersede all other commitments or agreements described in any previous document, or Agreement.

Charges or Services not identified in this Exhibit A shall be quoted upon request.

3. Participating Group Credits:

This Section 3 of Exhibit A sets forth various Rebates and credits to be paid or credited by CVS/caremark to Participating Group (collectively "**Participating Group Credits**") as identified in Section 1 of this Exhibit A**.** At the direction of and on behalf of the Participating Group, CVS/caremark will pay to NCRx the Rebates, and provide the credits, as set forth in this Agreement. It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, these Participating Group Credits shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. 1320a 7b(b)(3)(A). In addition, Participating Group acknowledges and agrees that, as a condition to its right to receive Participating Group Credits from CVS/caremark, all Participating Group Credits received shall be used exclusively for providing benefits to Plan Participants of the Plan and defraying the reasonable expense of administering the Plan.

3.1 Drug Rebates.

(a) 100% / 0%
(NCRx Allocation / CVS/caremark Retention)

CVS/caremark guarantees that Participating Group's share of Rebates shall be as Section 1 of this Exhibit A (the "**Guaranteed Rebate Amount**"). Guaranteed Rebate Amount shall be measured and reconciled in the aggregate across the entire NCRx, subject to the following exceptions:

If a Participating Group (i) provides CVS/caremark with written notice on or before October 1 of a particular calendar year of such Participating Group's desire to have its guaranteed Rebate amounts reconciled individually, (ii) has more than 5,000 Members as of the date on which Participating Group provides CVS/caremark such notice, CVS/caremark shall individually reconcile such Participating Group's guaranteed Rebate amounts for the following calendar year.

For the traditional Rebate offer, on behalf of Participating Group, CVS/caremark will receive the Rebates paid by pharmaceutical manufacturers to Participating Group. Within ninety (90) days following the end of each calendar quarter, CVS/caremark will remit to NCRx the Participating Group's minimum Guaranteed Rebate Amounts, as set forth above, for the drug Claims made during the calendar quarter, and CVS/caremark will provide documentation to NCRx showing the portion due to Participating Group, and NCRx will pay the same to Participating Group within thirty (30) days of such payment by CVS/caremark, less any fees or other amounts due from Participating Group to NCRx. Additionally, CVS/caremark will remit to NCRx the estimated Participating Group's share of Rebates received that exceed the previously paid Guaranteed Rebate Amount.

Not later than 180 days following the end of each Contract Year of the Agreement, CVS/caremark shall pay to NCRx all the Rebates received by CVS/caremark in the aggregate across the NCRx coalition for Participating Groups with less than 5,000 Members and who have not elected to be reconciled individually during the twelve (12) months of that Contract Year, net of the guaranteed per Claim Rebates and estimated Participating Group's share of Rebates received already paid for such period. If the Rebate amounts identified in the immediately preceding sentence are not identifiable by amounts due to Participating Group, but rather are identifiable only in the aggregate, the Board of Directors of NCRx will determine the distribution of Rebates paid according to the prior sentence in its discretion. Participating Group and NCRx each acknowledge and agree that it shall not have a right to interest on, or the time value of, any Rebate payments received by CVS/caremark or monies payable under the Participating Group Addendum. In addition to the security required under the Agreement, if any, CVS/caremark may delay remittance of Rebates to allow for final adjustments on termination of the Participating Group Addendum. Participating Group agrees to repay to NCRx any Rebates remitted to it that were not actually earned by it and that NCRx is required to repay to CVS/caremark under the Agreement.

In the event that Rebates paid to NCRx on behalf of Participating Group are less than the minimum Guaranteed Rebate Amount, CVS/caremark shall pay to NCRx the amount of any deficiency. Final reconciliation between Rebates paid and Rebates guaranteed pursuant to this Section shall be performed, in the aggregate across the NCRx coalition for Participating Groups with less than 5,000 Members and who have not elected to be reconciled individually, within 120 days after the close of collections of each Contract Year.

(b) Rebates Reinvested in the Brand Discount

In lieu of Rebates, CVS/caremark has provided an improved AWP discount for mail pharmacy services and retail pharmacy services. As such, CVS/caremark is authorized by NCRx to retain all Rebates for its own account. If for any reason, CVS/caremark's ability to receive Rebates from pharmaceutical companies' Rebate programs is materially adversely impacted, the parties shall re-negotiate the AWP discount for mail service and retail Claims.

(c) Point of Sale ("POS") Rebates

An estimate of the anticipated Rebate ("RTMD Estimated Rebate") shall be applied at the point of sale as a real time manufacturer discount (RTMD). The RTMD Estimated Rebate shall be applied to the ingredient cost of the adjudicated Claim after applying the appropriate network discount and before applying the applicable Cost Share amount. CVS/caremark shall review the RTMD Estimated Rebate at least quarterly

and make adjustments, if necessary, based on likelihood of collection, previous experience and potential pharmaceutical company issues. CVS/caremark shall use good faith efforts to project the anticipated RTMD Estimated Rebate. However, CVS/caremark shall have no responsibility or liability to Plan Participants for RTMD overpayments or underpayments.

Rebate invoiced amounts and RTMD Estimated Rebate payments shall be reported quarterly in the aggregate. Final reconciliation between (i) the RTMD Estimated Rebate payments made by CVS/caremark, and (ii) Rebates collected by CVS/caremark from pharmaceutical companies on the relevant utilization and payable to Participating Group pursuant to the terms of this Agreement ("Actual Rebates") shall be performed upon completion of collections from the pharmaceutical companies for each Rebate cycle. In the event Actual Rebates exceed the RTMD Estimated Rebate payments made by CVS/caremark, such excess shall be paid to the Participating Group with the next regular Rebate payment. In the event Actual Rebates are less than the RTMD Estimated Rebate payments made by CVS/caremark ("Rebate Overpayment"), such Rebate Overpayment shall be paid by Participating Group to CVS/caremark upon receipt of CVS/caremark's invoice or CVS/caremark may, at its sole discretion, offset such Rebate Overpayment against the next regular Rebate payment.

CVS/caremark may adjust the RTMD Estimated Rebate on future Claims in an equitable manner in the event: (i) a generic version of a branded product is unexpectedly introduced in the market; (ii) a branded product is recalled or withdrawn from the market; (iii) actual collection experience varies significantly from that expected; or (iv) prior RTMD payout experience varies significantly from Rebates earned.

To qualify for two-tier Rebates, the Plan Participants under this Agreement must be covered under a two-tier qualifying Plan design. A two-tier qualifying Plan design consists of an open Plan design with no minimum Cost Share differential between preferred brand and non-preferred brand tiers, but that includes formulary interventions recommended by CVS/caremark.

To qualify for three-tier non-qualifying Rebates, the Plan Participants under this Agreement must be covered under a three-tier non-qualifying Plan design. A three-tier non-qualifying Plan design consists of a Plan design with less than a $15.00 co-payment or coinsurance differential between preferred and non-preferred Brand Drugs.

To qualify for three tier qualifying Rebates, the Plan Participants under this Agreement must be covered under a three-tier qualifying Plan design. A three-tier qualifying Plan design consists of a Plan design with at least a $15.00 co-payment differential between preferred and non-preferred rand prescriptions, at least a $15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage between the preferred and non-preferred brand (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).

3.2 Implementation Credit. CVS/caremark shall provide Participating Group with an implementation credit of up to $5.00 per net new Plan Participant to defray certain transition costs associated with moving Participating Group business to CVS/caremark. This credit can be used to offset typical and/or mutually agreed upon implementation costs in transferring from the current provider to CVS/caremark. Participating Group shall be responsible for all transition and implementation expenses in excess of the implementation credit provided to Participating Group as set forth above. Examples of transition and implementation expenses include costs of customized Plan Participant I.D. cards, postage expense for direct mail of I.D. cards and other communication materials to Plan Participants, and special programming required by Participating Group's prior pharmacy benefit manager to provide data to CVS/caremark. Identification of the costs shall occur no later than six (6) months after the Effective Date of this Agreement. Participating Group shall provide CVS/caremark with documentation of eligible expenses directly incurred by Participating Group in the form of an invoice, an account statement, or other detailed documentation. For agreed upon implementation or transition Services provided by CVS/caremark towards this credit, CVS/caremark shall provide expense detail for such items. If Participating Group terminates this Agreement prior to the expiration of its Term for any reason (other than CVS/caremark's breach) or if CVS/caremark terminates this Agreement as a result of Participating Group's breach, Participating Group shall refund to CVS/caremark a pro-rata share of all

implementation credits provided to Participating Group by CVS/caremark. The parties acknowledge and agree that the implementation credits provided by CVS/caremark are commercially reasonable and necessary Services related to the implementation of this Agreement and represent fair market value for the Services provided.

3.3 Discount Credit. On behalf of Participating Groups, CVS/caremark shall provide NCRx with a discount credit of $0.75 per Plan Participant per month, which shall constitute an additional discount off the prices of drugs dispensed to Participating Groups under the Agreement. This discount credit shall be paid to NCRx on a monthly basis by electronic fund transfer ("EFT") or check, and treated as an additional discount by Participating Groups.

3.4 Annual Audit Credit. On behalf of Participating Groups, CVS/caremark shall provide NCRx with an annual audit credit in the amount of up to $40,000.00 per year which shall constitute an additional discount off the purchase price of drugs dispensed under this Agreement. This audit credit will be paid to NCRx on a monthly basis by electronic fund transfer ("EFT") or check, and treated as an additional discount by Participating Groups. Identification of the expenses attributable to this credit shall be mutually agreed upon. NCRx shall provide CVS/caremark with documentation of expenses actually incurred in the form of an invoice, an account statement, or other detailed documentation. Expenses applied to this credit will not exceed fair market value of such expenses. If NCRx terminates this Agreement prior to the expiration of its Term for any reason (other than CVS/caremark's breach) or if CVS/caremark terminates this Agreement as a result of NCRx's breach, NCRX shall refund to CVS/caremark a pro-rata share of all audit credits provided to NCRx by CVS/caremark.

3.5 Developmental Credit. On behalf of Participating Groups, CVS/caremark shall provide NCRx with an annual developmental credit of up to $1.00 per Member annually to be applied to (1) disease management programs that are developed by CVS/caremark, and (2) other Services provided by CVS/caremark. Funding for projects, programs, or services from the development pool credit will be evaluated and priced appropriately by CVS/caremark at fair market value. The fees and expenses associated with all projects, programs, or services shall be applied against the development credit and will be reflected as such on NCRx's invoice. Any unused amounts shall be forfeited by NCRx. In the event that NCRx terminates this Agreement prior to the end of the Term for any reason other than CVS/caremark breach, NCRx shall pay CVS/caremark a pro-rate share of all developmental credits.

3.6 CVS/caremark shall collect $0.20 per Member per month on behalf of NCRx, on the 15th day of each month, based upon the total number of Members on the 15th day of the prior month, which amount Participating Group agrees CVS/caremark shall pay directly to NCRx on behalf of the Participating Group and bill to Participating Group.

Attachment 1 to Exhibit A
Specialty Drug Fee Schedule
Traditional and Reinvested Option

		Exclusive	Open	
Drug Therapy	Drug Name	AWP Discount	AWP Discount	Notes
Acromegaly	OCTREOTIDE	30.25%	28.00%	
Acromegaly	SANDOSTATIN	19.75%	16.25%	
Acromegaly	SOMATULINE	18.25%	16.25%	
Acromegaly	SOMAVERT	19.75%	16.25%	
Alcohol Dependency	VIVITROL	19.75%	16.25%	
Allergen Immunotherapy	ORALAIR	17.00%	17.00%	
Allergic Asthma	CINQAIR	13.25%	11.00%	
Allergic Asthma	NUCALA	13.25%	11.00%	
Allergic Asthma	XOLAIR	17.00%	17.00%	
Alpha-1 Antitrypsin Deficiency	ARALAST NP	19.75%	17.25%	***
Alpha-1 Antitrypsin Deficiency	GLASSIA	19.75%	16.25%	***
Alpha-1 Antitrypsin Deficiency	ZEMAIRA	19.75%	16.25%	***
Anemia	ARANESP	17.50%	16.25%	
Anemia	EPOGEN	17.50%	17.25%	
Anemia	PROCRIT	17.50%	16.25%	
Atopic Dermatitis	DUPIXENT	18.75%	16.25%	
Botulinum Toxins	BOTOX	17.50%	16.25%	
Botulinum Toxins	DYSPORT	19.75%	16.25%	
Botulinum Toxins	MYOBLOC	17.50%	17.25%	
Botulinum Toxins	XEOMIN	17.00%	17.00%	
Cardiac Disorders	DOFETILIDE	19.75%	17.25%	
Cardiac Disorders	TIKOSYN	17.50%	17.25%	
Coagulation Disorders	CEPROTIN	17.00%	17.00%	
Contraceptives	IMPLANON	13.25%	11.00%	
Contraceptives	KYLEENA	13.25%	11.00%	
Contraceptives	MIRENA	13.25%	11.00%	
Contraceptives	NEXPLANON	13.25%	11.00%	
Contraceptives	SKYLA	17.00%	17.00%	
Cryopyrin Associated Periodic Syndromes	ARCALYST	17.50%	16.25%	
Cryopyrin Associated Periodic Syndromes	ILARIS	19.75%	16.25%	
Cystic Fibrosis	BETHKIS	18.75%	16.25%	
Cystic Fibrosis	KITABIS PAK	11.00%	16.25%	
Cystic Fibrosis	ORKAMBI	13.25%	11.00%	
Cystic Fibrosis	PULMOZYME	17.50%	16.25%	

Cystic Fibrosis	TOBI	17.50%	17.25%	
Cystic Fibrosis	TOBI PODHALER	18.75%	17.00%	
Cystic Fibrosis	TOBRAMYCIN	MAC	MAC	
Dupuytren's Contracture	XIAFLEX	19.75%	16.25%	
Electrolyte Disorders	SAMSCA	17.50%	16.25%	
Gastrointestinal	GATTEX	17.00%	17.00%	
Gastrointestinal	OCALIVA	13.25%	11.00%	
Gastrointestinal	SOLESTA	17.50%	16.25%	
Gout	KRYSTEXXA	17.50%	16.25%	
Growth Hormone	GENOTROPIN	17.50%	16.25%	
Growth Hormone	HUMATROPE	17.50%	16.25%	
Growth Hormone	INCRELEX	19.25%	17.00%	
Growth Hormone	NORDITROPIN	19.75%	16.25%	
Growth Hormone	NUTROPIN	19.75%	16.25%	
Growth Hormone	OMNITROPE	17.50%	16.25%	
Growth Hormone	SAIZEN	17.50%	16.25%	
Growth Hormone	SEROSTIM	17.50%	16.25%	
Growth Hormone	TEV-TROPIN	19.75%	16.25%	
Growth Hormone	ZOMACTON	17.50%	17.25%	
Growth Hormone	ZORBTIVE	17.50%	17.25%	
Hematopoietics	MOZOBIL	19.75%	16.25%	
Hematopoietics	NEUMEGA	17.50%	17.25%	
Hemophilia	ADVATE	30.00%	30.00%	
Hemophilia	ADYNOVATE	19.75%	17.25%	
Hemophilia	AFSTYLA	19.75%	16.25%	
Hemophilia	ALPHANATE	20.25%	18.00%	
Hemophilia	ALPHANINE SD	20.25%	18.00%	
Hemophilia	ALPROLIX	19.75%	17.25%	
Hemophilia	BEBULIN	20.25%	18.00%	
Hemophilia	BENEFIX	19.75%	17.25%	
Hemophilia	CORIFACT	20.25%	18.00%	
Hemophilia	ELOCTATE	19.75%	17.25%	
Hemophilia	FEIBA	34.00%	34.00%	
Hemophilia	HELIXATE	18.00%	18.00%	
Hemophilia	HEMOFIL M	34.00%	34.00%	
Hemophilia	HUMATE-P	20.25%	18.00%	
Hemophilia	IDELVION	19.75%	17.25%	
Hemophilia	IXINITY	17.50%	17.25%	
Hemophilia	KOATE	18.00%	18.00%	
Hemophilia	KOGENATE	18.00%	18.00%	
Hemophilia	KOVALTRY	17.50%	17.25%	

Hemophilia	MONOCLATE	20.25%	18.00%	
Hemophilia	MONONINE	20.25%	18.00%	
Hemophilia	NOVOEIGHT	11.00%	11.00%	
Hemophilia	NOVOSEVEN RT	18.00%	18.00%	
Hemophilia	NUWIQ	19.75%	17.25%	
Hemophilia	OBIZUR	19.25%	17.00%	
Hemophilia	PROFILNINE SD	18.00%	18.00%	
Hemophilia	RECOMBINATE	28.25%	26.00%	
Hemophilia	REFACTO	20.25%	18.00%	
Hemophilia	RIASTAP	18.00%	18.00%	
Hemophilia	RIXUBIS	19.75%	17.25%	
Hemophilia	STIMATE	17.50%	17.25%	
Hemophilia	TRETTEN	17.00%	17.00%	
Hemophilia	VONVENDI	13.25%	11.00%	
Hemophilia	WILATE	19.75%	16.25%	
Hemophilia	XYNTHA	20.25%	18.00%	
Hepatitis B	ADEFOVIR DIPIVOXIL	19.75%	17.25%	
Hepatitis B	BARACLUDE	19.75%	17.25%	
Hepatitis B	ENTECAVIR	MAC	MAC	
Hepatitis B	EPIVIR HBV	19.75%	17.25%	
Hepatitis B	HEPSERA	17.50%	17.25%	
Hepatitis B	LAMIVUDINE_HEPB	MAC	MAC	
Hepatitis B	TYZEKA	19.75%	17.25%	
Hepatitis B	VEMLIDY	17.50%	16.25%	
Hepatitis C	COPEGUS	19.75%	17.25%	
Hepatitis C	DAKLINZA	19.75%	16.25%	
Hepatitis C	EPCLUSA	19.75%	16.25%	
Hepatitis C	HARVONI	17.50%	16.25%	
Hepatitis C	INCIVEK	19.75%	16.25%	
Hepatitis C	INFERGEN	19.75%	16.25%	
Hepatitis C	OLYSIO	17.50%	16.25%	
Hepatitis C	PEGASYS	17.50%	16.25%	
Hepatitis C	PEG-INTRON	17.50%	16.25%	
Hepatitis C	REBETOL	17.50%	17.25%	
Hepatitis C	RIBAPAK	17.50%	16.25%	
Hepatitis C	RIBASPHERE	MAC	MAC	
Hepatitis C	RIBAVIRIN	MAC	MAC	
Hepatitis C	SOVALDI	19.75%	16.25%	
Hepatitis C	TECHNIVIE	19.75%	16.25%	
Hepatitis C	VICTRELIS	17.50%	16.25%	
Hepatitis C	VIEKIRA PAK	17.50%	16.25%	

Hepatitis C	ZEPATIER	19.75%	17.25%	
Hereditary Angioedema	BERINERT	19.75%	16.25%	
Hereditary Angioedema	CINRYZE	13.25%	11.00%	
Hereditary Angioedema	FIRAZYR	19.75%	16.25%	
Hereditary Angioedema	KALBITOR	17.00%	17.00%	
Hereditary Angioedema	RUCONEST	19.25%	17.00%	
HIV	ABACAVIR	MAC	MAC	
HIV	ABACAVIR SULFATE-LAMIVUDINE	19.75%	17.25%	
HIV	APTIVUS	19.75%	16.25%	
HIV	ATRIPLA	17.50%	17.25%	
HIV	COMBIVIR	19.75%	16.25%	
HIV	COMPLERA	18.75%	16.25%	
HIV	CRIXIVAN	19.75%	16.25%	
HIV	DESCOVY	17.50%	17.25%	
HIV	DIDANOSINE	MAC	MAC	
HIV	EDURANT	19.75%	16.25%	
HIV	EGRIFTA	19.75%	16.25%	
HIV	EMTRIVA	19.75%	16.25%	
HIV	EPIVIR	19.75%	17.25%	
HIV	EPZICOM	17.50%	16.25%	
HIV	EVOTAZ	19.75%	16.25%	
HIV	FUZEON	19.75%	16.25%	
HIV	GENVOYA	17.50%	17.25%	
HIV	INTELENCE	17.50%	16.25%	
HIV	INVIRASE	19.75%	16.25%	
HIV	ISENTRESS	17.50%	16.25%	
HIV	KALETRA	17.50%	16.25%	
HIV	LAMIVUDINE/ZIDOVUDINE	MAC	MAC	
HIV	LAMIVUDINE_HIV	MAC	MAC	
HIV	LEXIVA	19.75%	16.25%	
HIV	LOPINAVIR/RITONAVIR	19.75%	16.25%	
HIV	NEVIRAPINE	MAC	MAC	
HIV	NORVIR	17.50%	17.25%	
HIV	ODEFSEY	17.50%	17.25%	
HIV	PREZCOBIX	17.50%	16.25%	
HIV	PREZISTA	17.50%	16.25%	
HIV	RESCRIPTOR	17.50%	17.25%	
HIV	RETROVIR	17.50%	17.25%	
HIV	REYATAZ	17.50%	16.25%	
HIV	SELZENTRY	17.50%	16.25%	
HIV	STAVUDINE	MAC	MAC	

HIV	STRIBILD	17.50%	16.25%	
HIV	SUSTIVA	17.50%	16.25%	
HIV	TIVICAY	17.50%	17.25%	
HIV	TRIUMEQ	17.50%	17.25%	
HIV	TRIZIVIR	17.50%	16.25%	
HIV	TRUVADA	17.50%	17.25%	
HIV	TYBOST	17.50%	17.25%	
HIV	VIDEX	17.50%	17.25%	
HIV	VIRACEPT	17.50%	16.25%	
HIV	VIRAMUNE	17.50%	16.25%	
HIV	VIRAMUNE XR	17.50%	16.25%	
HIV	VIREAD	17.50%	16.25%	
HIV	VITEKTA	17.50%	17.25%	
HIV	ZERIT	19.75%	16.25%	
HIV	ZIAGEN	19.75%	16.25%	
HIV	ZIDOVUDINE	MAC	MAC	
Hormonal Therapies	AVEED	19.25%	17.00%	
Hormonal Therapies	ELIGARD	19.75%	17.25%	
Hormonal Therapies	FIRMAGON	19.75%	17.25%	
Hormonal Therapies	LEUPROLIDE ACETATE	19.75%	17.25%	
Hormonal Therapies	LUPANETA PACK	17.50%	17.25%	
Hormonal Therapies	LUPRON DEPOT	17.50%	16.25%	
Hormonal Therapies	NATPARA	13.25%	11.00%	
Hormonal Therapies	SUPPRELIN	19.75%	16.25%	
Hormonal Therapies	TRELSTAR	17.50%	16.25%	
Hormonal Therapies	VANTAS	19.75%	16.25%	
Hormonal Therapies	ZOLADEX	19.75%	17.25%	
I.V.I.G.	BIVIGAM	19.25%	17.00%	
I.V.I.G.	CARIMUNE	20.25%	18.00%	
I.V.I.G.	CUVITRU	19.75%	16.25%	
I.V.I.G.	CYTOGAM	20.25%	18.00%	
I.V.I.G.	FLEBOGAMMA	20.25%	18.00%	
I.V.I.G.	GAMASTAN S/D	20.25%	18.00%	
I.V.I.G.	GAMMAGARD	20.25%	18.00%	
I.V.I.G.	GAMMAGARD LIQUID	20.25%	18.00%	
I.V.I.G.	GAMMAKED	19.75%	17.25%	
I.V.I.G.	GAMMAPLEX	19.25%	17.00%	
I.V.I.G.	GAMUNEX	20.25%	18.00%	
I.V.I.G.	HEPAGAM B	17.50%	17.25%	
I.V.I.G.	HIZENTRA	20.25%	18.00%	
I.V.I.G.	HYPERHEP B	17.50%	17.25%	

I.V.I.G.	HYPERRHO S/D	17.50%	17.25%	
I.V.I.G.	HYQVIA	17.50%	17.25%	
I.V.I.G.	MICRHOGAM	17.50%	17.25%	
I.V.I.G.	NABI-HB	17.50%	17.25%	
I.V.I.G.	OCTAGAM	20.25%	18.00%	
I.V.I.G.	PRIVIGEN	18.00%	18.00%	
I.V.I.G.	RHOGAM	17.50%	17.25%	
I.V.I.G.	RHOPHYLAC	18.00%	18.00%	
I.V.I.G.	VARIZIG	19.75%	17.25%	
I.V.I.G.	WINRHO	20.25%	18.00%	
Idiopathic Thrombocytopenic Purpura	NPLATE	17.50%	16.25%	
Idiopathic Thrombocytopenic Purpura	PROMACTA	19.75%	16.25%	
Infectious Disease	ACTIMMUNE	19.75%	16.25%	
Infectious Disease	ALFERON N	19.75%	17.25%	
Infertility	BRAVELLE	17.50%	17.25%	
Infertility	CETROTIDE	17.50%	17.25%	
Infertility	CHORIONIC GONADOTROPIN	17.50%	17.25%	
Infertility	FOLLISTIM AQ	18.75%	17.25%	
Infertility	GANIRELIX ACETATE	17.50%	17.25%	
Infertility	GONAL-F	17.50%	17.25%	
Infertility	MENOPUR	17.50%	17.25%	
Infertility	NOVAREL	17.50%	17.25%	
Infertility	OVIDREL	17.50%	17.25%	
Infertility	PREGNYL	19.75%	17.25%	
Infertility	REPRONEX	17.50%	17.25%	
Inflammatory Bowel Disease	CIMZIA	19.75%	16.25%	
Inflammatory Bowel Disease	ENTYVIO	17.50%	16.25%	
Iron Overload	DEFEROXAMINE	19.75%	16.25%	
Iron Overload	DESFERAL	17.50%	16.25%	
Iron Overload	EXJADE	17.00%	17.00%	
Iron Overload	JADENU	13.25%	16.25%	
Lipid Disorder	KYNAMRO	19.75%	16.25%	
Lipid Disorders - PCSK9 Inhibitors	PRALUENT	13.25%	11.00%	
Lipid Disorders - PCSK9 Inhibitors	REPATHA	17.50%	17.25%	
Lipid Disorders - PCSK9 Inhibitors	VENCLEXTA	17.50%	16.25%	
Lysosomal Storage Diseases	ALDURAZYME	19.75%	16.25%	***
Lysosomal Storage Diseases	CERDELGA	17.00%	17.00%	
Lysosomal Storage Diseases	CEREDASE	17.50%	16.25%	***
Lysosomal Storage Diseases	CEREZYME	17.50%	16.25%	***
Lysosomal Storage Diseases	CYSTAGON	19.25%	17.00%	
Lysosomal Storage Diseases	ELAPRASE	19.75%	16.25%	***

Lysosomal Storage Diseases	FABRAZYME	17.50%	16.25%	***
Lysosomal Storage Diseases	LUMIZYME	19.75%	16.25%	***
Lysosomal Storage Diseases	MYOZYME	17.00%	17.00%	***
Lysosomal Storage Diseases	NAGLAZYME	17.50%	16.25%	***
Lysosomal Storage Diseases	VIMIZIM	17.50%	16.25%	***
Lysosomal Storage Diseases	VPRIV	19.75%	16.25%	***
Migraine	ZECUITY	11.00%	11.00%	
Movement Disorders	APOKYN	19.75%	16.25%	
Movement Disorders	NORTHERA	19.25%	17.00%	
Movement Disorders	NUPLAZID	13.25%	11.00%	
Movement Disorders	TETRABENAZINE	MAC	MAC	
Movement Disorders	XENAZINE	17.50%	16.25%	
Multiple Sclerosis	AMPYRA	19.00%	17.00%	
Multiple Sclerosis	AUBAGIO	19.00%	17.00%	
Multiple Sclerosis	AVONEX	19.75%	16.25%	
Multiple Sclerosis	BETASERON	17.50%	16.25%	
Multiple Sclerosis	COPAXONE 20	20.00%	16.25%	
Multiple Sclerosis	COPAXONE 40	20.00%	16.25%	
Multiple Sclerosis	EXTAVIA	17.50%	16.25%	
Multiple Sclerosis	GILENYA	18.75%	16.25%	
Multiple Sclerosis	GLATOPA	19.75%	17.25%	
Multiple Sclerosis	LEMTRADA	19.25%	17.00%	
Multiple Sclerosis	MITOXANTRONE	19.75%	17.25%	
Multiple Sclerosis	OCREVUS	13.25%	11.00%	
Multiple Sclerosis	PLEGRIDY	19.25%	17.00%	
Multiple Sclerosis	REBIF	18.75%	16.25%	
Multiple Sclerosis	TECFIDERA	19.75%	16.25%	
Multiple Sclerosis	TYSABRI	19.75%	16.25%	
Multiple Sclerosis	ZINBRYTA	13.25%	11.00%	
Neutropenia	GRANIX	17.50%	16.25%	
Neutropenia	LEUKINE	17.50%	16.25%	
Neutropenia	NEULASTA	17.50%	16.25%	
Neutropenia	NEUPOGEN	17.50%	16.25%	
Neutropenia	ZARXIO	17.50%	17.25%	
Oncology - Injectable	ADCETRIS	19.25%	17.00%	
Oncology - Injectable	ARZERRA	17.50%	16.25%	
Oncology - Injectable	AVASTIN	19.75%	17.25%	
Oncology - Injectable	AZACITIDINE	19.75%	16.25%	
Oncology - Injectable	BELEODAQ	13.25%	16.25%	
Oncology - Injectable	BENDEKA	13.25%	11.00%	
Oncology - Injectable	DACOGEN	19.75%	16.25%	

Oncology - Injectable	DARZALEX	13.25%	11.00%	
Oncology - Injectable	DECITABINE	19.25%	17.00%	
Oncology - Injectable	ELSPAR	19.75%	16.25%	
Oncology - Injectable	EMPLICITI	13.25%	11.00%	
Oncology - Injectable	ERBITUX	17.00%	17.00%	
Oncology - Injectable	EVOMELA	13.25%	11.00%	
Oncology - Injectable	FOLOTYN	19.75%	16.25%	
Oncology - Injectable	FUSILEV	19.75%	16.25%	
Oncology - Injectable	GAZYVA	17.50%	16.25%	
Oncology - Injectable	HALAVEN	17.00%	17.00%	
Oncology - Injectable	HERCEPTIN	17.00%	17.00%	
Oncology - Injectable	IMFINZI	13.25%	11.00%	
Oncology - Injectable	INTRON A	19.75%	16.25%	
Oncology - Injectable	IRESSA	13.25%	11.00%	
Oncology - Injectable	ISTODAX	17.50%	16.25%	
Oncology - Injectable	IXEMPRA	17.50%	16.25%	
Oncology - Injectable	JEVTANA	17.00%	17.00%	
Oncology - Injectable	KADCYLA	17.50%	16.25%	
Oncology - Injectable	KEYTRUDA	17.00%	17.00%	
Oncology - Injectable	KYPROLIS	19.25%	17.00%	
Oncology - Injectable	LEVOLEUCOVORIN CALCIUM	19.75%	17.25%	
Oncology - Injectable	ONCASPAR	17.50%	16.25%	
Oncology - Injectable	OPDIVO	11.00%	16.25%	
Oncology - Injectable	PERJETA	17.00%	17.00%	
Oncology - Injectable	PROLEUKIN	17.50%	16.25%	
Oncology - Injectable	RITUXAN	19.25%	17.00%	
Oncology - Injectable	RUBRACA	13.25%	11.00%	
Oncology - Injectable	SYLATRON	17.50%	16.25%	
Oncology - Injectable	TAGRISSO	13.25%	11.00%	
Oncology - Injectable	TECENTRIQ	13.25%	11.00%	
Oncology - Injectable	TEMODAR (INJECTABLE)	19.75%	16.25%	
Oncology - Injectable	THYROGEN	18.25%	17.00%	
Oncology - Injectable	TORISEL	19.75%	16.25%	
Oncology - Injectable	TREANDA	17.00%	17.00%	
Oncology - Injectable	VALSTAR	19.75%	16.25%	
Oncology - Injectable	VECTIBIX	19.75%	16.25%	
Oncology - Injectable	VELCADE	19.75%	16.25%	
Oncology - Injectable	VIDAZA	17.50%	16.25%	
Oncology - Injectable	XGEVA	19.75%	16.25%	
Oncology - Injectable	YERVOY	19.25%	17.00%	
Oncology - Injectable	ZALTRAP	19.25%	17.00%	

Oncology - Injectable	ZOLEDRONIC ACID_ONC	19.25%	17.00%	
Oncology - Injectable	ZOMETA	17.00%	17.00%	
Oncology - Oral	AFINITOR	18.50%	16.25%	
Oncology - Oral	ALECENSA	13.25%	11.00%	
Oncology - Oral	ALUNBRIG	13.25%	11.00%	
Oncology - Oral	BEXAROTENE CAP	19.75%	17.25%	
Oncology - Oral	BOSULIF	19.75%	16.25%	
Oncology - Oral	CABOMETYX	13.25%	11.00%	
Oncology - Oral	CAPECITABINE	MAC	MAC	
Oncology - Oral	COTELLIC	13.25%	11.00%	
Oncology - Oral	ERIVEDGE	17.00%	17.00%	
Oncology - Oral	FARYDAK	11.00%	11.00%	
Oncology - Oral	GLEEVEC	17.50%	16.25%	
Oncology - Oral	HYCAMTIN	17.50%	16.25%	
Oncology - Oral	IBRANCE	13.50%	11.00%	
Oncology - Oral	IMATINIB MESYLATE	MAC	MAC	
Oncology - Oral	INLYTA	18.50%	16.25%	
Oncology - Oral	JAKAFI	17.00%	17.00%	
Oncology - Oral	KISQALI	17.50%	16.25%	
Oncology - Oral	LONSURF	13.25%	11.00%	
Oncology - Oral	MEKINIST	19.75%	16.25%	
Oncology - Oral	MUGARD	19.25%	17.00%	
Oncology - Oral	NEXAVAR	19.75%	16.25%	
Oncology - Oral	NINLARO	13.25%	11.00%	
Oncology - Oral	ODOMZO	11.00%	11.00%	
Oncology - Oral	POMALYST	19.75%	16.25%	
Oncology - Oral	PURIXAN	11.00%	11.00%	
Oncology - Oral	REVLIMID	17.50%	16.25%	
Oncology - Oral	RYDAPT	19.75%	16.25%	
Oncology - Oral	SPRYCEL	19.75%	16.25%	
Oncology - Oral	STIVARGA	18.25%	16.25%	
Oncology - Oral	SUTENT	17.50%	16.25%	
Oncology - Oral	TAFINLAR	19.75%	16.25%	
Oncology - Oral	TARCEVA	18.25%	16.25%	
Oncology - Oral	TARGRETIN	19.75%	16.25%	
Oncology - Oral	TASIGNA	19.75%	16.25%	
Oncology - Oral	TEMODAR (ORAL)	19.75%	16.25%	
Oncology - Oral	TEMOZOLOMIDE	MAC	MAC	
Oncology - Oral	THALOMID	19.75%	16.25%	
Oncology - Oral	TYKERB	17.50%	16.25%	
Oncology - Oral	VOTRIENT	18.75%	16.25%	

Oncology - Oral	XALKORI	17.50%	16.25%	
Oncology - Oral	XELODA	17.50%	16.25%	
Oncology - Oral	XTANDI	19.25%	17.00%	
Oncology - Oral	YONDELIS	13.25%	11.00%	
Oncology - Oral	ZELBORAF	18.25%	17.00%	
Oncology - Oral	ZOLINZA	19.75%	16.25%	
Oncology - Oral	ZYKADIA	17.00%	17.00%	
Oncology - Oral	ZYTIGA	19.75%	16.25%	
Osteoarthritis	EUFLEXXA	19.75%	16.25%	
Osteoarthritis	GEL-ONE	17.50%	16.25%	
Osteoarthritis	GELSYN-3	17.50%	16.25%	
Osteoarthritis	GENVISC 850	11.00%	11.00%	
Osteoarthritis	HYALGAN	17.50%	16.25%	
Osteoarthritis	HYMOVIS	11.00%	11.00%	
Osteoarthritis	MONOVISC	19.25%	17.00%	
Osteoarthritis	ORTHOVISC	19.75%	16.25%	
Osteoarthritis	SUPARTZ	19.25%	17.00%	
Osteoarthritis	SYNVISC	19.75%	16.25%	
Osteoporosis	FORTEO	19.00%	16.25%	
Osteoporosis	PROLIA	17.00%	17.00%	
Osteoporosis	RECLAST	19.25%	17.00%	
Osteoporosis	ZOLEDRONIC ACID_OST	MAC	MAC	
Paroxysmal Nocturnal Hemoglobinuria	SOLIRIS	17.50%	16.25%	
Phenylketonuria	KUVAN	17.50%	16.25%	
Pre-Term Birth	MAKENA	19.75%	16.25%	
Psoriasis	AMEVIVE	19.25%	17.00%	
Psoriasis	COSENTYX	13.25%	16.25%	
Psoriasis	OTEZLA	17.00%	17.00%	
Psoriasis	STELARA	19.75%	16.25%	
Psoriasis	TALTZ	13.50%	11.00%	
Pulmonary Arterial Hypertension	ADCIRCA	17.00%	17.00%	
Pulmonary Arterial Hypertension	ADEMPAS	17.00%	17.00%	
Pulmonary Arterial Hypertension	EPOPROSTENOL	17.50%	16.25%	*
Pulmonary Arterial Hypertension	LETAIRIS	17.50%	16.25%	
Pulmonary Arterial Hypertension	OPSUMIT	18.00%	17.00%	
Pulmonary Arterial Hypertension	ORENITRAM	19.25%	17.00%	
Pulmonary Arterial Hypertension	REMODULIN	7.25%	5.00%	*
Pulmonary Arterial Hypertension	REVATIO	17.75%	17.00%	
Pulmonary Arterial Hypertension	SILDENAFIL CITRATE	MAC	MAC	
Pulmonary Arterial Hypertension	TRACLEER	17.50%	16.25%	
Pulmonary Arterial Hypertension	TYVASO	4.25%	2.00%	

Pulmonary Arterial Hypertension	UPTRAVI	13.25%	11.00%	
Pulmonary Arterial Hypertension	VELETRI	19.25%	17.00%	*
Pulmonary Arterial Hypertension	VENTAVIS	2.00%	2.00%	**
Pulmonary Disorders	ESBRIET	19.25%	17.00%	
Pulmonary Disorders	OFEV	11.00%	11.00%	
Renal Disease	SENSIPAR	17.50%	16.25%	
Retinal Disorders	EYLEA	17.50%	16.25%	
Retinal Disorders	ILUVIEN	13.25%	11.00%	
Retinal Disorders	LUCENTIS	18.75%	16.25%	
Retinal Disorders	MACUGEN	17.00%	17.00%	
Retinal Disorders	OZURDEX	17.00%	17.00%	
Retinal Disorders	RETISERT	17.50%	16.25%	
Retinal Disorders	VISUDYNE	17.00%	17.00%	
Rheumatoid Arthritis	ACTEMRA	17.00%	17.00%	
Rheumatoid Arthritis	ENBREL	19.50%	16.25%	
Rheumatoid Arthritis	HUMIRA	19.75%	16.25%	
Rheumatoid Arthritis	INFLECTRA	19.75%	16.25%	
Rheumatoid Arthritis	KEVZARA	11.00%	11.00%	
Rheumatoid Arthritis	ORENCIA	18.75%	16.25%	
Rheumatoid Arthritis	OTREXUP	17.00%	17.00%	
Rheumatoid Arthritis	RASUVO	17.00%	17.00%	
Rheumatoid Arthritis	REMICADE	17.50%	16.25%	
Rheumatoid Arthritis	SIMPONI	18.75%	16.25%	
Rheumatoid Arthritis	XELJANZ	17.00%	17.00%	
RSV	SYNAGIS	19.25%	16.25%	
Seizure Disorders	HP ACTHAR GEL	19.75%	16.25%	
Seizure Disorders	SABRIL	17.50%	16.25%	
Systemic Lupus Erythematosus	BENLYSTA	17.50%	16.25%	
Transplant	ASTAGRAF XL	17.50%	16.25%	
Transplant	CELLCEPT	17.50%	16.25%	
Transplant	CYCLOSPORINE	MAC	MAC	
Transplant	ENVARSUS XR	17.50%	17.25%	
Transplant	GENGRAF	MAC	MAC	
Transplant	MYCOPHENOLATE MOFETIL	MAC	MAC	
Transplant	MYCOPHENOLIC ACID	19.25%	17.00%	
Transplant	MYFORTIC	17.50%	16.25%	
Transplant	NEORAL	17.50%	16.25%	
Transplant	NULOJIX	19.75%	16.25%	
Transplant	PROGRAF	17.00%	17.00%	
Transplant	RAPAMUNE	17.50%	16.25%	
Transplant	SANDIMMUNE	19.75%	16.25%	

Transplant	SIROLIMUS	19.25%	17.00%	
Transplant	TACROLIMUS	MAC	MAC	
Transplant	ZORTRESS	17.50%	16.25%	
Urea Cycle Disorders	BUPHENYL	17.50%	16.25%	
Urea Cycle Disorders	RAVICTI	17.50%	16.25%	
Urea Cycle Disorders	SODIUM PHENYLBUTYRATE	17.00%	17.00%	
	Default Rate	18.75%	16.25%	
	MAC Effective Rate	45.00%	45.00%	
	Dispensing Fee:	$0.00	$0.00	$0.00

NOTES:

Exclusive

- New to market Specialty Brand Drugs will be priced at AWP -15.00% or MAC, if applicable
- New to market Specialty Generic Drugs will be priced at AWP – 15.00% or MAC, if applicable

- New to market Limited Distribution Drugs will be priced at AWP -10.00%
- New to market biosimilars will priced at AWP -10.00%

MAC: Certain dosage forms and strengths may not be included on the MAC list and shall be priced at the Specialty Drug default rate.

The exclusive specialty offer includes the provision by CVS/caremark of nurse-based rare condition care management services for Engaged Members (defined below) with the following rare conditions pursuant to the AccordantCare Specialty program established by CVS/caremark, as may be amended by CVS/caremark from time to time: Crohn's Disease, Cystic Fibrosis, Gauchers Disease, Hemophilia, Lupus, Multiple Sclerosis, Rheumatoid Arthritis, and Ulcerative Colitis (the "AccordantCare Specialty Program"). Pursuant to the AccordantCare Specialty Program, Participating Group acknowledges that CVS/caremark will utilize those Specialty Drug Claims that are filled by CVS/caremark's specialty pharmacy to identify and outreach to Members that CVS/caremark determines are likely to have one of the above listed rare conditions (each an "Eligible Member"), and CVS/caremark may communicate with medical and other healthcare providers and any health plans providing benefits to Engaged Members. Participating Group acknowledges that the AccordantCare Specialty Program is intended solely to provide education of, and support to, Engaged Members in the diagnosis and treatment provided by their healthcare providers. "Engaged Member" means an Eligible Member who elects to receive and receives AccordantCare Specialty Program services.

Open

- New to market Specialty Brand Drugs will be priced at AWP -15.00% or MAC, if applicable
- New to market Specialty Generic Drugs will be priced at AWP – 15.00% or MAC, if applicable

- New to market Limited Distribution Drugs will be priced at AWP -10.00%
- New to market biosimilars will priced at AWP -10.00%

MAC: Certain dosage forms and strengths may not be included on the MAC list and shall be priced at the Specialty Drug default rate.

New to market drugs will be evaluated during the annual market check process and will be added to the fee schedule as appropriate.

PER DIEMS, NURSING & EQUIPMENT:

* Remodulin, Veletri & Epoprostenol Sodium for Injection: $60 per day
**Ventavis: Participating Group acknowledges and agrees an I-Neb is necessary for the administration of Ventavis. For each I-Neb provided to Member, upon the initiation of therapy or in the event a replacement I-Neb is necessary, Participating Group shall reimburse CVS/caremark $1,811 for each I-Neb.
*** Unless otherwise stated above: $75 per dose

Nursing Charges: $225.00 per visit up to 2 hours, $110.00 for each hour thereafter. Alternatively, CVS/caremark can refer any medically necessary nursing services to the Participating Group's contracted nursing agency, in which case nursing services will be billed separately by those agencies.

In further consideration of the fees and charges to be paid to CVS/caremark under the Agreement, CVS/caremark will bill any applicable nursing and equipment charges and per diems to the Member's medical benefit. In the event it is not possible to bill such nursing and equipment charges and per diems to the Member's medical benefit or it is determined there is no coverage, CVS/caremark shall bill Participating Group directly for any nursing and equipment charges and per diem associated with Specialty Drugs.

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

PRODUCT SHORTAGE:
In the event of an industry-wide product shortage, CVS/caremark reserves the right to adjust pricing upon notice to Participating Group. For purposes of this "Product Shortage" Section only, an "industry-wide shortage" exists when the total supply of a medication does not meet demand for that drug on a nationwide or regional basis.

CONFIDENTIALITY:
Participating Group acknowledges and agrees that the information included is confidential, proprietary and trade secret to CVS/caremark and will agree to protect the information from disclosure.

Exhibit B
Business Associate Obligations

WHEREAS, Participating Group currently provides pharmacy benefits as part of its health care plan(s) for Members; Participating Group is a "**Covered Entity**" as that term is used in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, Title 45, Parts 160 and 164 of the Code of Federal Regulations; and, Participating Group desires to engage CVS/caremark to provide certain pharmacy benefit management services from time to time on behalf of and for the benefit of Participating Group pursuant to the Participating Group Addendum between CVS/caremark and Participating Group; and,

WHEREAS, CVS/caremark desires to provide certain pharmacy benefit management services from time to time on behalf of and for the benefit of Participating Group; and, CVS/caremark is a "**Business Associate**" as that term is used in HIPAA; and,

WHEREAS, Participating Group and CVS/caremark mutually agree to the terms of this Exhibit B, mutually agree to comply with the applicable requirements of HIPAA's implementing regulations dealing with the confidentiality of Protected Health Information, mutually agree that if any conflict exists between the terms of the Participating Group Addendum and this Exhibit B, the terms of this Exhibit B shall govern; and, mutually agree that this Exhibit B is applicable to CVS/caremark in its capacity as Participating Group's pharmacy benefits manager and not in its capacity as a mail order pharmacy or other health care provider, at which times CVS/caremark is a Covered Entity and is not serving as Participating Group's Business Associate.

NOW, THEREFORE, in consideration of the foregoing recitals, the mutual covenants and agreements contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereby covenant and agree as follows:

1. Definitions.

1.1 "**Protected Health Information**" (PHI) shall have the meaning given such term by HIPAA: e.g., any information, whether oral or recorded, in any form or medium, that is created or received by or on behalf of a health care provider, health plan, employer or health care clearinghouse and that:

a. relates to the past, present, or future physical or mental condition of any Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual; and

b. identifies the Individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual. PHI includes demographic information unless such information is de-identified according to the Privacy Rule.

1.2 "**Individual**" shall mean the person who is the subject of PHI and with regard to rights granted by the Privacy Rule, Individual shall also include a person who qualifies under the Privacy Rule as a personal representative of the Individual.

1.3 "**HITECH Act**" shall mean the Health Information Technology for Economic and Clinical Health Act (Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (2009)).

1.4 Capitalized terms used in this Exhibit B, but not otherwise defined in this Exhibit B, shall

have the meanings given those terms in the Privacy Rule (Title 45, Parts 160 and 164, Subparts A and E of the Code of Federal Regulations), the Security Rule (Title 45, Parts 160 and 164, Subparts A and C of the Code of Federal Regulations), the Breach Notification Rule (Title 45, Part 164, Subpart D of the Code of Federal Regulations), or otherwise in HIPAA, the HITECH Act (collectively, the "**HIPAA Rule**s"), and the Participating Group Addendum between CVS/caremark and Participating Group, as applicable. References to PHI in this Exhibit B shall also include, but are not limited to, Electronic PHI.

2. Prohibition on Unauthorized Use or Disclosure of PHI. CVS/caremark shall not use or disclose any PHI received from, or created, maintained or received by CVS/caremark on behalf of, Participating Group except as permitted or required in order to perform or improve the Services as specified in the Participating Group Addendum between Participating Group and CVS/caremark, as required by law, or as otherwise authorized by this Exhibit B or in writing by Participating Group. Except as otherwise provided in this Exhibit B, CVS/caremark may not use or disclose PHI in a manner that would violate the Privacy Rule if done by Participating Group.

3. Use and Disclosure of PHI. Except as described in Sections 4 and 5 of this Exhibit B, CVS/caremark may use or disclose PHI only for the following purpose(s):

3.1 CVS/caremark may use or disclose PHI to Participating Group, Participating Pharmacies, Members' providers and Members in a manner consistent with the performance of CVS/caremark's Services for Participating Group and the fulfillment of CVS/caremark's obligations to Participating Group under the Participating Group Addendum between CVS/caremark and Participating Group. CVS/caremark may assume that members of Participating Group's workforce who request or receive PHI are performing Plan administration activities for Participating Group and are authorized to receive PHI on its behalf.

3.2 CVS/caremark may use and, subject to the requirements of Section 4, disclose, PHI in order to create aggregated data, and may use the aggregated data alone or in combination with the data of other Covered Entities, to provide data analyses, as specified in the Participating Group Addendum, that relate to Participating Group's health care operations. CVS/caremark may also provide such data analyses to the other Covered Entities whose data was included in the analyses, to the extent permitted by 45 CFR § 164.504(e)(2)(i)(B).

3.3 To conduct Drug Utilization Review (DUR) for another Covered Entity if both Participating Group and the other Covered Entity have had a relationship with the Individual whose PHI is involved and the PHI relates to that relationship.

3.4 To report violations of Law to appropriate federal and state authorities, consistent with 45 CFR § 164.502(j)(1).

3.5 To NCRx for the purpose of NCRx conducting an audit of CVS/caremark Services and for the purpose of NCRx performing other services for Participating Group, as directed by Participating Group.

3.6 Pursuant to an Individual authorization in accordance with 45 CFR §164.508.

3.7 For treatment, payment and health care operations of health care providers and other Covered Entities as permitted by 45 CFR §164.506(c); and

3.8 As otherwise authorized in writing by Participating Group.

4. Use and Disclosure of PHI for Certain of CVS/caremark's Operations. CVS/caremark may use and/or disclose PHI received from, or created or received by CVS/caremark on behalf of, Participating Group to the extent necessary for CVS/caremark's proper management and administration, or to carry out

CVS/caremark's legal responsibilities, but only if such use and/or disclosure is not for Marketing, as defined by the HIPAA Rules, and provided that, in the case of any disclosures for this purpose:

4.1 The disclosure is required by law; or

4.2 CVS/caremark obtains reasonable assurances, evidenced by written contract, from any person or organization to which CVS/caremark shall disclose such PHI that such person or organization shall:

a. Hold such PHI in confidence and use or further disclose it only for the purpose for which CVS/caremark disclosed it to the person or organization, or as required by law; and

b. Notify CVS/caremark, who shall in turn promptly notify Participating Group, of any instance which the person or organization becomes aware of in which the confidentiality of such PHI was breached.

5. De-identified Information. CVS/caremark may use or disclose PHI, subject to the requirements of Section 7 of this Exhibit B, in order to de-identify such PHI in accordance with 45 CFR § 164.514 and may use and disclose such de-identified information for creating comparative databases and performing statistical analysis and for such other purposes as it deems appropriate.

6. Safeguarding PHI. CVS/caremark agrees that it has developed, implemented, maintains, and shall use appropriate administrative, technical, and physical safeguards to prevent the use or disclosure of all PHI, in any form or media, received from, or created or received by CVS/caremark on behalf of Participating Group other than as provided in this Exhibit B. CVS/caremark shall document and keep these security measures current. These security measures shall include the following elements:

6.1 In using and disclosing PHI for a purpose permitted by this Exhibit B, CVS/caremark shall comply with the minimum necessary standard and requirements set forth in 45 CFR § 164.502(b), 45 CFR § 164.514(d), Section 13405(b) of the HITECH Act and any binding guidance or interpretation set forth by the U.S. Department of Health and Human Services (U.S.) from time to time relating to the minimum necessary standard.

6.2 Safeguards for the transmission of PHI by email.

7. Subcontractors and Agents. CVS/caremark agrees to require that any agent, including any Subcontractor, to whom it delegates any function or activity it has undertaken to perform on behalf of Participating Group, and who creates, receives, maintains or transmits PHI on behalf of CVS/caremark, agrees to substantially the same restrictions and conditions on the use or disclosure of PHI as are imposed on CVS/caremark by this Exhibit B. CVS/caremark agrees to require any Subcontractor who creates, receives, maintains or transmits Electronic PHI on behalf of CVS/caremark to comply with the requirements of the Security Rule by entering into a contract that complies with 45 C.F.R. § 164.314(a).

8. Access to PHI. Upon the Participating Group's written request, CVS/caremark agrees to provide access to any PHI held by CVS/caremark in a Designated Record Set, in a reasonable time (but in no event later than ten (10) calendar days from CVS/caremark's receipt of the request) and manner as required for Participating Group to respond to requests for access under 45 CFR § 164.524. This access will be provided to Participating Group or, as directed by Participating Group in its written request, to an Individual or the Individual's designee, in order to meet the requirements under 45 CFR § 164.524. All Individual requests to exercise their rights under HIPAA must be directed to Participating Group and CVS/caremark will assist in responding to such requests forwarded to it by Participating Group as provided in this paragraph. CVS/caremark agrees that if it maintains PHI in an Electronic Health Record, as defined in the HITECH Act, it shall provide such access in electronic format if so requested by Participating Group, to the extent required by and in accordance with Section 13405(e) of the HITECH Act.

9. Amendment to PHI. Upon the Participating Group's written request, CVS/caremark agrees to make such amendments or corrections to PHI held by CVS/caremark in a Designated Record Set, in a time and manner as required by 45 CFR § 164.526.

10. Reporting of Unauthorized Uses or Disclosures of PHI and Security Incidents. CVS/caremark shall report to Participating Group any use or disclosure of PHI not authorized by this Exhibit B or in writing by Participating Group, of which it becomes aware, including any Security Incidents. CVS/caremark shall make the report to Participating Group's Privacy Official promptly, but not more than ten (10) business days after CVS/caremark learns of such use or disclosure. CVS/caremark's report shall, to the extent known by it, identify: (i) the nature of the unauthorized use or disclosure, (ii) the PHI used or disclosed, (iii) who received the unauthorized disclosure, (iv) what CVS/caremark has done or shall do to mitigate, to the extent practicable, any known deleterious effect of the unauthorized use or disclosure, and (v) what corrective action CVS/caremark has taken or shall take, to the extent practicable, to protect against future similar unauthorized use or disclosure. CVS/caremark shall provide such other information, including a written report, as reasonably requested by Participating Group's Privacy Official.

11. Notification in the Case of Breach.

11.1 Notification in the Case of Breach. If CVS/caremark accesses, receives, creates, transmits, maintains, retains, modifies, records, stores, destroys or otherwise holds, uses, or discloses Unsecured Protected Health Information, CVS/caremark shall notify Participating Group, in writing, of any Breach of such information, including any Breach discovered by an employee, officer, or other agent of CVS/caremark, as determined in accordance with the federal common law of agency.

a. Timing of Notification. CVS/caremark shall provide Participating Group with the written notification of a Breach of Unsecured Protected Health Information without unreasonable delay and in no case later than twenty (20) calendar days following the first day on which such Breach is discovered by CVS/caremark. A Breach shall be treated as discovered by CVS/caremark as of the first day on which such Breach is known to CVS/caremark or, by exercising reasonable diligence, would have been known to CVS/caremark. CVS/caremark shall be deemed to have knowledge of a Breach if the Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or other agent of CVS/caremark, as determined in accordance with the federal common law of agency.

b. Content of Notification. CVS/caremark's written notification to Participating Group shall include the following:

(i) the identification of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by CVS/caremark to have been, accessed, acquired, or disclosed during such Breach;

(ii) a brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

(iii) a description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

(iv) any steps Individuals should take to protect themselves from potential harm resulting from the Breach;

(v) a brief description of what CVS/caremark is doing to investigate the

Breach, to mitigate harm to Individuals, and to protect against any further Breach; and

(vi) the name and contact information of the individual designated by CVS/caremark to answer questions from Participating Group regarding the Breach.

c. Law Enforcement Delay. Notwithstanding Section 11.1(a) of this Exhibit B above, if a Law Enforcement Official states to CVS/caremark that the notice otherwise required under Section 11.1(a) of this Exhibit B would impede a criminal investigation or cause damage to national security, CVS/caremark shall: (1) if the statement is in writing and specifies the time for which a delay is required, delay such notice for the time period specified by the official; or (2) if the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notice no longer than 30 days from the date of the oral statement, unless a written statement as described in (1), above, is submitted during that time. CVS/caremark shall promptly notify Participating Group of any statement it receives from a Law Enforcement Official, whether in writing or oral, to delay such notification, and forward a copy of such statement to Participating Group upon request.

d. Costs of Notification. CVS/caremark shall reimburse Participating Group for any and all reasonable costs incurred by Participating Group to notify Individuals or their next of kin (if the Individual is deceased) of any Breach of such Individuals' Unsecured Protected Health Information, as well as any reasonable costs associated with the Breach, including but not limited to, credit monitoring subscriptions for affected Individuals, only if such Breach is caused by CVS/caremark, its employees, officers, or directors failure to implement reasonable and appropriate safeguards as required by this Exhibit B, and not due in whole or in part to the acts or omissions of Participating Group.

e. Notification to Individuals. The Parties agree that Participating Group shall have sole responsibility for notifying Individuals of any Breach of Unsecured Protected Health Information, regardless of whether such Breach is caused, in whole or in part, by CVS/caremark. CVS/caremark further agrees not to provide any notification of or information regarding any actual or potential Breach, whether in writing or orally, to the affected Individuals.

12. Security and Privacy Requirements of HITECH ACT.

12.1 Security Requirements. CVS/caremark shall comply with the applicable requirements of the Security Rule, including, but not limited to, developing, implementing, maintaining and using appropriate administrative, technical, physical and organizational safeguards to preserve the confidentiality, integrity, and availability of all electronically maintained or transmitted PHI received from, or created or received by CVS/caremark on behalf of, Participating Group, as required by 45 CFR §§ 164.306, 164.308, 164.310, 164.312, and 164.316. CVS/caremark shall document and keep these security measures current and available for inspection, upon request.

12.2 Privacy and Security Provisions. CVS/caremark agrees to comply with the additional security and privacy requirements of the HITECH Act that are made applicable to Covered Entities as required by sections 13401 and 13404(a) respectively of the HITECH Act. CVS/caremark may use and disclose PHI only if such use or disclosure, respectively, is in compliance with the applicable provisions of 45 CFR § 164.504(e). The parties acknowledge and agree that 45 CFR § 164.504(e)(1)(ii) shall apply to CVS/caremark in

the same manner that such section applies to Participating Group with respect to compliance with the standards in 45 CFR § 164.502(e) and 45 CFR § 164.504(e), as required by Section 13404(b) of the HITECH Act.

13. Mitigating Effect of Unauthorized Disclosures or Misuse of PHI. CVS/caremark agrees to mitigate, to the extent practicable, any harmful effect that is known to CVS/caremark of a use or disclosure of PHI by CVS/caremark in violation of this Exhibit B and/or the HIPAA Rules.

14. Accounting of Disclosures. If CVS/caremark makes any disclosures subject to an accounting under 45 CFR § 164.528, CVS/caremark shall maintain an ongoing log of the details relating to such disclosures as would be required for Participating Group to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. For each such disclosure, the log shall note the information required by 45 CFR §164.528 or: (i) the date made, (ii) the name of the person or organization who received the PHI, (iii) the recipient's address, if known, (iv) a description of the PHI disclosed, and (v) the reason for the disclosure. CVS/caremark shall, within twenty (20) business days of a Participating Group's written request, provide such log to Participating Group to permit Participating Group to respond to a request by an Individual for an accounting of disclosures of his/her PHI. CVS/caremark must maintain the log for a rolling period of up to six (6) years preceding a request from Participating Group or HHS for such log.

15. Accounting to Covered Entity and to Government Agencies. CVS/caremark shall make its internal practices, policies, procedures, books and records relating to the use and disclosure of PHI received from, or created or received by CVS/caremark on behalf of, Participating Group available at the written request of Participating Group or HHS, to HHS in a time and manner reasonably designated by HHS, for inspection and copying, for the purpose of determining Participating Group's compliance with the Privacy Rule. To the extent permitted by law, CVS/caremark shall promptly notify Participating Group of communications with HHS regarding PHI provided by or created by Participating Group pursuant to a request by HHS that specifically names Participating Group as a subject of the inquiry and shall, to the extent permitted by law and excluding any data CVS/caremark deems proprietary, provide Participating Group with copies of any information CVS/caremark has made available to HHS under this provision.

16. Termination.

16.1 This Exhibit B shall take effect upon execution and shall terminate upon termination of the Participating Group Addendum, except to the extent provided in Section 16.2(b) of this Exhibit B below.

16.2 If CVS/caremark materially breaches any of its obligations under this Exhibit B, Participating Group, in its sole discretion, shall have the right to:

a. exercise any of its rights to reports, access, and inspection under this Exhibit B; and/or

b. provide CVS/caremark with thirty (30) business days (or longer in Participating Group's discretion) to cure the breach and terminate the Participating Group Addendum and this Exhibit B if CVS/caremark does not cure the breach within the specified time; and/or

c. terminate the Participating Group Addendum and this Exhibit B immediately if cure is not possible; and/or,

d. if the breach is not cured and termination is not feasible, report the violation to HHS.

16.3 Before exercising any of these options, Participating Group shall provide written notice to CVS/caremark describing the violation and the action it intends to take.

17. Return or Destruction of PHI. Upon termination, cancellation, expiration, or other conclusion of the Services provided by CVS/caremark for, or on behalf of, Participating Group, CVS/caremark shall:

a. Subject to subsection (b), at Participating Group's request, return to Participating Group all PHI which was created or received by CVS/caremark on behalf of Participating Group, in whatever form or medium said PHI exists, including all related data, in a form that can be converted by Participating Group and held by the database systems chosen by Participating Group as directed by Participating Group. Participating Group agrees to reimburse CVS/caremark for any expenses (e.g., materials and postage) related to returning the PHI in a form chosen by Participating Group. Prior to incurring any expenses, CVS/caremark shall provide, in writing, an estimate of likely expenses related to returning the PHI. Unless subsection (b) applies, CVS/caremark shall retain no copies of PHI, including any compilations which include PHI, and shall destroy or require destruction or return of all copies in its possession and in the possession of any of its subcontractors or agents. CVS/caremark shall complete such return and destruction as promptly as possible, but not more than thirty (30) days after the effective date of the conclusion of the Services provided by CVS/caremark. Within such thirty (30) day period, CVS/caremark shall certify on oath in writing to Participating Group that such return and destruction has been completed. This provision shall also apply to all PHI that is in the possession of subcontractors or agents of CVS/caremark to whom it delegated any Services performed by it for Participating Group.

b. If return or destruction is not feasible because CVS/caremark is required by law to maintain documents for a certain period of time, or because Participating Group's agreement with CVS/caremark requires CVS/caremark to maintain records for a certain period of time, or because it is not operationally or legally feasible for CVS/caremark to return or destroy such PHI, then CVS/caremark agrees that its obligation to protect said PHI in accordance with this Exhibit B shall be continuous for so long as it retains any PHI and shall survive any termination, cancellation, expiration, or other conclusion of the Participating Group Addendum and/or this Exhibit B. However, CVS/caremark shall limit any further uses and disclosures to the purposes that make return or destruction of the PHI not feasible. At such time as CVS/caremark determines that it is feasible to return or destroy the PHI, CVS/caremark shall return or destroy said PHI within 30 days of making such determination.

19. Miscellaneous.

a. A reference in this Exhibit B to a section in the Privacy Rules, Security Rule and the HITECH Act means the section Participating Group or CVS/caremark is required to comply with, whether the section is in effect at the time of execution, or subsequently amended, or interpreted by the courts in a manner impacting Participating Group's or CVS/caremark's compliance obligations.

b. Upon the effective date of any amendment to the regulations promulgated by HHS with regard to PHI, the parties agree to promptly negotiate in good faith to amend this Exhibit B so that the obligations imposed on the parties shall remain in compliance with such regulations.

c. Any ambiguity in this Exhibit B shall be resolved in favor of a meaning that permits the parties to comply with the Privacy Rules, Security Rule and the HITECH Act.

d. In conducting standard transactions electronically for or on behalf of Participating Group, CVS/caremark will comply with each applicable requirement of HIPAA and its

implementing regulations for Standard Electronic Transactions and Code Sets, found at 45 CFR Part 162 and require any subcontractors and agents to comply with such requirements.

e. CVS/caremark will provide Participating Group, upon request, CVS/caremark's guidelines for Member verification and the disclosure of PHI to Members and third parties, including the immediate family of a Member who is the subject of the PHI. CVS/caremark agrees to cooperate and work with Participating Group to revise these guidelines if the parties agree that they do not comply with the requirements of the HIPAA Rules.

f. Changes to this Exhibit B. The parties agree to negotiate in good faith to amend this Exhibit B or the Participating Group Addendum between CVS/caremark and Participating Group as necessary to comply with any changes in the HIPAA Rules.

Exhibit C
Audit Procedures

CVS/caremark and NCRx agree the following guidelines shall apply to any audit described by this Agreement.

1. Audit Notification Letter

A NCRx request for an audit of CVS/caremark will be directed to the NCRx's account manager either in writing on NCRx's letterhead or by e-mail. Audits require sixty (60) days prior written notice, including receipt of a fully executed confidentiality agreement by the NCRx's auditor and CVS/caremark, detailed audit scope document, and a complete Claims Sample, if applicable.

2. Use of Third Party Auditor

In the event a third party auditor is used, the auditor shall be a mutually acceptable independent third praty retained by NCRx The third party auditor shall execute a confidentiality agreement with CVS/caremark in a form and substance reasonably acceptable to CVS/caremark prior to conducting an audit.

3. Teleconference

Upon CVS/caremark's receipt of a request for an audit, CVS/caremark will organize and conduct an initial teleconference between NCRx and CVS/caremark. This teleconference will address the following:

- Individual audit participants
- Requirement and purpose of an approved confidentiality agreement (for use with outside audit firms or other NCRx representatives, as applicable)
- Onsite requirements
- Mutually established timelines
- Claims tape needs and costs
- Prescription copies: timelines, availability and cost
- Guidelines for acceptable verification of audit questions
- CVS/caremark's right to respond within a reasonable time after questions arise and before audit results are disseminated by the auditor to NCRx
- Audit process confirmation letter
- Other appropriate issues.

4. Mutually Agreed Timelines

NCRx and CVS/caremark will mutually agree upon an audit timeline, taking into consideration individual circumstances and constraints. An example of a standard timeline is as follows (*from the time a signed confidentiality agreement is secured*):

- Claim tape request – two (2) weeks
- Standard screen prints – fourteen (14) business days
- Mail service prescription copies – six (6) weeks (cost is typically $5.00 per script copy)

- Audit report reply – 30 business days for a maximum of 300 Claims sample.

5. Response to Sampling Questions

NCRx can submit to CVS/caremark questions related to provided Claim samples. Answers to generic questions are normally provided within fourteen (14) business days after the questions have been presented. Answers to Claim level questions are normally provided within 30 business days for a maximum of 300 Claims sample.

6. Claims Tape Requests

Claims tape specifications shall be clarified during the initial teleconference and processed following CVS/caremark's receipt of a signed confidentiality agreement from any third party auditor. Delivery to the specified party normally takes place within two (2) weeks for the prior Contract Year of data and at CVS/caremark's standard data fees ($125 per month of data). Audits requiring more than a prior Contract Year of data may be conducted at CVS/caremark's standard audit cost plus additional data fees ($5,000 per year of data) and a mutually agreed upon timetable. Such fees can be submitted under an available Audit Credit.

7. Audit Report

In the event of an audit by a third party, the third party auditor or NCRx shall provide CVS/caremark with a copy of any proposed audit report, and CVS/caremark will have a reasonable opportunity, but no more than 30 business days, to comment on any such report before it is finalized.

8. Close of Audit

Upon finalization of audit results and agreement between NCRx and CVS/caremark on any identified financial discrepancies, the audit period under review will be closed. Any adjustments, payments and/or reimbursements determined to be necessary as a result of any examination or audit shall be paid by the appropriate party within thirty (30) days of execution of an appropriate release document covering the audit period.

9. Audit Costs

NCRx shall be responsible for all reasonable expenses of the audit.

Exhibit D
Performance Guarantees

For purposes of the performance standards herein, the term "Business Day" will mean CVS/caremark's normal business hours on any day other than a Saturday or Sunday or a day on which CVS/caremark is closed for general business purposes.

Conditions:

The proposed performance guarantees will be adjusted equitable by the parties to the extent that CVS/caremark has suffered a force majeure event during the applicable measurement period.

CVS/caremark will diligently attempt to maintain its performance at the levels represented herein, provided that failure to achieve or maintain those levels does not by itself constitute a default for purposes of the termination provisions set forth in the Agreement.

CVS/caremark will not be liable to NCRx or Participating Group for any failure to satisfy a performance standard during any time that no Agreement existed between CVS/caremark and Participating Group, even if a subsequent written agreement between the parties provides that the effective date of the Agreement is prior to the time at which the Agreement actually was executed by the parties.

If CVS/caremark fails to satisfy a performance standard that is measured for all CVS/caremark clients utilizing the same process platform, CVS/caremark will have satisfied a performance standard regarding NCRx or Participating Group if it satisfies that standard with respect to NCRx or Participating Group only.

If any period covered by the Agreement is less than the period covered by the proposed performance standard, and CVS/caremark has not met such performance standard for such period, the penalty associated with such failure will be prorated to reflect the actual period during which the Agreement was in effect.

The maximum penalty that CVS/caremark will have at risk for any calendar year will be $1,500,000.00 for ongoing guarantees. The total amount at risk may be allocated at NCRx's discretion provided 1) no more than 20% and no less than 1% of the amount at risk will be allocated to any one guarantee; 2) the total amount allocated equals 100% of the total amount at risk; 3) CVS/caremark receives written notice of NCRx's allocations at least thirty (30) days prior to the effective date or contract anniversary. If CVS/caremark does not receive written notice of NCRx's allocation, the total amount at risk will be allocated equally among the performance guarantees, unless otherwise stated in the performance guarantees. Each Contract Year, NCRx will have the option to re-allocate penalty dollars for ongoing guarantees based on the conditions above. CVS/caremark is also offering a one-time implementation guarantee of $10.00 per eligible Plan Participant for each new Participating Group. The total amount at risk for implementation shall be allocated equally across the guarantees.

CVS/caremark shall provide a "Performance Guarantee Report Card" no later than ninety (90) days after the end of the applicable calendar year. Any applicable amounts owed to Participating Group or NCRx on behalf of Participating Groups will be credited on the month end invoice following the month of the reporting date.

In the event CVS/caremark fails to meet the proposed standards, the penalties described above will be the sole and exclusive remedy available to NCRx and Participating Group for such failure, with the exception of Electronic Claims Processing Accuracy. For Electronic Claims Processing Accuracy, CVS/caremark will pay the amounts of the incorrect payments identified in a final audit report in addition to any penalties.

IMPLEMENTATION

1. ID Cards & Welcome Packets. CVS/caremark guarantees 98% of Member ID cards and welcome packets will be mailed to Members ten (10) days prior to the effective date of the Plan, on the condition that the Participating Group or NCRx provides CVS/caremark with clean, accurate eligibility according to a mutually agreed upon schedule.

2. Benefit Design Set-Up. The Participating Group or NCRx's benefit designs will be successfully and accurately loaded, defined as a 98% pass rate, in CVS/caremark's Claims system at least fifteen (15) calendar days prior to the implementation date of coverage, on the condition that the client provides CVS/caremark with benefit design sign-off according to a mutually agreed upon schedule.

3. Implementation Satisfaction. CVS/caremark shall conduct a survey of three designated client personnel to measure satisfaction associated with implementation of the Plan. Your organization guarantees a satisfaction rating of at least an average of three (3) on a five (5) point scale. CVS/caremark shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys.

4. Claims Adjudication Issue Resolution. CVS/caremark guarantees to resolve agreed upon high/critical severity defects within seven (7) Business Days of being reported, unless otherwise mutually agreed upon by the client and CVS/caremark.

5. Testing – Issue Resolution. For Eligibility, Claims and Accumulator file testing, CVS/caremark guarantees to resolve agreed upon high/critical severity defects within seven (7) Business Days of being reported, unless otherwise mutually agreed upon.

ONGOING GUARANTEES

1. Benefit Changes for Existing Participating Groups. With Participating Group's written sign-off of the accuracy of Plan design and/or requested changes and testing, CVS/caremark guarantees that Participating Group's Plan design will be implemented with 99% accuracy. Should CVS/caremark fail to meet the above stated guarantee, CVS/caremark shall credit Participating Group $4.00 per impacted Plan Participant up to the annual maximum allocated to this guarantee. This is measured on a calendar year and Participating Group specific basis.

2. Pricing Changes for Existing Participating Groups. CVS/caremark guarantees that Participating Group's pricing will be implemented with 99% accuracy based on information contained in Participating Group's Participating Group Addendum. Should CVS/caremark fail to meet the above stated guarantee, CVS/caremark shall credit Participating Group $4.00 per impacted Plan Participant up to the annual maximum allocated to this guarantee. This is measured on a Participating Group specific basis.

3. Benefit Design Setup. CVS/caremark guarantees 98% of the Participating Group's ongoing benefit designs or pricing changes will be successfully and accurately loaded in CVS/caremark's Claims system within fifteen (15) Business Days of receipt of Participating Group's approval via an established sign-off form/process, on the condition that Participating Group provides CVS/caremark with benefit design sign-off according to a mutually agreed upon schedule. Should CVS/caremark fail to meet the above stated guarantee, CVS/caremark shall credit Participating Group $4.00 per impacted Plan Participant up to the annual maximum allocated to this guarantee. This is measured on a calendar year and Participating Group specific basis.

4. Defect Resolution. CVS/caremark guarantees it will resolve 98% or greater Severity Level 1 benefit setup issues within two (2) Business Days of being properly documented and jointly approved by CVS/caremark and the Participating Group. The two (2) Business Day timeframe starts once the mutually agreed defect is entered into Salesforce.com. CVS/caremark guarantees that 98% or greater of non-Severity Level 1 identified errors in benefit design set-up will be corrected within five (5) Business Days unless mutually agreed upon by the Participating Group and CVS/caremark. This guarantee is measured and reported on a calendar year and Participating Group specific basis. CVS/caremark will provide an initial root cause analysis within five (5) Business Days of when the issue is identified. Impact analysis will be completed within five (5) Business Days after the issue is fixed. In the event that an impact analysis is complex and may require more time, CVS/caremark and Participating Group will mutually agree on a reasonable estimated competition date.

   For the purposes of this guarantee, a "Severity Level 1" is defined as an error that creates a major disruption to Participating Group's business and must be Resolved immediately, a significant access to care issue, or a HIPAA violation. "Resolved" is defined as a fix that has been implemented and the issue no longer occurs in production or has a validated workaround that resolves the issue.

   This guarantee will be determined based on all Severity Level 1 Benefit Design errors meeting the aforementioned criteria and will be measured based on the total number of Benefit Design errors failing to meet the threshold criteria divided by the total number of Benefit Design errors processed for the Participating Group during the same time period rounded to the nearest tenth of a percent. CVS/caremark shall credit the Participating Group 10% of the total amount at risk during the reporting period for the Benefit Design Error Resolution guarantee for each 1% below the target, up to the total amount at risk for this guarantee. This is measured and reported on a calendar year and Participating Group specific basis.

5. Electronic Claims Processing Accuracy. Electronic Claims processing accuracy for both retail and mail service pharmacies will be at least 99.5% in any calendar year for which NCRx conducts a Claims audit as provided in the audit rights section of this Agreement. Upon a final and conclusive determination of any discrepancies discovered by such a Claims audit, the electronic Claims processing accuracy rate shall be calculated based upon the following formula: ((total number of electronic retail and mail service paid Claims processed in sample) - (number of electronic retail and mail service paid Claims processed incorrectly in sample)) / (total number of electronic retail and mail service paid Claims processed in sample). CVS/caremark shall credit NCRx 25% of the total amount at risk for this guarantee for each full percentage point below target accuracy rate, up to a maximum annual penalty of 100% of the total amount at risk for this guarantee. This is measured on a NCRx specific basis.

6. Mail Service Prescription Accuracy. CVS/caremark's accuracy in dispensing prescriptions from its mail service pharmacy (correct drug, correct strength, correct dosage form, correct directions, and correct Plan Participant) shall be at least 99.990%, as measured on a calendar year and NCRx basis.

7. System Availability. CVS/caremark's online Claims processing system will be available for access by CVS/caremark's contracted pharmacies no less than 99.5% of the time, excluding normal scheduled maintenance, as measured on a calendar year and CVS/caremark book of business basis. This standard will not apply when CVS/caremark does not have total control over the environment or communication links that impact the Claims adjudication process due to third-party involvement. Scheduled maintenance will not be performed during routine pharmacy business hours.

8. Eligibility Updates. 99% of clean Participating Group eligibility files (i.e., a Participating Group eligibility files meeting mutually agreed upon specifications/format and not exceeding agreed upon thresholds) will be loaded into the CVS/caremark adjudication platform within 24 hours from the

receipt of a Participating Group eligibility file by CVS/caremark (excluding any scheduled adjudication system/software upgrade downtime hours). This is measured and reported on a calendar year and NCRx specific basis.

9. Eligibility Error Reports. For all clean Participating Group eligibility files (i.e., Participating Group eligibility files meeting mutually agreed upon file specifications/format), CVS/caremark guarantees to produce and distribute, to the Participating Group, a set of error reports (secure email or electronic file) for Participating Group eligibility file updates within an average of 24 hours from the CVS/caremark adjudication platform file load completion. This performance guarantee is calculated by dividing the sum of the Error Report duration times (from the CVS/caremark adjudication platform file load completion to Error Report transmission to the Participating Group) by the total number of clean files received from the Participating Group. The penalty(s) paid for not meeting this performance guarantee will not exceed contractually agreed upon per occurrence or aggregate amounts. This is measured and reported on a calendar year and NCRx specific basis.

10. Eligibility Processing Accuracy. CVS/caremark guarantees that standard clean Participating Group eligibility files will be loaded into the CVS/caremark adjudication platform accurately. A standard clean eligibility file meet mutually agreed upon specifications including file format, load schedule and does not exceed agreed upon thresholds. This performance guarantee is calculated by dividing the number of standard clean eligibility files loaded without CVS/caremark caused eligibility errors, by the total number of files received from the Participating Group in the same period. A CVS/caremark caused eligibility error is any error caused by an eligibility profile setup error that causes Member Claim rejects. Errors that apply against this standard will be reported by either party within ninety (90) calendar days of when the error occurred. An accuracy rate less than 100% shall be considered a failure to perform with respect to this Performance Guarantee. This is measured and reported on a calendar year and NCRx specific basis.

11. Retail Pharmacy Audit. CVS/caremark guarantees it will perform an on-site audit each year of 3% of its retail pharmacies in CVS/caremark's National Network that submit 500 or more Claims a year to CVS/caremark. This is measured and reported on a calendar year and CVS/caremark book of business basis.

12. Network Pharmacy Access. CVS/caremark guarantees that changes to your retail network arrangement will not impact more than 30% of Participating Group's membership as measured by absolute Member disruption (not geo-access). This is measured and reported on a calendar year and NCRx specific basis.

13. Claim File Transfer Timeliness. A Claim detail file shall be transferred successfully to designee within 24 hours following the end of each day. Should CVS/caremark fail to meet this guarantee, a penalty of $250 for each late file shall be assessed, not to exceed the total amount at risk for this guarantee. This guarantee is measured and reported on a calendar year and NCRx specific basis.

14. Report Distribution. CVS/caremark guarantees that the Participating Group quarterly standard management reports shall be available within thirty (30) days after the end of each calendar quarter. This guarantee is measured and reported on a calendar year and NCRx specific basis.

15. On-Line Reporting. CVS/caremark guarantees that data for on-line reporting will be available within fifteen (15) Business Days following the end of each month. This guarantee is measured and reported on a calendar year and NCRx specific basis.

16. Account Management Satisfaction. A satisfaction survey shall be conducted annually among NCRx's management team. Overall satisfaction ratings of at least 4 on a 5-point scale (5 is best rating) shall be guaranteed. For the purposes of this guarantee, satisfaction shall be defined as Very Good or better on

the following 5-point scale; Excellent, Very Good, Good, Fair, Poor. CVS/caremark shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys. This is measured on a NCRx specific basis.

17. Mail Turnaround Time (Not Requiring Intervention). Within an average of two (2) working days of receipt, CVS/caremark shall dispense and ship all clean (not requiring intervention or clarification) mail service pharmacy prescriptions, as measured on a calendar quarter and NCRx specific basis. The average calculation is determined by taking the total number of prescriptions metered (as recorded by CVS/caremark's systems standard practices) multiplied by the number of days these prescriptions took to meter divided by the total number of metered prescriptions.

18. Mail Turnaround Time (Requiring Intervention). Within an average of four (4) Business Days of CVS/caremark shall dispense and ship all non-clean (requiring intervention or clarification) mail service pharmacy prescriptions. The average calculation is determined by taking the total number of prescriptions metered (as recorded by CVS/caremark's systems standard practices) multiplied by the number of days these prescriptions took to meter divided by the total number of metered prescriptions. This guarantee is measured and reported on a calendar year and NCRx specific basis.

19. Participant Submitted Paper Claim Turnaround Time. CVS/caremark guarantees 95% of Member-submitted paper Claims requiring no intervention will be paid or denied within a weighted average of fifteen (15) calendar days. This is measured and reported on a calendar year and NCRx specific basis.

20. Paper Claim Handling Turnaround Time for Prescription Drugs (with intervention). PBM guarantees Member-submitted paper Claims requiring intervention will be paid or denied within thirty (30) calendar days. This is measured and reported on a calendar year and NCRx specific basis.

21. ID Card Implementation or Re-Issue. CVS/caremark guarantees that, based on receipt of a clean, accurate and complete electronic eligibility file no later than the 5th day of the month that is prior to the Effective Date of the Agreement or mutually agreed upon re-issue date, 98% of enrollees to CVS/caremark will be mailed ID cards and/or Welcome Booklets five (5) days prior to the Effective Date or re-issue date. This is measured and reported on a calendar year and NCRx specific basis.

22. Phone Average Speed of Answer. Inbound calls to CVS/caremark's toll-free customer service lines shall be answered within an average time of thirty (30) seconds or less. Measurement excludes calls routed to an IVR, as measured on a calendar quarter and NCRx specific basis.

23. Phone Abandonment Rate. Inbound calls to CVS/caremark's toll-free customer service lines shall be answered with an abandonment rate of 3% or less, as measured on a calendar quarter and NCRx basis. Measurement excludes calls routed to an IVR and excludes calls abandoned by the Plan Participant within the first thirty (30) seconds.

24. Written Inquiries. CVS/caremark guarantees 95% of written inquiries received by CVS/caremark's Customer Care Department from all Plan Participants will be responded to within ten (10) Business Days following the Business Day on which such inquiry was received. This is measured and reported on a calendar year and NCRx specific basis.

25. E-mail Inquiries. CVS/caremark guarantees 95% of e-mail inquiries received by CVS/caremark's Customer Care Department from all Plan Participants will be responded to within 24 hours following the Business Day on which such inquiry was received (excluding Sunday). This guarantee is measured and reported on a calendar year and NCRx specific basis.

26. Plan Participant Satisfaction. Satisfaction surveys shall be conducted during the Plan year among NCRx's base of prescription drug benefit Plan Participants. Survey respondents shall be selected at random from Plan Participants who have recent experiences with one or more of the following CVS/caremark services: 1) Retail Pharmacy benefits; 2) Mail Service Pharmacy benefits; 3) Customer Care.

    Overall satisfaction ratings of at least 90% shall be guaranteed. If Participating Group does not have sufficient Members with mail or retail Claims at any time during the measurement period, or if NCRx has not provided CVS/caremark with sufficient Member contact information to support a statistically valid sample, CVS/caremark will conduct the survey without risk of penalty. For the purposes of this guarantee, satisfaction shall be defined as Satisfied or better on the following 5-point scale; Completely Satisfied, Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied. CVS/caremark shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys. This guarantee is measured and reported on a calendar year and NCRx specific basis.

27. First Call Resolution. CVS/caremark will resolve at least 93% of issues at the first point of contact. First call resolution is the number of inquiries completely resolved at the time of initial contact divided by the total inquiries. This is reported and measured on a calendar year and CVS/caremark book of business basis.

28. Account Management Responsiveness. CVS/caremark guarantees that Account Team Members will respond to 98% of communications by the NCRx submitted through the agreed upon channels within one (1) Business Day of receipt. This is measured on a NCRx specific basis.

29. Account Management Issue Resolution. CVS/caremark guarantees that if any issue cannot be resolved within two (2) Business Days, CVS/caremark will provide an estimated time of resolution via electronic or verbal communication to requestor 98% of the time. This is measured and reported on a calendar year and NCRx specific basis.

30. Action Log. CVS/caremark guarantees that the Account Team will maintain and distribute on a bi-weekly basis an accurate action log which documents and tracks any administrative, operational, clinical, and financial issues. This is measured and reported on a calendar year and NCRx specific basis.

31. Quarterly Meetings. CVS/caremark guarantees that the Account Team will schedule and participate in quarterly meetings onsite at the NCRx's preferred location to discuss quarterly utilization, financial, and clinical results. The account team will prepare and distribute agenda and meeting materials at least five (5) Business Days prior to the meeting date. Meeting notes and follow-up items will be distributed by the Account Team within five (5) Business Days following the meeting. This is measured and reported on a calendar year and NCRx specific basis.

32. Call Blockage. CVS/caremark guarantees that inbound calls to CVS/caremark's toll free customer service lines will have a blockage rate of 1% or less, as measured on a calendar quarter and NCRx basis.

33. Modeling/Forecasting. Provided that all information necessary to perform the analysis is provided, CVS/caremark will provide any modeling/forecasting for Plan design changes to the NCRx within an average of ten (10) Business Days of written request starting from when all details of the request are mutually agreed upon and when all data elements are available (ex. if this applies to external downstream prospect analysis). Requests for modeling/forecasting for formulary/Rebate changes will be provided within an average of ten (10) Business Days of written requests. This is measured and reported on a calendar year and Participating Group specific basis.

Exhibit E
Appeals

ERISA Appeals:

1. Participating Group represents that its Plan is governed by ERISA.

2. Participating Group represents that it will provide CVS/caremark with a current and accurate copy of the Plan Document, as defined herein. The "**Plan Document**" shall be the written document, as required by ERISA, which sets forth the Plan design and all other information concerning Participating Group's prescription drug benefit plan including, but not limited to, eligibility for such benefits, the benefits to be provided, limitations on such benefits and the Plan's Claims and review procedures. For the purpose of this Exhibit E, the Plan Document may include the Plan's "summary plan description" as required by ERISA. Participating Group, at its expense, will provide CVS/caremark with sufficient advance notice of any proposed amendments to the Plan Document.

3. CVS/caremark will provide Participating Group with the appeals program described in Sections 3.a. and 3.b. below ("**Appeals Program**").

   a. *Review of Benefit Coverage*. CVS/caremark shall conduct appeals relating to eligibility and coverage of prescription drug benefit determinations. Such reviews will be based on the Plan Document provisions and criteria approved by the Participating Group, with respect to coverage of prescription drug benefits only, and shall not include a review of medical necessity as may be defined under the terms of the Plan Document. With respect to such review of benefit coverage, CVS/caremark shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of CVS/caremark shall be final, subject to External Review under Section 4 of this Exhibit E, if applicable to Participating Group, or available judicial review. CVS/caremark may, in its sole discretion, consider the opinions of additional medical and/or legal experts with respect to interpretation of the Plan Document. Under the Appeals Program, CVS/caremark agrees to be a fiduciary to the Plan solely for the purpose of adjudicating appeals relating to the coverage of prescription drug benefits. CVS/caremark will review appeals in accordance with the rules and procedures established by CVS/caremark to govern appeals from the denials of Claims, as may be amended from time to time. Such rules and procedures shall comply with applicable ERISA requirements.

   b. *Review of Medical Necessity*. CVS/caremark has contracted with an independent vendor or vendors for the processing of appeals resulting from a denial of authorization of prescription benefits where the Plan Participant or beneficiary is entitled to obtain a review of the denial by an independent physician specialist. CVS/caremark has entered or will enter into an agreement with the independent vendor(s), which provides for an appeals process consistent with the Appeals Program. The decision of the independent vendor shall be final, subject to External Review under Section 4 of this Exhibit E, or available judicial review only for abuse of discretion. Such independent vendor shall be a fiduciary of the Plan for the purpose of adjudicating such appeals and shall comply with applicable ERISA requirements.

4. *External Review*. This Section 4 shall apply only if Participating Group has elected to receive Independent (External) Appeals Review in the Plan Document. CVS/caremark has contracted with independent review organizations ("**IROs**") to provide external review of benefit determinations that are subject to external review under PPACA. The decision of the IRO shall be final and binding on the Plan and Plan Participant, subject only to any judicial review. Participating Group or CVS/caremark may terminate at any time the external review services provided under this Exhibit by providing the other parties with sixty (60) days prior written notice.

5. As consideration for the Services provided hereunder, Participating Group shall pay CVS/caremark the fees set forth in Exhibit A of this Agreement. Payment shall be due in accordance with Section 7.2 of the Agreement.

Non-ERISA Appeals:

1. Participating Group represents that its Plan is NOT governed by ERISA.

2. Participating Group represents and warrants to CVS/caremark that the Appeals Program, as defined in Section 5 below, satisfies any and all laws applicable to the Plan with respect to appeals from denials of Claims for prescription drug benefits. Participating Group shall promptly notify CVS/caremark in writing in the event a change in law causes the Appeals Program to be in non-compliance with applicable laws. Upon such notice, CVS/caremark shall have the option of revising its Appeals Program to be in compliance with such change in law or terminating this Appeals Program.

3. CVS/caremark may from time to time modify the Appeals Program. In the event of any such modification, CVS/caremark shall provide Participating Group with written notice of such modification at least thirty (30) days prior its implementation. If Participating Group determines that any such modification would cause the Appeals Program to be in non-compliance with applicable laws, Participating Group shall so notify CVS/caremark prior to the end of the thirty (30) day period. CVS/caremark shall then have the option of further modifying its Appeals Program to be in compliance with applicable laws or terminating this Appeals Program. If Participating Group does not so notify CVS/caremark, then CVS/caremark shall implement the modification and shall continue to rely on the representation and warranty set forth in Section 2 above.

4. Participating Group represents that it will provide CVS/caremark with a current and accurate copy of the Plan Document, as defined herein. The "**Plan Document**" shall be the written document, which sets forth the Plan design and all other information concerning Participating Group's prescription drug benefit plan including, but not limited to, eligibility for such benefits, the benefits to be provided, limitations on such benefits and the Plan's Claims and review procedures. Throughout the Term of this Agreement, Participating Group, at its expense, will provide CVS/caremark with sufficient advance notice of any proposed amendments to the Plan Document.

5. CVS/caremark will provide Participating Group with the appeals program described in Sections 5.a. and 5.b. below ("**Appeals Program**").

   a. *Review of Benefit Coverage*. CVS/caremark shall conduct appeals relating to eligibility and coverage of prescription drug benefit determinations. Such reviews will be based on the Plan Document provisions and criteria approved by the Participating Group, with respect to coverage of prescription drug benefits only, and shall not include a review of medical necessity as may be defined under the terms of the Plan Document. With respect to such review of benefit coverage, CVS/caremark shall have the sole and absolute discretion to interpret the Plan Document and to make factual findings. The decision of CVS/caremark shall be final, subject to any external review under Section 6 of this Exhibit E, if applicable to Participating Group, or available judicial review. CVS/caremark may, in its sole discretion, consider the opinions of additional medical and/or legal experts with respect to interpretation of the Plan Document. Under the Appeals Program, CVS/caremark agrees to be a fiduciary to the Plan solely for the purpose of adjudicating appeals relating to the coverage of prescription drug benefits. CVS/caremark will review appeals in accordance with the rules and procedures established by CVS/caremark to govern appeals from the denials of Claims, as may be amended from time to time.

   b. *Review of Medical Necessity*. CVS/caremark has contracted with an independent vendor or vendors for the processing of appeals resulting from a denial of authorization of prescription benefits where the Plan Participant or beneficiary is entitled to obtain a review of the denial by an independent physician specialist. CVS/caremark has entered or will enter into an agreement with the independent vendor(s), which provides for an appeals process consistent with the Appeals Program. The decision of the independent vendor shall be final, subject to External Review under Section 6 of this Exhibit E, or available judicial review only for abuse of discretion. Such independent vendor shall be a fiduciary of the Plan for the purpose of adjudicating such appeals.

6. *External Review*. This Section 6 shall apply only if Participating Group has elected to receive Independent (External) Appeals Review in the Plan Document. CVS/caremark has contracted with independent review organizations to provide external review of benefit determinations that are subject to external review under

PPACA. The decision of the IRO shall be final and binding on the Plan and Plan Participant, subject only to any right of judicial review. Either party may terminate at any time the external review services provided under this Exhibit by providing the other parties with sixty (60) days prior written notice.

7. As consideration for the Services provided hereunder, Participating Group shall pay CVS/caremark the fees set forth in Exhibit A of this Agreement. Payment shall be due in accordance with Section 7.2 of the Agreement.

Exhibit F
Participating Group Addendum

Participating Group Name: _____

Participating Group Address: _____

_____

_____

Contact Person: _____

Participating Group Addendum Effective Date: _____

Participating Group Addendum End Date: _____

Participating Group represents that the Plan is [_____] / is not [_____] governed by ERISA.

This Addendum ("**Participating Group Addendum**") supplements the Amended and Restated Coalition Master Prescription Benefit Services Agreement effective January 1, 2019 ("**Master Agreement**"), as amended, between CaremarkPCS Health, L.L.C., a Delaware limited liability company ("**CVS/caremark**"), and National CooperativeRx, a Wisconsin Cooperative ("**NCRx**"), on its own behalf and on behalf of the Participating Group. All capitalized terms used in this Participating Group Addendum shall have the meaning set forth in the Master Agreement.

1. The undersigned Participating Group ("**Participating Group**") is, and shall remain, a cooperative member of NCRx during the Term. Participating Group has reviewed the Master Agreement and desires that CVS/caremark provide to it the products and Services described in the Master Agreement on the terms and conditions set forth in the Master Agreement, as amended from time to time, and this Participating Group Addendum. By signing this Participating Group Addendum, Participating Group agrees to the terms and conditions of the Master Agreement, including the Exhibits attached thereto and any subsequent amendments to the Master Agreement which may be entered into between NCRx and CVS/caremark, and this Participating Group Addendum.

2. CVS/caremark agrees to provide Services to the undersigned Participating Group under the same terms and conditions set forth in the Master Agreement, including any amendments or other applicable written agreements which may be entered in writing between NCRx and CVS/caremark during the Term, as applicable. This Participating Group Addendum shall terminate automatically upon termination of the Master Agreement, except as otherwise set forth in Section 6.10 of the Master Agreement, consistent with the terms of the Master Agreement.

3. Participating Group elects the pricing options and optional Services as further described in the Master Agreement, as reflected in the PDD documents approved by Participating Group:

Retail Network (Select one):

☐ **Retail - National Network**
☐ **Retail - CareChoice Network**

☐ **Advanced Choice Network**

Formularies (Select those that apply):

☐ Aligned CVS/caremark Performance Drug List – Standard Control
☐ Aligned CVS/caremark Performance Drug List – Standard Control with PA Option
☐ Aligned CVS/caremark Performance Drug List – Standard Formulary Opt Out
☐ Advanced Control Formulary (Includes Advanced Control Specialty Formulary)
☐ Advanced Control Specialty Formulary
☐ Value Formulary (Incentivized)
☐ Value Formulary (Closed)

Rebates

☐ Traditional
☐ POS Rebates
☐ Reinvested Rebates

Specialty Medications (Select those that apply):
Note: Advanced Control Specialty Formulary is not offered with the PDPD Program.)
Specialty pricing will be included in a Specialty Drug List – See applicable Attachment 1 to Exhibit A (Traditional Rebates) or Attachment 2 to Exhibit A (Reinvested Rebates) in Master Agreement.

☐ Open Specialty Arrangement
☐ Exclusive Specialty Arrangement
☐ Open Specialty Arrangement with PDPD Program
☐ Exclusive Specialty Arrangement with PDPD Program

Select only one of the following 90-day network options, if any:

Maintenance Choice Program

☐ Maintenance Choice Program – Mandatory/Incentivized Option available to Plan Participants
☐ Maintenance Choice Program – Voluntary Option available to Plan Participants
☐ Maintenance Choice Program – Opt-Out Option available to Plan Participants
☐ **Extended Day Supply (EDS) - 90**

If elected, select one of the following optional services (if eligible) as further described in the Master Agreement:
Generic Step Therapy Program
☐ High Performance Generic Step Therapy
☐ Traditional Generic Step Therapy

4. Market Check. Participating Group delegates the authority to negotiate the market check pricing terms applicable to Participating Group, if any, to NCRx. Once the revised pricing terms are agreed upon by NCRx and CVS/caremark, NCRx shall advise Participating Group of the revised pricing in advance of the effective date of such revised pricing.

5. This Participating Group Addendum, together with the Master Agreement constitutes the entire agreement between the parties with respect to the subject matter herein and supersedes all prior understandings, agreements, contracts or arrangements between the parties, whether oral or written.

[6. Administrative Fees Paid by Participating Group to NCRx. On behalf of NCRx and at Participating Group's written direction, CVS/caremark shall collect _____ per Claim on a monthly basis and remit such fee to NCRx within forty-five (45) days of the end of the month collected. CVS/caremark shall not be required to remit any fees to NCRx until such time as CVS/caremark has received payment from Participating Group. It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, these administrative fees shall constitute and shall be treated as a discount against the off the purchase price of drugs dispensed under the Agreement within the meaning of 42 U.S.C. 1320a-7b(b)(3)(A).

Participating Group acknowledges that its execution of this Participating Group Addendum, constitutes written direction to CVS/caremark to collect and remit the above administrative fees to NCRx. CVS/caremark, on behalf of NCRx and at Participating Group's written direction, and Participating Group will continue to pay administrative fees from this Section 6 of this Addendum as long as Participating Group is receiving NCRx pricing through CVS/caremark.]

[**PARTICIPATING GROUP**]

By: _____
Name: _____
Title: _____
Date: _____

AUTHENTICATION

NCRx signs below to certify that this Participating Group Addendum is entered into under and in accordance with the provisions of the Master Agreement, and is approved by it in form and substance. No amendments or other modifications to this Participating Group Addendum are effective until NCRx has reviewed such modifications and approved them in a written amendment to this Participating Group Addendum.

NCRX COOPERATIVE

By:

Name: Josh Bindl

Title: CEO

Exhibit G
Medicare Part D Subsidy

RECITALS

WHEREAS, the Centers for Medicare and Medicaid Services ("**CMS**") have adopted regulations regarding the Medicare Prescription Drug Benefit ("**Part D**"), which regulations allow for a retiree drug subsidy ("**Subsidy**") from CMS; and

WHEREAS, Participating Group has informed CVS/caremark that Participating Group intends to apply for the Subsidy payments specified in 42 CFR Part 423, Subpart R for its prescription drug coverage for qualifying covered retirees as defined in 42 CFR §423.880 ("**Covered Retirees**"); and

WHEREAS, Participating Group desires to have CVS/caremark assist Participating Group with applying for such Subsidy and, if qualified, to assist Participating Group with complying with CMS requirements for obtaining and maintaining such Subsidy.

1. CVS/caremark Responsibilities.

1.1 Part D Subsidy Services. CVS/caremark will provide Participating Group the services set forth in this Exhibit and the services described in any attachment or amendment hereto (collectively the "**Subsidy Services**"). CVS/caremark may recommend changes to the Subsidy Services from time to time, and may use Claims Information and other Protected Health Information (as defined in the Agreement) to improve or recommend additional Subsidy Services to Participating Group, or suggest alternate drug coverage options for Covered Retirees, so long as such changes are consistent with the requirements of Part D and do not materially alter any of the provisions of this Exhibit or the Agreement. Participating Group, acting on behalf of its Plan, also authorizes CVS/caremark to use and disclose Protected Health Information as necessary to perform its Subsidy Services and otherwise assist the Plan in submitting information to CMS as necessary to enable Participating Group to claim the Subsidy from CMS.

1.2 Application. CVS/caremark agrees to assist Participating Group with completing the Subsidy Application (the "**Application**"). Upon Participating Group's written request at least thirty (30) business days prior to the Application submission deadline, CVS/caremark agrees to provide to Participating Group CVS/caremark's vendor ID, cost reporter designee ID and Plan sponsor technical contact as obtained by CVS/caremark from CMS' Retiree Drug Subsidy ("**RDS**") website and other information held by CVS/caremark and required by Participating Group to complete the Application.

1.3 Creditable and Non-Creditable Coverage Notices. Upon Participating Group's independent determination as to whether its Plan qualifies as creditable prescription drug coverage within the meaning of 42 CFR §423.56(a), CVS/caremark agrees to send to Participating Group's Part D eligible Covered Retirees notices of creditable or non-creditable coverage, as applicable, in accordance with Part D requirements under 42 CFR §423.56(f) based on creditable coverage information provided by Participating Group. Participating Group agrees that CVS/caremark shall not have any further responsibility to provide any further Subsidy Services under this Exhibit with respect to non-creditable coverage plan(s).

1.4 Actuarial Equivalence Determination. CVS/caremark agrees to provide Claims data and analytical tools to assist Participating Group in determining whether its Plan meets the actuarial equivalence tests specified in 42 CFR §423.884(d)(1). Participating Group acknowledges and agrees that it is responsible for determining that its Plan meets the actuarial equivalence tests in 42 CFR §423.884(d)(1) and for obtaining and providing to CMS the actuarial equivalence attestation required by 42 CFR §423.884(d).

1.5 Eligibility Reporting and Reconciliation. If requested by Participating Group, CVS/caremark agrees to submit to CMS, in an electronic format acceptable to CMS, the eligibility information about Covered Retirees and periodic updates to such information, that Participating Group provides to CVS/caremark pursuant to Section 2.2. CVS/caremark shall have no responsibility, or liability to Participating Group, for verifying that the eligibility information it submits to CMS on behalf of Participating Group is complete, accurate or correct, and its sole responsibility shall be to transmit the information, as provided by Participating Group, to CMS.

1.6 Drug Cost Reporting. If requested by Participating Group, CVS/caremark agrees to upload directly to the CMS RDS website, in an electronic format required by CMS and on the frequency indicated by Participating Group, the drug costs incurred by Participating Group's Covered Retirees as CVS/caremark reasonably believes is required by 42 CFR §423.888(b)(2) and (b)(4). Participating Group, shall remain fully responsible for determining whether drug cost data provided by CVS/caremark meets CMS' requirements, including, without limitation, the definitions of "**gross retiree costs**" and "**allowable retiree costs**" as provided in 42 CFR §423.882. In the case of direct uploads to the CMS RDS website, CVS/caremark agrees to upload the data in sufficient time for Participating Group to review and formally initiate the request for payment via the RDS website. In the case of submissions to the Participating Group, CVS/caremark agrees to provide such data in sufficient time to allow Participating Group to submit such information via the CMS RDS website within the time periods specified by CMS. Additionally, CVS/caremark agrees to respond to the records returned from CMS related to the submission of the Participating Group's drug cost data. For all interim and final drug cost data whether uploaded by CVS/caremark or Participating Group to the RDS website, Participating Group shall be responsible for reviewing the cost data, determining whether it meets CMS requirements, deciding to submit the payment request, accepting the terms of the payment agreement and providing its electronic signature for final submission of the payment request to CMS. The CMS RDS Payment Instructions are available on the Medicare Retiree Drug Subsidy Center website at http://rds.cms.hhs.gov and may be amended by CMS from time to time.

1.7 Drug Cost Reconciliation. CVS/caremark agrees to submit the drug cost information required for final reconciliation to CMS within fifteen (15) months after the end of the Plan year, or within any other longer time limit permitted by CMS. Participating Group agrees to take such steps and provide such information as are required to complete final reconciliation, including providing any additional information necessary to resolve reject responses from CMS, if applicable.

1.8 Supplemental Customized Reporting. Participating Group may request customized reports which will be subject to an additional fee as referenced in Attachment A.

1.9 Non-Part D Drugs. Participating Group acknowledges and agrees that it is responsible for complying with the laws governing determination of whether a drug is a covered Part D drug (as defined in 42 CFR §423.100). Participating Group will indicate the method for determining whether drug costs for certain categories of prescription drugs that may be covered under either Medicare Part B or Part D depending upon the circumstances under which they were prescribed, dispensed or administered are for Part D drugs, and thus eligible for inclusion in the drug cost data to be provided to CMS pursuant to Section 1.6. Participating Group shall pay for such Subsidy Services in accordance with the fee schedule set forth in Attachment A to this Exhibit.

2. Participating Group Responsibilities.

2.1 Actuarial Equivalence and Creditable Coverage. Participating Group shall be responsible for obtaining and submitting the actuarial equivalence attestation required by 42 CFR §423.884(d) and for determining whether its Plan qualifies as creditable coverage under 42 CFR §423.56, and CVS/caremark shall not have any responsibility to Participating Group for making such determinations.

2.2 Identification of Covered Retirees. Participating Group will provide to CVS/caremark eligibility file(s), in the format designated by CVS/caremark that include the Covered Retirees. Such files shall include each Covered Retiree's (i) social security number or Health Information Claims number; (ii) date of birth, and (iii) such other information as may be required by CVS/caremark. Participating Group shall provide the initial file and periodic updates to such files to CVS/caremark in a timely manner If Participating Group wishes CVS/caremark to submit the eligibility information directly to CMS on Participating Group's behalf, Participating Group agrees to provide such eligibility file, including periodic updates, to CVS/caremark at least fifteen (15) business days prior to the required submission date to CMS. Otherwise, if Participating Group will be submitting the eligibility file to CMS itself, Participating Group will provide the file to CVS/caremark no later than the date it submits its Application to CMS and will provide periodic updates to the eligibility file on a timely basis thereafter. Participating Group also agrees to forward to CVS/caremark the RDS retiree response file it receives from CMS immediately upon receipt of such files by Participating Group.

3. Fees.

3.1 Participating Group shall pay to CVS/caremark the fees set forth in Attachment A for Subsidy Services under this Exhibit. CVS/caremark will invoice Participating Group for such fees, and payment will be due as set forth in the Agreement.

3.2 Participating Group acknowledges and agrees that if Participating Group should discontinue coverage of Covered Retirees under Participating Group's Plan during the Term of the Agreement, then upon mutual agreement of the parties, CVS/caremark shall have the right to adjust fees, Rebates and other pricing terms set forth in the Agreement to reflect accurately the discontinuation of coverage for such Covered Retirees.

4. General Provisions.

4.1 Books and Records. CVS/caremark shall maintain documentation of all Claims processed for six (6) years. In addition, CVS/caremark shall maintain, for a period of six (6) years, or such longer period as may be required pursuant to 42 CFR §423.888(d)(2), books, records, documents and other evidence of accounting procedures and practices directly related to the financial and other aspects of its administration of the Plan consistent with 42 CFR §423.888(d)(1). Subject to this Section, all such records, while maintained by CVS/caremark, shall be accessible by Participating Group for examination and audit during the Term of and in accordance with this Agreement.

4.2 Audit Services. CVS/caremark agrees to make available for audit by CMS or its designee the Claims data and such data in CVS/caremark's possession as required to be disclosed pursuant to 42 CFR §423.884(b) and as required to be retained pursuant to 42 CFR §888(d)(3), for CMS to verify the Subsidy payment claimed by Participating Group, for the period specified in 42 CFR §423.888(d)(1) or 42 CFR §423.888(d)(2), as applicable.

4.3 Federal Funds. CVS/caremark acknowledges that information and Subsidy Services it provides in connection with this Exhibit will be used by Participating Group for the purpose of obtaining Federal Funds, as that term is further described in the Application.

4.4 Retiree Drug Subsidy Payment Instructions. Subsidy payment instructions are available on the Medicare Retiree Drug Subsidy Center website at http://rds.cms.hhs.gov.

ATTACHMENT A To Exhibit G

Fee Schedule

Subject to minimum $1,000 annual fee per Participating Group, the fees set forth in this Attachment A are in addition to any fees set forth in the Agreement and any Exhibits or other Attachments thereto.

Core Administrative Service Package - $.20 PMPM for Covered Retirees. Includes:

a. Upon request, provide analytical tools to assist Participating Group in determining whether its Plan meets the actuarial equivalence tests specified in 42 CFR §423.884(d)(1).

b. Prepare interim and final cost reports.

c. As part of final reconciliation: (i) adjust drug costs for actual Rebates and other required cost adjustments; (ii) take into account any additional Claims or changes in Claims; and (ii) revise the Covered Retiree list as necessary to reflect actual Covered Retirees.

d. Store Claims in accordance with CMS record retention guidelines.

e. Provide Claims and support during CMS audits.

f. Medicare account services team to work directly with Participating Group on RDS application and other RDS issues.

Optional Additional Subsidy Services:

a. Letter of Creditable or Non-creditable Coverage - $1.25 per mailing. Mailing one (1) letter of creditable coverage to each beneficiary once per year, or as required by CMS (includes postage).

b. Supplemental Customized Reporting - $100.00 per hour. Any customization to alter CMS-ready standard reporting.

c. Eligibility Submission and Reconciliation – Submission and processing of retiree response files returned from CMS related to the direct submission to CMS of the initial and ongoing retiree files to CMS. - $.20 PMPM for Covered Retirees.

d. Submit RDS drug cost files on behalf of Participating Group on the payment frequency schedule indicated by Participating Group and for interim and final drug cost reporting purposes. Drug Cost Report Upload and Reconciliation – Upload and processing of response records returned from CMS related to the submission of the CMS aggregate drug costs - $.30 PMPM for Covered Retirees.

Note: All pricing, rates and fees are subject to change and are contingent upon final CMS requirements. All reporting and eligibility deliverables are provided to the Participating Group and not to CMS, unless otherwise noted.

Exhibit H
Preventive Care Drugs

WHEREAS, the parties have entered into that certain Prescription Benefit Services Agreement, as amended from time to time ("**Agreement**"); and

WHEREAS, the Internal Revenue Service ("**IRS**") has adopted regulations regarding a Preventive Care Safe Harbor ("**Safe Harbor**"), which regulations allow drugs used to prevent illness ("**Preventive Care Drugs**") to be covered by a Health Savings Account compatible High Deductible Health Plan ("**HDHP**") before the Plan deductible has been met; and

WHEREAS, Participating Group has informed CVS/caremark that Participating Group intends to cover Preventive Care Drugs for its High Deductible Health Plan participants as permitted by the Safe Harbor by carving out certain drugs approved by the Food and Drug Administration ("**FDA"**) from the deductible required under the HDHP at the point of sale; and

WHEREAS, Participating Group desires to have CVS/caremark administer Participating Group's Preventive Care Drug Program ("**Preventative Care Program**").

1. Participating Group's Preventative Care Program.

a. **Identification of Preventive Care Drugs.** CVS/caremark will utilize methodology consistent with IRS Code Section 223(c)(2)(c) and IRS Notice 2004-23 and any subsequent applicable federal regulation and guidance, to develop and maintain a listing of drug classes and included drugs within the classes that are used for preventive care. CVS/caremark will identify Preventive Care Drugs that are prescribed for preventive indications in most cases as Level I drugs ("**Level I Drugs**"). CVS/caremark will use commercially reasonable efforts to identify drugs as Preventive Care Drugs in accordance with existing applicable federal regulations and guidance and to maintain Participating Group's Level I Drugs list for Participating Group's Preventative Care Program.

b. **Preventative Care Program**. Participating Group shall be responsible for selecting the drug classes to be included in Participating Group's Preventative Care Program, including selecting the drugs for a Level I Drugs list. CVS/caremark will implement and maintain an adjudication process whereby the drug classes and included drugs selected by Participating Group for its Preventative Care Program will automatically bypass the required deductible and will be subject to the applicable co-pay as defined by the Participating Group's Plan.

c. **Participating Group Acknowledgement.** Participating Group acknowledges that Participating Group's Preventative Care Program may impact the Agreement and underwriting assumptions, including Rebates. CVS/caremark will not be responsible for any lost Rebates or other direct or indirect costs to Participating Group related to Participating Group's Preventative Care Program. CVS/caremark will not be liable for any loss, expense, cost, liability, damages or legal claims incurred by Participating Group as a result of Participating Group's Preventative Care Program, including but not limited, to the IRS' disallowance of any drug Claim that bypassed a HDHP deductible through Participating Group's Preventative Care Program. Participating Group accepts and adopts the Level I Drugs list as a part of Participating Group's Plan design to be administered by CVS/caremark.

2. Fees. Participating Group will pay no additional fees for Services under this Exhibit.

Exhibit I
Vaccine Program Terms and Conditions

This Vaccine Program Terms and Conditions Exhibit ("Exhibit") describes CVS/caremark's Vaccine Program (the "Program"), pursuant to which CVS/caremark shall arrange for the provision of certain vaccination services through participating retail pharmacies to those individuals selected by Participating Group, as set forth below.

1. **Program Overview.** The Program consists of the following three (3) components, as described further in this Exhibit: (a) an eligibility-based program for seasonal influenza vaccines (the "**Influenza Program**"); (b) an eligibility-based program for vaccines other than the seasonal influenza vaccines (the "**Non-Seasonal Program**"); and (c) a retail voucher-based program for seasonal influenza vaccine (the "Retail **Voucher Program**"). These components are collectively referred to herein as the "Program" with respect to terms or conditions that apply to all components. Each Program component is optional and Participating Group may elect to participate in or end its participation in any or all Program components at any time, as set forth in Section 1.5, below.

   1.1 Influenza Seasons. The Influenza Program and the Retail Voucher Program provide coverage for influenza vaccines. Influenza vaccine formulation generally changes each year. Accordingly, the exact vaccine options and pricing may vary each Flu Season. A "Flu Season" will generally begin in August or September of a calendar year and continue for several months thereafter into the succeeding calendar year, typically ending in April. Influenza vaccine formulated for one Flu Season will generally be labeled with an expiration date corresponding to the end of the respective Flu Season, after which date influenza vaccine will generally no longer be available in the marketplace until the following Flu Season. Specific Program offerings may also vary from one Flu Season to the next based on relevant considerations, including, but not limited to, vaccine availability, Participating Group requests, and availability of qualified personnel to administer vaccinations.

   1.2 Eligibility-Based Coverage. Under the Influenza Program and the Non-Season Program, Plan Members desiring a vaccination covered by Participating Group's Plan, may receive such vaccination upon presentation of a valid prescription benefit Plan Member ID Card, at a Participating Vaccine Pharmacy (as defined below), and payment of the applicable Cost Share, if any.

   1.3 Participating Vaccine Pharmacies. Participating Pharmacies administering vaccinations under the Program are referred to herein as "Participating Vaccine Pharmacies". Not all Participating Pharmacies are able to administer vaccinations under the Program. Subject to pharmacy schedule and vaccine availability, Participating Vaccine Pharmacies shall administer the vaccination(s) covered under the Program components elected by Participating Group in accordance with the terms of this Exhibit. Availability of vaccines may vary by Participating Vaccine Pharmacy location. MinuteClinic locations may elect to participate in the Program. The annual notification provided to Participating Group by CVS/caremark, pursuant to Section 2.4 of this Exhibit, shall confirm whether MinuteClinic shall be a Participating Vaccine Pharmacy under the Program during an annual Flu Season. At Participating Group's request CVS/caremark shall provide Participating Group with a current list of Participating Vaccine Pharmacies. Participating Group understands and acknowledges that all Participating Pharmacies are offered the opportunity to administer vaccinations as Participating Vaccine Pharmacies in the Broader Vaccine Network (as defined in Section 2.1, below), but not all Participating Pharmacies have chosen to do so.

   1.4 Program Elections. Unless otherwise specified herein, Participating Group elections regarding the Program shall be made through the PDD, as defined in the Agreement, as amended from time to time with Participating Group's written approval.

1.5 Terminating Participation. Unless the Agreement or this Exhibit is expressly terminated, this Exhibit shall continue in force for as long as CVS/caremark continues to offer the Program and Participating Group continues to elect to participate in the Program, even in the event that Participating Group elects not to participate in, or CVS/caremark elects not to offer, any specific Program component during any portion of the Term of the Agreement. Participating Group may, upon at least thirty (30) days' prior written notice to CVS/caremark, terminate participation in (a) the Influenza Program component and/or the Voucher Program component as of the end of any Flu Season, and (b) the Non-Seasonal Program component at any time.

2. Influenza Program Terms. The following terms apply to the Influenza Program.

2.1 Network Options. CVS/caremark offers two Participating Vaccine Pharmacy networks under the Influenza Program, the Broader Vaccine Network, and the CVS Only Vaccination Network. Participating Group has the option to participate in either network option, but no Participating Group Plan may participate in both networks simultaneously. The Broader Vaccine Network includes any Participating Vaccine Pharmacies participating in the Program. The CVS Only Vaccination Network consists only of CVS/pharmacy retail pharmacy locations, including Longs Drugs and Navarro Pharmacy locations.

2.2 Automatic Enrollment. Unless Participating Group has directed CVS/caremark, in writing, to not implement the Influenza Program, or elected in writing to participate in the CVS Only Vaccination Network, Participating Group shall be enrolled in the Broader Vaccine Network. If Participating Group elects to participate in the CVS Only Vaccination Network at any time, Participating Group's participation in the Broader Vaccine Network shall cease as of the effective date of such election. If Participating Group has directed CVS/caremark, in writing, to not implement the Influenza Program, this Section 2 of this Exhibit shall not be applicable and Participating Group shall not be enrolled in the Influenza Program.

2.3 Vaccine Fee Composition. Participating Group will be invoiced a single charge for each vaccination administered to a Plan Member under the Influenza Program. This fee shall include the cost of the vaccine, the vaccine administration fee, and the dispensing fee.

2.4 Vaccine Availability and Annual Pricing Notifications. Each Flu Season, the influenza vaccinations available through the Influenza Program may vary and may include, but not be limited to, trivalent, quadrivalent, high-dose and/or flu mist vaccines. In addition, pricing for the vaccines available may vary from Flu Season to Flu Season based on availability, wholesale pricing and other relevant factors. Each Flu Season that Participating Group participates in the Influenza Program CVS/caremark shall provide Participating Group written notification of the vaccines that will be available through each of the Broader Vaccine Network and the CVS Only Vaccine Network and the corresponding charges. This written notification shall be provided to Participating Group not less than thirty (30) days prior to the start of the respective Flu Season and Participating Group shall have fifteen (15) days from receipt of such notification to make any changes in its Influenza Program elections, including suspending or terminating its participation in the Influenza Program, which changes, if any, shall be made by written notification to CVS/caremark. If Participating Group does not elect to change its Influenza Program elections, the charges in CVS/caremark's notification to Participating Group shall apply to any influenza vaccinations administered to Plan Members under the Influenza Program during the respective Flu Season.

2.5 Invoicing. CVS/caremark shall invoice Participating Group pursuant to the standard Claims invoicing and payment terms of the Agreement.

3. Non-Seasonal Program Terms. Under the Non-Seasonal Program, certain non-seasonal vaccine offerings may be available from time to time, which will be set forth in the PDD, as approved by the Participating Group in writing. Non-seasonal vaccine services under the Non-Seasonal Program shall be provided on an open-ended basis and not on a Flu Season-specific basis. Elections made in the PDD

shall remain in effect for so long as CVS/caremark offers the Non-Seasonal Program, until modified or terminated by the Participating Group or the termination of the Agreement.

3.1 Non-Seasonal Vaccine Availability and Network. The Non-Seasonal Program will be provided through the Broader Vaccine Network, notwithstanding which, if any, election Participating Group has made under the Influenza Program, above. Not all Participating Vaccine Pharmacies will stock all available non-seasonal vaccines. Plan Members should call the pharmacy to confirm availability.

3.2 Non-Seasonal Vaccine Pricing. Non-seasonal vaccines will adjudicate (a) using the same AWP discount and dispensing fee as would a standard 30-day supply brand drug claim at a retail pharmacy under the Agreement, plus (b) an administration fee of $20.50 for Zostavax or $15.00 for any other available vaccine. In the event of a change in the administration fees set forth in the preceding sentence, CVS/caremark shall provide Participating Group written notification of such change at least thirty (30) days prior to the effective date of the change and Participating Group shall have fifteen (15) days from receipt of such notification to make any changes in its Non-Seasonal Program elections, including suspending or terminating its participation in the Non-Seasonal Program, which changes, if any, shall be made by written notification to CVS/caremark. If Participating Group does not elect to change its Non-Seasonal Program elections, the charges in CVS/caremark's notification to Participating Group shall apply to any non-seasonal vaccinations administered to Plan Members under the Non-Seasonal Program on and after the effective date set forth in CVS/caremark's notification. Caremark Retail-90, CVS-90 and Maintenance Choice pricing terms, if any, do not apply to non-seasonal vaccines.

3.3 Invoicing. CVS/caremark shall invoice Participating Group pursuant to the standard Claims invoicing and payment terms of the Agreement.

4. Retail Voucher Program Terms. The Retail Voucher Program is not eligibility-based. Individuals selected by Participating Group, who may or may not be Plan Members, obtain an influenza vaccination by presenting a voucher, as further set forth below. Participation in the Retail Voucher Program is optional and if Participating Group does not elect, in writing, to participate, this Section 4 of this Exhibit shall be of no force or effect. The following terms apply to the Retail Voucher Program, if elected by Participating Group.

4.1 Enrollment Form. Upon request, CVS/caremark shall provide Participating Group with a Retail Voucher Program enrollment form. The enrollment form shall set forth the pricing, the time period the vouchers shall be available for redemption and other relevant Program details.

4.2 Distribution of Retail Vouchers. CVS/caremark shall provide Participating Group with a portable document file (pdf) electronic file ("Electronic File"), from which the vouchers may be printed. Participating Group shall be responsible for selection of individuals eligible to receive the vouchers ("Voucher Recipients") and distribution of the Electronic File or the vouchers to Voucher Recipients.

4.3 Redemption of Retail Vouchers. CVS/caremark shall arrange for the provision of vaccinations to Voucher Recipients exclusively through the CVS Only Network. The vaccination indicated on the voucher shall be provided upon presentation of a voucher, which must be relinquished at the time the Voucher Recipient receives the vaccination.

4.4 Invoicing. CVS/caremark shall invoice Participating Group for Retail Voucher Program services in accordance with the rates and terms specified in the respective Program enrollment form. If no invoicing terms are specified in the enrollment form, CVS/caremark shall invoice Participating Group monthly and invoices shall be paid within thirty (30) days of receipt.

EXHIBIT J
CVS/CAREMARK NCRx PERSONNEL

Sales Account Executive. At all times when this Agreement is in force, CVS/caremark will provide NCRx with Sales Account Executive support to the business of NCRx and its Participating Groups at no cost to NCRx or any Participating Group.

Implementation Managers. At all times when any Participating Group is converting and/or implementing the CVS/caremark software and systems under a Participating Group Addendum, CVS/caremark will provide NCRx and the Participating Group with the Services of an appropriate number of Implementation Managers adequate to meet the needs of the conversion and/or implementations then underway at no cost to NCRx or the Participating Group.

Strategic Account Executive. At all times when this Agreement is in force, CVS/caremark will provide NCRx with a Strategic Account Executive for the business of NCRx and its Participating Groups at no cost to NCRx or any Participating Group.

Clinical Advisor. At all times when this Agreement is in force, CVS/caremark will provide NCRx with a Clinical Advisor for the business of NCRx and its Participating Groups at no cost to NCRx or any Participating Group.

Account Managers. At all times when this Agreement is in force, CVS/caremark will provide NCRx with an appropriate number of Account Managers for the business of NCRx and its Participating Groups at no cost to NCRx or any Participating Groups.

Advisor Support. At all times when this Agreement is in force, CVS/caremark will provide NCRx with an Advisor Support for the business of NCRx and its Participating Groups at no cost to NCRx or any Participating Group.

Manager of Account Management. At all times when this Agreement is in force, CVS/caremark will provide NCRx with a Manager of Account Management for the business of NCRx and its Participating Groups at no cost to NCRx or any Participating Group.

Personnel Review Sessions. The parties agree to hold personnel review sessions to ensure that the CVS/caremark personnel dedicated to NCRx and its Participating Groups is adequate to meet the service needs. These personnel review sessions will be held as requested by NCRx and its Participating Groups, but will be held at minimum on an annual basis. CVS/caremark agrees to add and/or change personnel as mutually agreed upon in these personnel review sessions.

Exhibit K
Maintenance Choice Program
[Mandatory, Opt Out Mandatory, or Voluntary]

Whereas, CVS/caremark will provide the Maintenance Choice Program as described as described below to Participating Groups that are governed by ERISA.

MAINTENANCE CHOICE PROGRAM TERMS AND CONDITIONS

1. Each of Participating Group's Plans that participate in the CVS/caremark Maintenance Choice Program (the "**Maintenance Choice Program**") must be a qualified ERISA Plan, and Participating Group must have a qualifying Plan design as identified by CVS/caremark. Some Plan designs may not qualify for participation in the Maintenance Choice Program.

2. The Maintenance Choice Program will be a change to Participating Group's existing Plan design. Participating Group's Plan is responsible for complying with all laws and regulations applicable to Participating Group's Plan, for making any appropriate notifications to its Plan Participants concerning the Maintenance Choice Program and for making any appropriate changes to its Plan Design Documents to reflect Participating Group's participation in the Maintenance Choice Program.

3. CVS/caremark will implement and administer the Maintenance Choice Program as part of the Services CVS/caremark provides under this Agreement. All terms and conditions set forth in this Agreement will apply to the Maintenance Choice Program, although the Maintenance Choice Program will be governed by the terms and conditions in this Exhibit to the extent of any conflict between this Exhibit and the Agreement.

4. The Maintenance Choice Program applies only to Maintenance Choice Prescriptions. A Maintenance Choice Prescription is a prescription for more than an 83-day supply of certain medications that are covered by Participating Group's Plan(s), excluding specialty medications ("**Maintenance Choice Prescription**").

5. A Maintenance Choice Prescription will be dispensed by a CVS retail pharmacy, but Participating Group's Plan(s) will receive the same pricing discounts and Dispensing Fees, if any, that would apply if the prescription had been filled at one of CVS/caremark's mail service pharmacies. The Plan Participant will pay, and CVS/caremark will direct the dispensing CVS pharmacy to collect, the same Cost Share the Plan Participant would have paid if the prescription had been filled at one of CVS/caremark's mail service pharmacies. Maintenance Choice Prescriptions will not be subject to the Usual and Customary price or other retail network pricing charged by the CVS pharmacy.

6. Maintenance Choice Prescriptions will be treated the same as prescriptions filled at CVS/caremark's mail service pharmacies for purposes of any mail pricing guarantees and generic dispensing rate guarantees set forth in this Agreement. Maintenance Choice Prescriptions will be disregarded and therefore excluded for purposes of calculating all mail service pharmacy non-financial performance guarantees set forth in the Agreement.

7. **(Optional – for Participating Groups electing Opt-Out Maintenance Choice)** The Maintenance Choice Program Participating Group's Plan has elected allows the Plan's Participants

to opt out of the Maintenance Choice Program by calling CVS CVS/caremark's Customer Care Center. Upon opting out, Plan Participants can continue to fill their 30 day maintenance medication prescriptions at a retail pharmacy of their choice. The prescriptions that are dispensed pursuant to the opt out request: (i) are excluded from the definition of Maintenance Choice Prescriptions set forth in paragraph 4 above and (ii) are subject to the retail network pricing set forth in the Agreement.

8. **(Optional – for Participating Groups electing Voluntary Maintenance Choice)** The Maintenance Choice Program Participating Group's Plan has elected is CVS/caremark's voluntary Maintenance Choice Program. This voluntary Maintenance Choice Program allows Plan's Participants to: (i) receive prescriptions from all Participating Pharmacies for 30-day maintenance medications; and (ii) receive 90 day prescriptions of Maintenance Choice Prescriptions from CVS/Pharmacy retail locations and CVS/caremark mail service. All 30-day maintenance medications dispensed by Participating Pharmacies will be charged in accordance with the retail rates set forth in the Agreement.

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

9. Upon written notice to Participating Group, CVS/caremark may modify the Maintenance Choice Program or suspend Participating Group's participation in the Maintenance Choice Program. Additionally, upon written notice to Participating Group, CVS/caremark may modify the financial guarantees in this Agreement that are impacted by Participating Group's participation in the Maintenance Choice Program, but only in a manner that maintains the total aggregate economic value of Participating Group's existing financial guarantees.

PROVIDER NETWORK MANAGEMENT AGREEMENT

PARTIES

Blue Cross and Blue Shield of Arizona, Inc. (“BCBSAZ”), an Arizona non-profit corporation and an independent licensee of the Blue Cross and Blue Shield Association and Lake Havasu Unified School District #1 Employee Benefit Trust (the “Trust”) headquartered in Arizona.

EFFECTIVE DATE

The Effective Date of this Provider Network Management Agreement (the "Agreement") is July 1, 2018.

RECITALS

A. The Trust has established a self-funded employee welfare benefit plan (the "Plan"), which provides certain hospital, medical and/or dental benefits to certain employees of the Trust and for certain dependents of the employees (collectively the "Participants"), on terms and conditions more fully described in the Summary Plan Description(s) created by the Trust.

B. The Trust desires BCBSAZ to provide the Participants with access to its provider network(s) and other services, and BCBSAZ desires to provide such services and access on the terms and conditions provided in this Agreement.

C. The Trust has retained a claims administrator (the "Claims Administrator") other than BCBSAZ to provide administrative and/or claims processing services in conjunction with the Plan or provides the administrative and claims processing service itself. If there is no third-party Claims Administrator or other entity with which the Trust has contracted to provide administrative and/or claims processing services, all references to Claims Administrator in this Agreement shall refer to the Trust.

I. AGREEMENT

DEFINITIONS

A. **BCBSAZ Allowed Amount** -the amount payable by or through BCBSAZ for a Covered Service, including any contracted discounts and amount payable by the Subscriber, i.e., deductibles, coinsurance or copayments.

B. **Billed Charges** - all charges for Covered Services rendered or supplied to Participants billed by Providers and for which the Trust is the primary payor.

C. **Claim** - a request in a format approved by BCBSAZ for the payment of specific services and/or supplies rendered or delivered by Providers to Participants.

D. **Claims Savings** - covered services provided by Providers, the Billed Charge minus the BCBSAZ Allowed Amount. Claims Savings may be expressed as a percentage by dividing the Claims Savings by the Billed Charge(s).

E. **Contract Year** - a twelve (12) month period during the term of this Agreement. The initial Contract Year will begin on the Effective Date and end twelve- (12) months later. Subsequent Contract Years will begin on the anniversary of the Effective Date and end twelve (12) months later; however, the final Contract Year will end on the date this Agreement terminates.

F. **Covered Services** - health care services and supplies rendered or delivered to Participants for which benefits are available under the Plan.

G. **Completed Claim** – a claim that may be processed without obtaining additional data from the provider of service or from a third party.

H. **Day** – calendar day unless otherwise expressly stated.

I. **Provider** – any properly licensed, certified or registered person furnishing care.

J. **Provider Network** – Providers with whom BCBSAZ has negotiated reimbursement amounts for Covered Services.

K. **Received Claim Date** – the Date Claims Administrator first receives the Provider claim.

II. TERM; TERMINATION

A. Term - The initial term of this Agreement will commence at 12:01 a.m., M.S.T., on the Effective Date and will continue in effect for a period of twelve (12) consecutive months, unless sooner terminated as provided in this Agreement.

This Agreement will renew automatically for additional twelve- (12) month periods unless either Party terminates this Agreement by providing written notice to the other Party at least thirty (30) days prior to the anniversary date of this Agreement. Such termination will be effective upon the anniversary date.

B. Termination - Except as provided in Subsection II.A., this Agreement may be terminated only as provided below:

1. Either Party may terminate this Agreement at any time in the event of a substantial breach of the Agreement by the other, but only if the breach is not cured within thirty (30) days after written notice of the breach is given to the breaching Party.

2. BCBSAZ may terminate this Agreement upon any substantial breach in accordance with Paragraph II.B.1. of this section which shall include but not limited to the following:

a) Failure by the Trust to pay when due the fees and charges referred to in Subsection IV.A, but only if the failure is not cured within five (5) days after written notice of the failure is given to the Trust.

b) The sale, exchange or transfer of (i) all or substantially all of the assets of the Trust to a third party or (ii) more than twenty-five percent (25%) of the outstanding stock in the Trust or controlling interest in the Trust, whichever is less.

c) Insolvency, appointment of a receiver or a trustee for the Trust, assignment for the benefit of creditors by the Trust, or the commencement of any proceedings under a bankruptcy or insolvency laws by the Trust that continues for sixty (60) days, or the attachment, levy or other seizure by legal process of any substantial part of the assets of the Trust, and such attachment, levy or seizure is not quashed, stayed or released within sixty (60) days of its occurrence.

d) Default by the Trust under any other agreement with BCBSAZ.

e) The sale, exchange or transfer of any of the following to an entity which BCBSAZ, in its discretion, considers to be a BCBSAZ competitor: (i) all or substantially all of the assets of the Claims Administrator, or (ii) an ownership interest (*i.e.* stock, membership interest, partnership interest) in the Claims Administrator, or (iii) control of the Claims Administrator. Termination for the reasons stated in this Subparagraph II.B.2.e shall be effective upon sixty (60) days prior written notice to Trust.

3. This Agreement will terminate automatically upon the occurrence of any of the following:

a) Termination of the Plan in its entirety; or

b) The enactment of any law or the promulgation of any regulation that makes it illegal to continue this Agreement or for BCBSAZ to perform any of the services required under this Agreement.

4. After this Agreement has been in effect for twelve (12) months, either Party may terminate this Agreement at any time, without cause, as of the last day of any calendar month by giving sixty (60) days' prior written notice to the other Party.

C. Effect of Termination - Upon termination of this Agreement, BCBSAZ will have no further duties of performance under this Agreement, except that:

1. For a period of twelve (12) months following termination of this Agreement (the "Run Out Period"), Trust shall continue to pay claims incurred during the term of the Agreement if the claim is submitted within the Run Out Period.

In addition, for a period of twelve 12 months after the date a claim is processed (the "Adjustment Period"), Trust shall process adjustments to the claim if the request for adjustment is submitted within the Adjustment Period.

With respect to claims processed during the Run Out Period and/or adjusted within twelve (12) months following the Run Out Period, BCBSAZ shall (i) continue to price such claims at no cost to Trust and (ii) charge no access fees.

All of the Trust's obligations under this Agreement will remain in effect through the end of the Run-Out Period.

III. DUTIES OF BCBSAZ

A. Access to Provider Network - During the term of this Agreement, BCBSAZ grants Participants access to its Provider Network. BCBSAZ will provide the Trust with electronic Provider Network directories (i.e. internet, adobe format).

Participants' access to the Provider Network will be subject to the following:

1. The Providers will be reimbursed for services provided to Participants pursuant to the applicable provisions of the Participation Agreements between BCBSAZ and the Providers. Except as provided in Paragraph III.A.3. below, the Providers will accept the BCBSAZ Allowed Amount as the only payment for Covered Services required from and on behalf of Participants.

2. Participants will be responsible for payment of all applicable copayments, deductibles and coinsurance, as well as expenses incurred for non-Covered Services, including services in excess of specified benefit maximums. In most cases, Providers are permitted under their Participation Agreements to seek payments for these amounts directly from Participants. In some instances, including, but not limited to laboratory services, Providers are required by applicable Participation Agreements to waive collection of copayments, deductibles and coinsurance, unless such waiver is prohibited by the Participant's benefit plan or applicable federal or state law.

3. In addition, Providers are not prevented under their Participation Agreements with BCBSAZ from collecting the difference between the BCBSAZ Allowed Amount and Billed Charges when there is compensation for Covered Services from other sources, up to the amount paid by such other sources, so long as collecting from such other sources is permitted by applicable Arizona and federal law. Except as specifically provided in this Paragraph III.A.3., Providers may not balance bill Participants for Covered Services for any amount in excess of the BCBSAZ Allowed Amount.

B. Pricing of Certain Claims

1. BCBSAZ will receive and price Claims of the BCBSAZ contract Providers as set forth on Exhibit 1. BCBSAZ will use reasonable efforts to price such Claims within five (5) business days after receipt. The Trust and BCBSAZ acknowledge that (i) BCBSAZ's receipt and pricing of such Claims does not alter the status of the Claims Administrator and the Trust as the parties responsible for the overall administration of the Plan for the Trust and (ii) such receipt and pricing are deemed to be ancillary to the other services provided by BCBSAZ under this Agreement and (iii) BCBSAZ's pricing of the claim does not include all claims processing edits and the term "claims processing edits" as used herein includes, but is not limited to, coding/upcoding, bundling/unbundling, mutually exclusive and incidental or included procedures.

2. BCBSAZ will provide the Claims Administrator by electronic means BCBSAZ's Allowed Amount to be used by the Claims Administrator to process and pay Claims from Providers other than those in Paragraph III.B.1. herein. If changes are made to the Allowed Amount in the interim, BCBSAZ will provide the Claims Administrator with such changes.

3. BCBSAZ will review Provider grievances for: (1) accuracy of BCBSAZ's pricing of a claim; and (2) whether the Trust (or Trust's Third Party Administrator) has complied with the provisions of the BCBSAZ Provider Agreement ("grievances").

C. Provider Network - BCBSAZ will provide the Claims Administrator by electronic means a listing of all Providers comprising the Provider Network. As changes are made to the Provider Network, BCBSAZ will provide such updated information to the Claims Administrator.

D. Notification of Changes - At least ninety (90) days prior to each anniversary of the Effective Date, if BCBSAZ wishes to renew, BCBSAZ will advise the Trust in writing of any proposed changes in the fees for the subsequent Contract Year. Except as otherwise provided in this Agreement, BCBSAZ may change the fees effective only upon an anniversary of the Effective Date.

IV. DUTIES OF THE TRUST

A. Fees - For access to the Provider Network and the services provided by BCBSAZ under this Agreement, the Trust agrees to pay BCBSAZ in United States funds from a United States bank and branch the fees and charges set forth on Exhibit 2, as it may be amended from time to time by the Parties.

Access Fees are due and payable the first day of each month. This Agreement has a grace period of thirty-one (31) days for the payment of access fees. If an access fee is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Agreement will remain in force. However, the Trust will be responsible for any access fees that are or become due.

At the time the access fees are paid, the Trust or Claims Administrator will provide BCBSAZ a report, as set forth in Exhibit 4, reflecting (i) the BCBSAZ-assigned Group Number or Group Name; and (ii) the number of Employees sorted by: 5-digit zip code, medical network, and dental network, and (iii) the number of Participants sorted by: 5-digit zip code, medical network, and dental network, and (iv) changes to the previous month's enrollment count.

B. Incentive to use the Provider Network(s) - The Trust agrees to provide the Participants with an incentive to utilize the Provider Network. The incentive shall provide for at least a ten percent (10%) difference in the coinsurance levels for services provided by PPO Providers and services provided by any other Providers or providers.

C. Funding of the Plan - Funding for the payment of all benefits available to Participants under the Plan is the sole responsibility of the Trust, and the Trust agrees to pay or cause to be paid by Claims Administrator all Claims for such benefits in a timely manner, as set forth in this Agreement.

D. Benefit Plan Book(s)/Summary Plan Descriptions, Explanation of Benefits and Identification Cards – The Trust agrees to include in its Benefit Plan Book(s)/Summary Plan Descriptions, Explanation of Benefits and Identification Cards the following provision, and any other requirements as mandated by the Blue Cross and Blue Shield Association:

"Blue Cross® Blue Shield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross and Blue Shield Plans outside of Arizona."

Except as indicated herein, the Trust will not refer to BCBSAZ in its Summary Plan Descriptions, Benefit Plan Book(s), Identification Cards or other documents distributed to Participants without BCBSAZ's prior review and written consent.

E. Compliance with Provider Agreements and TPA Administrative Manual – The Trust agrees to comply with, and to require the Claims Administrator to comply with, the terms and conditions of the Provider Agreements between BCBSAZ and the Providers in the Provider Network, as amended from time to time during the term of this Agreement. If the terms and conditions of the Provider Agreements require the amendment or modification of this Agreement, BCBSAZ will provide written notice of such amendment or modification to the Trust at least thirty (30) days prior to the effective date. If the Plan conflicts with the terms and conditions of the various Provider Agreements, the terms and conditions of the Provider Agreements shall be deemed to control. Additionally, BCBSAZ will prepare and provide to the Claims Administrator a TPA Administrative Manual. Trust agrees to cause the Claims Administrator to comply with the terms of the TPA Administrative Manual, as amended from time to time during the term of this Agreement. The TPA Administrative Manual is available to Trust upon request.

F. Direct Payment to Providers - Trust shall process Claims as stated in Paragraphs IV.F.1., 2., 3. and 4. "Process" means pay or deny. "Pay" means to either pay the Provider or send notification to the Provider that the allowance was applied to the Member's benefits (e.g., co-pay, coinsurance, deductible). To merely approve for payment or to merely request the Trust to fund the account is not "paying". The date of payment to the Provider is the date on which the Trust or the Third Party Administrator or other vendor mails the check to the Provider or electronically transfers funds to the Provider. The Trust or Claims Administrator shall maintain and make available a record of: (a) the date the check is mailed to the Provider; (b) the date the funds are electronically transferred to the Provider; and/or (c) if any allowance was applied to the Participant's benefits, the date notification thereof was sent to the Provider.

Trust shall:

1. Pay Providers directly for Covered Services; and

2. Except with respect to claims originally submitted by the Provider in paper format, process ninety-nine percent (99%) of all Claims within thirty (30) calendar days from the date the Claims Administrator received the priced Claim; and

3. With respect to paper claims the Claims Administrator receives from the Provider and prices, the claims timeliness standards stated in Subsection (2) herein shall be measured from the date Claims Administrator received the Claim from the Provider. With respect to paper claims which the Claims Administrator converts to an electronic format and transmits to BCBSAZ for pricing, the claims timeliness standards stated in Subsection (2) herein shall be measured from the date the Claims Administrator received the Claim from the Provider.

   Within fifteen (15) calendar days following the end of each calendar month, the Trust or Claims Administrator shall provide BCBSAZ with a claims timeliness summary report ("claims timeliness summary" or "report"). The report shall identify the total number of claims for Providers that were; (i) received in the applicable month; (ii) processed in the applicable month (sorted by payment or denial); (iii) the number of claims processed within fourteen (14) calendar days from the Received Claim Date; (iv) the number of claims processed within thirty (30) calendar days

from the Received Claim Date; (v) the number of claims processed thirty-one (31) or more calendar days from the Received Claim Date; and

4. All BCBSAZ Provider Claims shall be processed as follows: (a) At least 97% (ninety-seven percent) of all claims must be processed accurately; (b) At least 99% (ninety-nine percent) accuracy (based on absolute, not net dollars), must be met; (c) The terms "accurately" and "accuracy" mean processed in accordance with all of the following: (i) the amount at which BCBSAZ priced the claim; and (ii) the PNM Agreement; and (iii) the Summary Plan Description; and (d) "At least 99% financial accuracy" will be satisfied only if the difference between the aggregate claims amount paid and the aggregate claims amount that would have paid if the claims had been processed accurately does not exceed 1% (one percent) provided however that in computing the totals, no "netting" shall be allowed. For example, if one claim was overpaid by $150 and another claim was underpaid by $150, the two claims shall not cancel each other out and instead shall count as an error of $300.

5. Within one (1) week of BCBSAZ's request, the Trust shall make available to BCBSAZ claim detail sufficient to support the submitted claim timeliness summary report including, but not limited to, the following fields: BCBSAZ Claim Number, TPA Claim Number, Group Name, Provider Tax ID Number, Member Name, Billed Charges, Service From, Service Thru, Date Claim Received (as defined in Paragraphs IV.F.2. and 3.), Date Claim Processed (as defined in Paragraph IV.F.), Paid or Denied, Payee Check Number or Electronic Funds Transfer (EFT) Number, Payee Amount, Statement of whether the TPA initially received the claims from the Provider or BCBSAZ.

G. Provider and Participant Inquiries - The Trust (or Claims Administrator) will respond to Provider and Participant inquiries regarding (i) the benefits available under the Plan and (ii) the Trust's responsibilities under this Agreement.

H. Confidentiality Agreement between BCBSAZ and Claims Administrator - The Trust will require its Claims Administrator to enter into a Confidentiality Agreement in a form substantially the same as Exhibit 3 as a condition to administering and processing Claims under this Agreement.

I. Agreement Compliance Information - The Trust shall provide or cause to be provided to BCBSAZ, in addition to the specific information stated herein, all additional information BCBSAZ reasonably requests to verify the Trust's compliance with the terms of this Agreement.

J. Access to Medical Information - The Trust will obtain (or facilitate BCBSAZ's obtaining) from each Participant written authorization for release of medical records, if required by applicable law or regulation, to permit BCBSAZ access to individual Participant medical information required by BCBSAZ to perform its duties under this Agreement.

K. Other Administrative Information - The Trust will furnish BCBSAZ with any other instructions, information, contracts and documents deemed necessary by BCBSAZ to properly perform its duties under this Agreement.

L. Designation of Authorized Representative – The Trust designates the person(s) set forth on Exhibit 6 to act on its behalf as its authorized representative(s) in all matters relating to the day-to-day details of the administration of this Agreement by BCBSAZ. The Trust agrees that BCBSAZ may rely upon the decisions and instruction of the designated person(s) as being the duly authorized decisions and instructions of the Trust to BCBSAZ.

M. Compliance with Applicable Laws - The Trust will be responsible for the status of the Plan and compliance with all applicable State and federal laws governing the Plan, including, but not limited to any state and federal laws regarding timely payment of claims.

N. Taxes - The Trust agrees to pay any and all taxes, licenses and fees levied, if any, by all local, state or federal authorities in connection with the duties of BCBSAZ under this Agreement, excluding BCBSAZ's income taxes and BCBSAZ's own employee benefits taxes. If state or federal law impacting premium tax payments is implemented or amended during the term of this Agreement, BCBSAZ reserves the right to adjust, retroactively or prospectively, the fees then in effect accordingly. Further, BCBSAZ specifically reserves the right to recover from the Trust any premium tax deficiencies that may be assessed against BCBSAZ with respect to prior periods of coverage under this Agreement, whether such deficiencies are assessed during the term of this Agreement or following its termination. The Trust shall indemnify, defend and hold BCBSAZ harmless from liability for such taxes, licenses and fees, and this indemnification will survive termination of this Agreement.

O. Trust's Designee - Wherever the words "or Claims Administrator" appear in this Section, the Trust may enlist the assistance of the Claims Administrator to perform those duties; however, the use of Claims Administrator to perform those duties will not relieve the Trust from any liability with respect to the Claims Administrator's failure to perform those duties.

P. Claims Processing Report – The Trust agrees to provide, or cause to be provided, to BCBSAZ a monthly report which sets forth, for the claims received by Trust (or Claims Administrator) in the immediately preceding month: (a) the total number of BCBSAZ Network claims received, (b) the total number of BCBSAZ Network claims processed (sorted by payment or denial), and (c) the total number of BCBSAZ Network claims processed within fourteen (14) calendar days from the date of Trust's (or Claims Administrator's) receipt, and (d) the total number of BCBSAZ Network claims processed within thirty (30) calendar days from the date of Trust's (or Claims Administrator's) receipt; and (e) the number of claims processed thirty-one (31) or more calendar days from the date of Trust's (or Claims Administrator's) receipt. Such report shall be provided to BCBSAZ within fifteen (15) days after the end of each month.

Q. Audits of Claims Administrator – The Trust shall conduct regular audits of the Claims Administrator to ensure that Claims Administrator is processing claims in accordance with the terms of this Agreement, the Provider Agreements and the TPA Administrative Manual.

R. Terms and Conditions - The Trust agree to the terms and conditions set forth in the Bid/Renewal Rate Acceptance (Exhibit 7) which is part of this Agreement and is incorporated herein by reference.

V. LIMITATION OF LIABILITY AND INDEMNIFICATIONS

A. Scope of Responsibility - With respect to the Plan, BCBSAZ will be considered a provider of claims pricing services only, and not the Plan administrator or a Plan fiduciary under the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). With respect to the Plan, both Parties acknowledge and agree that the Trust is the Plan administrator and Plan fiduciary for purposes of ERISA and COBRA; as such, the Trust is responsible and liable for all related regulatory compliance, including, but not limited to, applicable notice, reporting and disclosure requirements related to the Plan or

this Agreement. BCBSAZ does not assume any responsibility for the general policy direction of the Plan, the adequacy of its funding, any act or omission or any breach of duty by the Trust. BCBSAZ is not in any way to be deemed an insurer, underwriter or guarantor with respect to any benefits payable under the Plan, nor is BCBSAZ a fiduciary under the Plan. Additionally, BCBSAZ provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims.

B. Indemnification By BCBSAZ - BCBSAZ will indemnify, hold harmless and defend the Trust and its directors, officers, employees and agents from and against any and all actions, suits, claims, judgments, settlements, liabilities, damages, penalties, losses and/or expenses, and costs, including, without limitation, attorneys' fees, punitive and exemplary damages, directly resulting from and to the extent of the gross negligence, fraud or willful misconduct of BCBSAZ, its directors, officers, employees or agents.

C. Indemnification By The Trust - The Trust will indemnify, hold harmless, and defend BCBSAZ, its directors, officers, employees or agents from and against any and all actions, causes of action, suits, claims, judgments, settlements, liabilities, damages, penalties, losses and/or expenses, and costs, including, without limitation, attorneys' fees, punitive and exemplary damages, resulting from or arising out of or in connection with:

1. Any and all acts or omissions of BCBSAZ under this Agreement, unless it is determined that the liability was the direct consequence of the gross negligence, fraud or willful misconduct of BCBSAZ, its directors, officers, employees or agents; and

2. Any acts or omissions of the Trust, its directors, officers, employees or agents.

D. Legal Defense - Except as provided in Subsection V.B. herein, the Trust will be responsible for the cost of defense of any legal action involving a claim for benefits under the plan by or on behalf of any Participant, fiduciary or other third party; such responsibility will include the payment of counsel fees and costs. As such fees and costs are incurred, the Trust agrees to reimburse BCBSAZ periodically and within thirty (30) days of receipt of a billing from BCBSAZ with appropriate supporting documentation to substantiate such billing.

E. Termination or Expiration - The terms and conditions of this Section V. will survive the termination or expiration of this Agreement.

VI. GENERAL PROVISIONS

A. Amendment - Except as expressly set forth in this Agreement, the terms and conditions of this Agreement may be modified only by a written amendment to this Agreement signed by an authorized representative of each Party.

B. Applicable Law and Venue - This Agreement will be governed by and construed according to the laws of the State of Arizona and any applicable federal law without regard to any conflict of law principles. The Parties consent to the jurisdiction of and to venue for any dispute involving this Agreement in the state courts of the State of Arizona or the United States District Court for the District of Arizona.

C. Assignment - Neither Party may assign or transfer any right, benefit, obligation or duty under the terms of this Agreement without the advance written consent of the other; except BCBSAZ may transfer and assign this Agreement to a subsidiary or parent or an entity or person acquiring control of BCBSAZ or its assets or acquiring a division of BCBSAZ providing administration services under this Agreement.

D. Attorneys' Fees - If any legal action is brought to enforce or interpret any of the terms, conditions or obligations of this Agreement, the prevailing Party will be entitled to recover all court costs and reasonable attorneys' fees from the non-prevailing Party.

E. Audits - Upon reasonable prior written notice to the other Party and during that Party's normal working hours, each Party may audit the records of payments made to providers and other data specifically related to performance of the Parties under this Agreement. In addition, the Trust agrees to secure the right of BCBSAZ to audit such records of the Claims Administrator according to the terms of this paragraph. Each Party agrees to provide reasonable assistance and information to the auditors without charge. Any special costs of an audit will be borne by the Party requesting the audit. Each Party agrees to provide such additional information and reports as the other Party reasonably requests. Nothing in this Section or in this Agreement shall require BCBSAZ to give notice of any kind before contacting any BCBSAZ network provider(s) to determine the date on which the provider(s) received payment.

F. Entire Contract - Except as set forth on Exhibit 5, this Agreement, including all Exhibits to this Agreement, constitutes the entire arrangement between the Parties with respect to its subject matter. No promises, terms, conditions or obligations other than those contained in this Agreement will be valid or binding. Any prior oral or written agreements, statements, promises, negotiations, inducements or representations made by either Party or agents of either Party that are not contained in this Agreement are of no force and effect.

G. Errors and Omissions coverage - Each Party will provide the other with a Certificate of Insurance evidencing at least $1,000,000 of Errors and Omissions coverage, and such coverage will remain in effect at all times during the term of this Agreement. BCBSAZ may provide its coverage through self-insurance and will provide the Trust with written certification of at least $1,000,000 in reserves in connection with any self-insurance plan. The Trust agrees to name BCBSAZ as an additional insured on the Trust's insurance policy.

H. Financial Obligation of BCBSAZ and BCBSAZ's Relationship to the Blue Cross and Blue Shield Association – Trust on behalf of itself and its Participants hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between Trust and Blue Cross Blue Shield of Arizona (BCBSAZ) which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting BCBSAZ to use the Blue Cross and/or Blue Shield Service Marks in the State of Arizona, and that BCBSAZ is not contracting as the agent of the Association. Trust on behalf of itself and its Participants further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than BCBSAZ and that no person, entity, or organization other than BCBSAZ shall be held accountable or liable to Trust for any of BCBSAZ's obligations to Trust created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSAZ other than those obligations created under other provisions of this agreement.

I. Independent Contractors - BCBSAZ is an independent contractor with respect to the services being performed under this Agreement and will not for any purpose be deemed an employee of the Trust, nor will BCBSAZ and the Trust be deemed partners, joint ventures or governed by any legal relationship other than that of independent contractor.

J. Mediation/Arbitration - If a claim or controversy arising out of or relating to this Agreement or any claimed breach of this Agreement cannot be resolved by the Parties in the normal course of business, each Party shall designate a member of its senior management to meet in an attempt to resolve the dispute.

A dispute that cannot be resolved to the satisfaction of the Parties in this manner shall be referred for mediation or arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association's Regional office in Phoenix, Arizona or such other rules as may be agreed to by the Parties, and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction.

K. Non-Disclosure of Proprietary Information - The Parties acknowledge, in contemplation of entering into this Agreement and as a result of the contractual relationship created by this Agreement, each Party has revealed and disclosed, and will continue to reveal and disclose to the other Party, information that is proprietary and/or confidential. Each Party agrees to keep such information of the other Party in strict confidence, not to disclose such information of the other Party to any third parties or to any of its employees not having a legitimate need to know and not to use such information of the other Party for any purpose not directly related to and necessary for the performance of its obligations under this Agreement. Information revealed or disclosed by a Party will not be considered confidential information for purposes of this Agreement, if, when, and to the extent it is or becomes generally available to the public without the fault or negligence of the other Party, or if the unrestricted use of such information by the other Party has been expressly authorized in writing in advance by an authorized representative of the disclosing Party. For purposes of this Agreement, confidential information is any information in written, human-readable, machine-readable, or electronically recorded form (whether legend as confidential and/or proprietary or not) disclosed in connection with this Agreement, including, but not limited to, plans, policies, practices, pricing information, procedures, files, records and correspondence concerning the Parties' respective business or finances. “Pricing information” includes information about pricing and discount arrangements between BCBSAZ and its contracted health care providers but does not include the rate, charge or fee paid by the group to BCBSAZ. The terms and conditions of this Subsection VI.K. will survive the termination or expiration of this Agreement.

L. Notices - All notices and other communications to a Party shall be (i) in writing, (ii) addressed to the other Party at its respective address set forth below or such other addresses as either Party may designate in writing to the other from time to time for such purposes and (iii) served or delivered by hand delivery or by U.S. mail. Notice shall be complete upon receipt by the Party. Notices and other communications in writing need not be mailed either by registered or certified mail, although a signed return receipt received through the U.S. Post Office shall be conclusive proof as between the Parties of delivery of any notice or communication and of the date of such delivery.

M. Paragraph Headings - The paragraph headings contained in this Agreement are for reference purposes only and will not affect in any way the meaning or interpretation of this Agreement.

N. Parties to the Agreement - This Agreement is between BCBSAZ and the Trust and does not create any rights or legal relationships between BCBSAZ and any Participants.

O. Severability - If any provision of this Agreement is held to be illegal, invalid or unenforceable under current or future laws or regulations effective during the term of this Agreement, the illegal, invalid or unenforceable provision will be severed from this Agreement; this Agreement will be construed and enforced as if such illegal, invalid or unenforceable provision had never comprised a part of this Agreement; and the remaining provisions will remain in full force and effect and will not be affected by such illegal, invalid or unenforceable provision or by its severance.

P. Successors and Assigns - The provisions of this Agreement will be binding upon and inure to the benefit of the Parties, their successors and their assigns.

Q. Use of Trade Name - The Trust agrees not to use the corporate name or any trade name, trademark or service mark of BCBSAZ in any advertising, publications, press releases, brochures or other public communications without the prior written consent of BCBSAZ.

R. Waiver - There will be no waiver of any term, provision or condition of this Agreement unless in writing and signed by both Parties.

S. Entire Agreement - The Agreement constitutes the entire agreement of the Parties and supersedes all prior agreements relating to the subject matter hereof.

T. BCBSAZ's "Fee Schedule" - The schedule that lists the dollar amounts BCBSAZ uses, among other things, to determine the amount payable for a covered service. Trust acknowledges and understands that BCBSAZ's Fee Schedule is proprietary and is not based on, nor intended to be reflective of, fees that are or may be described as "usual and customary," "reasonable and customary," "reasonable and necessary" and/or any combination of such terms. BCBSAZ's "Fee Schedule" means the Schedule of fees that lists the dollar amounts BCBSAZ uses, among other things, to determine the amount payable for a covered service.

VII. Health Insurance Portability and Accountability Act of 1996

A. Definitions

Any capitalized term used, but not defined, in this Section shall have the meaning set forth in the HIPAA Rules. The HIPAA Rules include the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164. The "HIPAA Privacy Rule" is at 45 CFR, part 160 and part 164, subparts A and E. The "HIPAA Security Rule" is at 45 C.F.R. Parts 160 and 164. The "HIPAA Breach Notification Rule" is at 45 CFR Part 164 Subpart D.

B. Certification

Trust certifies that the plan document of Plan has been amended to comply with the requirements of 45 C.F.R. § 164.504(f)(2) and 45 C.F.R. §164.314(b), including, but not limited to (a) prohibiting use or disclosure of Protected Health Information for employment related actions, and (b) ensuring separation of records between the Plan and Trust. The amendment provides the required satisfactory assurance that Trust will appropriately safeguard and limit the use and disclosure of the Plan Participants' Protected Health Information that Trust may receive from Plan or BCBSAZ to perform the Plan Administration Functions.

C. **Privacy Of Protected Health Information.**

1. BCBSAZ will protect all Protected Health Information that BCBSAZ creates or receives on Plan's behalf or receives from Plan (or another Business Associate of Plan) in the performance of its duties under the Agreement, as required by this Addendum and applicable law. As a Business Associate, BCBSAZ recognizes and agrees that it is obligated by law to meet the applicable provisions of the HIPAA Rules.

2. BCBSAZ is permitted to use or disclose Protected Health Information it creates or receives for or from Plan, or a Business Associate of Plan, or to request Protected Health Information on the Plan's behalf as follows:

   a. BCBSAZ is permitted to request Protected Health Information on the Plan's behalf and to use and to disclose Protected Health Information it creates or receives for or from the Plan, or a Business Associate of Plan, to perform its obligations under this Agreement. Without limiting the foregoing, BCBSAZ is permitted to disclose Protected Health Information to the Plan's stop loss carrier, the Plan's designated utilization review agent, the Plan's designated broker and benefits consultant, the Plan's auditor and any vendor the Plan uses to perform enrollment, eligibility, COBRA Administration, HSA, HRA or FSA administration or similar functions (collectively, "Plan Contractors") which such Plan Contractors request.

   b. For any use, disclosure or request of Protected Health Information, BCBSAZ shall utilize a Limited Data Set if practicable or, if not practicable, use, disclose, and request of the Plan only the minimum amount of the Plan's Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request. In addition, BCBSAZ agrees to implement and follow appropriate minimum necessary policies in the performance of its obligations under this Agreement.

   c. BCBSAZ may use the Protected Health Information it creates or receives for or from the Plan, or from another Business Associate of the Plan, for BCBSAZ's proper management and administration or to carry out BCBSAZ's legal responsibilities.

   d. BCBSAZ may disclose Protected Health Information for the proper management and administration of BCBSAZ or to carry out the legal responsibilities of BCBSAZ, provided that disclosures are Required By Law, or BCBSAZ obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies BCBSAZ of any instances of which it is aware in which the confidentiality of the information has been breached.

3. BCBSAZ will neither use nor disclose Protected Health Information it creates or receives for or from the Plan or from another Business Associate of the Plan, except as permitted or required by this Agreement, as permitted or required by law, as otherwise permitted in writing by the Plan, or as authorized by a particular Participant with respect to their Protected Health Information.

4. BCBSAZ may use and disclose PHI to provide Data Aggregation Services related to the Plan's Health Care Operations. BCBSAZ also may de-identify PHI it obtains or creates in the course of providing services to Plan.

5. BCBSAZ shall not directly or indirectly receive remuneration in exchange for PHI except where consistent with applicable law.

6. BCBSAZ shall not directly or indirectly receive payment for any use or disclosure of PHI for marketing purposes except where consistent with applicable law or pursuant to an individual authorization.

7. BCBSAZ will use appropriate safeguards to prevent uses or disclosures of the information other than as provided for or by this Agreement.

8. BCBSAZ will require any of its subcontractors and agents, to which BCBSAZ is permitted to disclose Protected Health Information, to provide reasonable assurance, evidenced by written contract, that subcontractor or agent will comply with the same privacy and security obligations as BCBSAZ with respect to such Protected Health Information.

9. Prior to requesting any Protected Health Information from BCBSAZ or directing BCBSAZ to provide Protected Health Information to a Plan Contractor or other third-party, the Trust and Plan shall ensure that they, and any of Plan's Business Associates, take any required actions and obtain any required authorizations which may be necessary for such disclosure.

D. **Safeguards for Securing Electronic Protected Health Information.**

1. BCBSAZ will use appropriate administrative, technical, and physical safeguards that reasonably and appropriately protect the integrity, confidentiality and availability of Electronic Protected Health Information created or received for or from the Plan or on the Plan's behalf, consistent with the HIPAA Security Rule.

2. BCBSAZ will require its agents and subcontractors, to whom it provides such Electronic Protected Health Information, to implement reasonable and appropriate safeguards to protect it, consistent with the HIPAA Security Rule.

E. **Reporting.**

1. BCBSAZ will report to Plan, following discovery and without unreasonable delay, any "Breach" of "Unsecured Protected Health Information" as these terms are defined by the HIPAA Breach Notification Rule. BCBSAZ shall cooperate with Plan in investigating the Breach and in meeting the Plan's obligations under the Breach Notification Rule and any other security breach notification laws. Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by BCBSAZ to have been, accessed, acquired, or disclosed during such Breach, along with any other information required to be reported under the HIPAA Rules.

2. BCBASAZ will report to the Plan any Security Incident, of which it becomes aware, affecting Participant Electronic Protected Health Information and resulting in a disclosure not permitted by this Agreement.

F. **Access, Amendment And Disclosure Accounting.**

1. Upon receipt of the Plan's written request, BCBSAZ will make available to the Plan or, at the Plan's direction, to the individual, Protected Health Information maintained in a designated record set in accordance with 45 C.F.R. §164.524. BCBSAZ shall make such information available in electronic format where directed by Plan. If BCBSAZ receives such a request directly from a Participant, BCBSAZ will provide such information directly to the Participant or person designated by the Participant.

2. Upon receipt of the written request of the Plan or a Participant, BCBSAZ will make available Protected Health Information maintained in a designated record set for amendment and will incorporate amendments to Protected Health Information maintained in a designated record set in accordance with 45 C.F.R. §164.526.

3. Upon receipt of the Plan's written request in response to a request from a Participant, BCBSAZ will make available to Plan or, at Plan's direction, to the Participant, information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528. If BCBSAZ receives a request for accounting directly from a Participant, BCBSAZ will provide such accounting directly to the Participant or person designated by the Participant.

4. BCBSAZ will make its internal practices, books, and records, relating to its use and disclosure of the Protected Health Information it creates or receives for or from the Plan, along with required documentation of security policies and procedures, available to the U.S. Department of Health and Human Services for purposes of determining compliance with HIPAA Administrative Simplification requirements.

G. **Termination for Breach of Privacy or Security Obligations.**

1. Termination

Plan will have the right to terminate this Agreement if BCBSAZ has engaged in a pattern of activity or practice that constitutes a material breach or violation of BCBSAZ's obligations regarding Plan's Protected Health Information under this Agreement and, on notice of such material breach or violation from Plan, fails to take reasonable steps to cure the breach or end the violation. If BCBSAZ fails to cure the material breach or end the violation within thirty (30) days after receipt of Plan's notice, Plan may terminate the Agreement by providing BCBSAZ written notice of termination, stating the uncured material breach or violation that provides the basis for the termination and specifying the effective date of the termination. If for any reason Plan determines that BCBSAZ has breached the terms of this Section VII. and such breach has not been cured, but Plan determines that termination of the Agreement is not feasible, Plan may report such breach to the U.S. Department of Health and Human Services.

2. Obligations upon Termination.

a. Upon termination, cancellation, expiration or other conclusion of Agreement, BCBSAZ will, if feasible, return to the Plan or destroy all Protected Health Information that BCBSAZ created or received for or from the Plan. If such information cannot feasibly be returned, BCBSAZ will limit its further use or disclosure of that Protected Health Information to those purposes that make return or destruction of that Protected Health Information infeasible.

b. BCBSAZ's obligation to protect the privacy of the Protected Health Information it created or received for or from the Plan will be continuous and survive termination, cancellation, expiration or other conclusion of Agreement.

Intending to be legally bound, the Parties have executed this Contract as of its Effective Date.

BCBSAZ
BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC., an Arizona nonprofit corporation

By:_____
(signature)

Name:_____

Its:_____
_____

Address: 2444 West Las Palmaritas
P.O. Box 13466
Phoenix, AZ 85002-3466
Attn: Legal Division

TRUST
LAKE HAVASU UNIFIED SCHOOL DISTRICT#1

By:_____
(signature)

Name:_____

Its:_____

Address: 2200 Havasupai Blvd.
Lake Havasu City, AZ
86403

EXHIBIT 1
PRICING OF CLAIMS

Claims will be priced as follows:

1. **Institutional Claims**

BCBSAZ will price all Institutional Claims. "Institutional Claims" means claims submitted by any of the following types of providers:

Hospitals
Skilled Nursing Facilities
Urgent Care Facilities
Freestanding Emergency Facilities
Recovery Care Facilities
Rehabilitation Facilities
Cardiac Rehabilitation Facilities
Home Health Agencies
Freestanding Ambulatory Surgery Centers

2. **Professional Claims**

BCBSAZ will price all Professional Claims except as follows:

A. With respect to Paper Claims received by the Claims Administrator from the Provider, Claims Administrator will price the claim unless, within five (5) days of the Claims Administrator's receipt of the claim, Claims Administrator converts the claim to electronic format and successfully transmits it to BCBSAZ.

B. With respect electronic claims received by the Claims Administrator, Claims Administrator will price the claim unless within five (5) days of Claims Administrator's receipt of the claim, Claims Administrator successfully transmits it to BCBSAZ.

3. **Definitions**

For purposes of this Exhibit, the following terms mean the following:

A. "Institutional Claim" means a claim submitted by any of the types of providers listed in Section 1 of this Exhibit 1 which is attached hereto and incorporated into this Agreement by reference.

B. "Professional Claim" means any claim that is not an Institutional Claim.

C. "Claim" means a claim the Plan Participant incurred in Arizona and, if the claim is one from a Provider contracted with BCBSAZ, a claim incurred in any state.

D. "Paper Claim" means a claim in a format other than electronic format.

E. "Successfully transmits" means BCBSAZ was able to both receive and accept the transmitted claim.

EXHIBIT 2

ACCESS FEES

For the Contract Year beginning July 1, 2018 and ending June 30, 2018 the Trust agrees to pay BCBSAZ the following fees for access to BCBSAZ provider network(s) and claims pricing:

- $15.00 per Participating Employee per month during the Contract Year.
- For any month in which the number of employees with access to the BCBSAZ network is fewer than 100, the Medical Access Fee will be a flat monthly fee and not a per employee per month fee. The flat fee will be $1,500.
- If no Dental Access Fee is indicated, BCBSAZ's dental provider rates and fees may not be used for routine dental services.

INITIALS

TRUST	BCBSAZ
_____	_____

EXHIBIT 3

SAMPLE CONFIDENTIALITY AGREEMENT

PARTIES:

Blue Cross and Blue Shield of Arizona, Inc. ("BCBSAZ"), an Arizona nonprofit corporation and an independent licensee of the Blue Cross and Blue Shield Association, and _____ ("Claims Administrator").

EFFECTIVE DATE:

The Effective Date of this Confidentiality Agreement is _____.

RECITALS:

A. BCBSAZ enters into Provider Network Management Agreements (the "PNM Agreements") with Trusts who have established self-funded employee welfare benefit plans (the "Plans"), whereby Trusts' participants have access to certain BCBSAZ Provider Networks.

B. The Claims Administrator is the agent for the Trusts with respect to the administration and processing of participants' claims for benefits under the Plan.

C. Under the terms of the PNM Agreement, BCBSAZ provides the Trusts with certain trade secrets and proprietary and confidential information (collectively the "Proprietary Information"). In addition, BCBSAZ provides Claims Administrator with Proprietary Information necessary for Claims Administrator's administration and processing of claims for benefits under the Plan.

Therefore, the Parties agree as follows:

AGREEMENT

1. Claims Administrator agrees that all information BCBSAZ provides to Claims Administrator shall be considered Proprietary Information and will remain the sole and exclusive property of BCBSAZ. Proprietary Information includes, but is not limited to, trade secrets, subscription lists, provider network information, pricing information, technical data, video, audio and computer tapes, manuals of instruction, reports and other business records with respect to the business of BCBSAZ. Claims Administrator agrees that it will use the Proprietary Information only as BCBSAZ directs and will keep it strictly confidential.

2. The obligations of this Agreement shall not be applicable to any information that (i) was lawfully in Claims Administrator's possession before it was obtained from BCBSAZ, (ii) is rightfully obtained by Claims Administrator from a source other than BCBSAZ or (iii) generally becomes available to the public other than as a result of unauthorized disclosure by Claims Administrator.

3. If Claims Administrator is requested or required by oral questions, interrogatories, requests for information or documents, subpoena or similar process to disclose any confidential information, claims administrator agrees to provide BCBSAZ with prompt written notice of such request or requirement prior to disclosing such information so that BCBSAZ may seek an appropriate protective order or waive compliance with the applicable provisions of this Confidentiality Agreement.

4. Except as required in the normal course of business pursuant to its duties and responsibilities as agent for the Trust, Claims Administrator may not disclose any Proprietary Information to a third party without the prior express written consent of BCBSAZ's executive vice president and chief operating officer.

5. Except for back-up purposes, Claims Administrator may not make copies of any Proprietary Information. Upon termination of this Confidentiality Agreement or upon BCBSAZ's written request during the term of this Confidentiality Agreement, Claims Administrator agrees to promptly return to BCBSAZ or destroy (written certification of such destruction required from a Claims Administrator officer) all Proprietary Information and all documents and other materials prepared on the basis of such information.

6. This Confidentiality Agreement will terminate five (5) years from the date the Claims Administrator no longer acted as an agent for an Trust which had a PNM Agreement with BCBSAZ.

7. If any provision of this Confidentiality Agreement is held to be illegal, invalid, unenforceable or in conflict with any law of a federal, state or local government having jurisdiction over this Confidentiality Agreement, the provision will be severed from this Confidentiality Agreement and the validity of the remaining sections will not be affected.

8. Claims Administrator agrees that a remedy at law for any breach of this Confidentiality Agreement will be inadequate and that BCBSAZ will be entitled to injunctive relief in addition to any other remedy it might have.

9. This Confidentiality Agreement is governed by and will be interpreted and construed in accordance with Arizona law. For any action arising under this Confidentiality Agreement, the parties agree to the jurisdiction of and venue in the state courts of the state of Arizona or the United States District Court of the District of Arizona. Claims Administrator agrees to pay for all damages arising from enforcement of this Confidentiality Agreement and for costs and fees, including reasonable attorneys' fees, incurred by BCBSAZ in connection with such enforcement.

10. Each person signing this Confidentiality Agreement certifies that s/he has the appropriate corporate authority to bind the respective party.

Intending to be legally bound, the Parties have entered into this Confidentiality Agreement as of its Effective Date.

BLUE CROSS AND BLUE SHIELD OF ARIZONA, an Arizona nonprofit corporation	Claims Administrator Name Here
By:_____ (signature)	By: _____ (signature)
Name:_____	Name:_____
Title:_____	Title:_____

EXHIBIT 4

BCBSAZ –Assigned Group Number	Zip Code	Medical EEs*	Dental EEs*	Medical Participants (EEs + Dependents)	Dental Participants (EEs + Dependents)
ABC001	85224	10		25	
ABC001	85226	20		45	
ABC001	85230	70		150	
ABC001	85304	125	100	300	250
ABC001	85310	250	200	400	450
ABC001	85325	25		50	
Total		400	300	970	700
Retroactivity Adjustment		-10	0	-20	0
Grand Total*		**390**	**300**	**950**	**700**

*Access Fees are paid on the Grand Total count of Employees (EEs).
Do not include Medicare-eligible retirees in the enrollment counts.

EXHIBIT 5

OTHER AGREEMENTS

The Trust and BCBSAZ have entered into one or more other agreements as indicated below:

____ Administrative and Claims Services Agreement

____ Group Master Contract

____ Workers' Compensation Provider Network Management Agreement

____ Maximum Aggregate and Specific Liability Agreement

____ Minimum Premium Plan Group Master Contract

_x___ No other Agreement Exists

____ Other _____

INITIALS

TRUST	BCBSAZ
_____	_____

EXHIBIT 6

DESIGNATION OF AUTHORIZED REPRESENTATIVES

Principal Authorized Representative of the Trust:

Tiffany Lopuszynski

Secondary Authorized Representative of the Trust:

INITIALS

TRUST	BCBSAZ
_____	_____

EXHIBIT 7

BID/RATE ACCEPTANCE PAGE

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

*CHS Renewal Rate Acceptance**

(Network Access Only)

* must be signed by a designated authorized representative prior to renewal effective date

Exhibit 2

Name of Trust:	Lake Havasu Unified School District #1 Employee Benefit Trust	
BCBSAZ Group Number:	LHU001	
Effective Date:	7/1/2018 to 6/30/2019	
Number of In-State Employees:	505	*(Out-of-state not eligible)*
Renewal Notice Days:	60	

I. Network Requested: Medical PPO Plans & Mayo Network

II. Access Fees

Medical Access Fee [a)] : **$15.00 PEPM** (per employee per month)

III. Commission: Rates are net of commission

IV. Caveats

a) For any month in which the number of employees with access to the Blue Cross Blue Shield of Arizona (BCBSAZ) network is fewer than 100, the Medical Access Fee will be a flat monthly fee and not a per employee per month fee. The flat fee will be $1,500 per month.

b) BCBSAZ will not act as a Stop Loss carrier under this agreement.

c) BCBSAZ will be the sole leased medical network provider in Arizona.

d) Under this network leasing arrangement, BCBSAZ contracts only with the Trust. Under no circumstance will this agreement be between BCBSAZ and any Third-Party Administrator (TPA) or any other referring entity.

e) The Trust is responsible for the TPA's performance as claims administrator. BCBSAZ reserves the right to decline the Trust's choice of TPA if the proposed TPA is not a TPA that currently administers claims for other BCBSAZ Employers.

f) The Trust shall be liable for and shall either pay or cause its contracted TPA to pay BCBSAZ contracted provider medical claims no less frequently than weekly.

g) BCBSAZ's dental provider rates and fees do not apply to any Trust that has not leased BCBSAZ's dental network, regardless of whether the dental rate and fees are visible to the Trust via the TPA Portal.

h) The coinsurance benefit differential between the Trust's Medical PPO in-network and out-of-network must be 10% or greater.

i) The stated access fees do not include any Affordable Care Act ("ACA") fees. Payment of any applicable ACA fees is the responsibility of the Employer.

BlueCross BlueShield of Arizona, Inc., an Arizona Non-Profit Corporation	**Employer Trust Lake Havasu Unified School District #1 Employee Benefit Trust**
By: _____ (signature)	By: Kari Thompson (signature)
Michael Tilton (printed)	Kari Thompson (printed)
Title: **Vice President, Sales**	Title: EBT Chair
Date: 6/19/18	Date: 6-15-18

Erin P. Collins & Associates, Inc.

Phone: 928.753.4700 x302
Fax: 877.866.5732
1115 Stockton Hill Rd., Ste. 101
Kingman, AZ 86401
jaimes@ecollinsandassociates.com

MEMORANDUM

TO: **LHSEBT Trustees**

FROM: **ERIN P. COLLINS & ASSOCIATES, INC. (ECA)**
Jaime Schulenberg, Sr. Account Manager

DATE: October 11, 2018

RE: July 01, 2018 Prescription Co-Pay Implementation

As Trustees will recall, ECA learned in July that the revised prescription co-payments approved by the Board during the budget process had not been implemented by CVS because they did not receive the signed paperwork required to update their system from ECA. This error resulted in members paying a lower co-payment for generic and specialty drugs than what was adopted.

CVS ultimately updated their system and the new co-payments went into effect July 20, 2018. We had them run a report to determine the additional dollar amount the Trust would have received had the system been correct as of July 01; a copy of that report is attached for your review and information.

The column highlighted in yellow entitled "Total Copay Amount" is the amount that was actually collected; the column highlighted in green entitled "Add'l Co-Pay Owed" is the additional amount the member should have paid. The additional amount totals $1,839.57 and ECA has written a check payable to LHSEBT in that amount for deposit to make the Trust whole.

We apologize again for the error.

If you have any questions between now and the date of the meeting, I can be reached at (928) 753-4700 ext. 302 or via email at jaimes@ecollinsandassociates.com.

Havasu Claims

Report Filter:

{Claim Status Code} (ID) = "P" And {Claim Source Code} (ID) = "X" And {Claim Source Code} (ID) = "X" And {Claim Fill Date} (ID) Between 7/1/2018 and 7/19/2018 And Carrier=4929:WISRX-LAKE HAVASU SCHOOLS

Carrier		Claim Fill Date	Product/Drug Label Name	Brand/Generic/Specialty Breakout	Specialty Drug Indicator	Total Gross Cost	Total Dispensed Unit Quantity	Total Days Supply	Total Ingredient Cost Paid	Total Dispensing Fee	Total Sales Tax	Total Copay Amount	Total Net Cost	Member Applied Deductible Amount	Add'l Co-Pay Owed
4929	ACTIVES GOLD	7/18/2018	METHYLPRED TAB 4MG DPAK	Generic	N	$10.92	21	6	$10.27	$0.65	$0.00	$5.00	$5.92	$0.00	$5.00
4929	ACTIVES GOLD	7/14/2018	BUPROP 24 XL TAB 300MG	Generic	N	$62.19	90	90	$62.19	$0.00	$0.00	$15.00	$47.19	$0.00	$15.00
4929	ACTIVES GOLD	7/11/2018	HYDROC/APAP TAB 7.5-325M	Generic	N	$2.51	10	3	$1.86	$0.65	$0.00	$2.51	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	LEVOTHYROXIN TAB 0.1MG	Generic	N	$13.30	30	30	$12.65	$0.65	$0.00	$5.00	$8.30	$0.00	$5.00
4929	ACTIVES GOLD	7/16/2018	MEDROXYPR AC TAB 2.5MG	Generic	N	$3.53	30	30	$2.88	$0.65	$0.00	$3.53	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	RAMIPRIL CAP 10MG	Generic	N	$7.74	30	30	$7.09	$0.65	$0.00	$5.00	$2.74	$0.00	$2.74
4929	ACTIVES GOLD	7/9/2018	LANSOPRAZ DR CAP 30MG RX	Generic	N	$36.16	30	30	$35.51	$0.65	$0.00	$5.00	$31.16	$0.00	$5.00
4929	ACTIVES GOLD	7/9/2018	METFORMIN TAB 500MG	Generic	N	$1.63	60	30	$0.98	$0.65	$0.00	$1.63	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/9/2018	METOPROLO ER TAB SUC100MG	Generic	N	$13.64	30	30	$12.99	$0.65	$0.00	$5.00	$8.64	$0.00	$5.00
4929	ACTIVES GOLD	7/9/2018	POT CHLORIDE TAB 8MEQ ER	Generic	N	$18.39	60	30	$17.74	$0.65	$0.00	$5.00	$13.39	$0.00	$5.00
4929	ACTIVES GOLD	7/8/2018	ESTRADIOL TAB 1MG	Generic	N	$4.46	30	30	$3.81	$0.65	$0.00	$4.46	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	METHYLPHENID TAB 36MG ER	Generic	N	$445.12	60	30	$444.47	$0.65	$0.00	$5.00	$440.12	$0.00	$5.00
4929	ACTIVES GOLD	7/3/2018	METHYLPHENID TAB 10MG	Generic	N	$17.87	30	30	$17.22	$0.65	$0.00	$5.00	$12.87	$0.00	$5.00
4929	ACTIVES GOLD	7/16/2018	DEXMETHYLPH CAP 40MG ER	Generic	N	$63.99	12	12	$63.34	$0.65	$0.00	$5.00	$58.99	$0.00	$5.00
4929	ACTIVES GOLD	7/16/2018	DEXMETHYLPH TAB 5MG	Generic	N	$22.41	36	12	$21.76	$0.65	$0.00	$5.00	$17.41	$0.00	$5.00
4929	ACTIVES GOLD	7/7/2018	OXYCODONE TAB 5MG	Generic	N	$2.71	12	3	$2.06	$0.65	$0.00	$2.71	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/12/2018	PORTIA (28) TAB 0.15/30	Generic	N	$11.60	28	28	$10.95	$0.65	$0.00	$0.00	$11.60	$0.00	$0.00
4929	ACTIVES GOLD	7/8/2018	CLONAZEPAM TAB 1MG	Generic	N	$3.57	60	30	$2.92	$0.65	$0.00	$3.57	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/13/2018	PAROXETINE TAB 30MG HCL	Generic	N	$34.04	180	90	$34.04	$0.00	$0.00	$15.00	$19.04	$0.00	$15.00
4929	ACTIVES GOLD	7/18/2018	TESTOST(AN) PUM 1%12.5MG	Generic	N	$337.86	150	60	$337.21	$0.65	$0.00	$10.00	$327.86	$0.00	$10.00
4929	ACTIVES GOLD	7/5/2018	AMLODIPINE TAB 10MG	Generic	N	$2.02	30	30	$1.37	$0.65	$0.00	$2.02	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/4/2018	DULOXETINE CAP 30MG DR	Generic	N	$33.16	30	30	$32.51	$0.65	$0.00	$5.00	$28.16	$0.00	$5.00
4929	ACTIVES GOLD	7/4/2018	PROPRANOLOL TAB 20MG	Generic	N	$56.46	270	90	$56.46	$0.00	$0.00	$15.00	$41.46	$0.00	$15.00
4929	ACTIVES GOLD	7/6/2018	SERTRALINE TAB 50MG	Generic	N	$3.22	30	30	$2.57	$0.65	$0.00	$3.22	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/19/2018	ROSUVASTATIN TAB 10MG	Generic	N	$45.96	90	90	$45.96	$0.00	$0.00	$15.00	$30.96	$0.00	$15.00
4929	ACTIVES GOLD	7/16/2018	OXCARBAZEPIN TAB 150MG	Generic	N	$24.00	90	90	$24.00	$0.00	$0.00	$15.00	$9.00	$0.00	$9.00

4929	ACTIVES GOLD	7/1/2018	DULOXETINE CAP 30MG DR	Generic	N	$97.52	90	90	$97.52	$0.00	$0.00	$15.00	$82.52	$0.00	$15.00
4929	ACTIVES GOLD	7/18/2018	ALPRAZOLAM TAB 0.5MG	Generic	N	$1.80	30	30	$1.15	$0.65	$0.00	$1.80	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/19/2018	IBU TAB 600MG	Generic	N	$2.42	30	10	$1.77	$0.65	$0.00	$2.42	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	OXYCODONE TAB 5MG	Generic	N	$4.22	21	4	$3.57	$0.65	$0.00	$4.22	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	LISINOP/HCTZ TAB 20-25MG	Generic	N	$1.55	30	30	$0.90	$0.65	$0.00	$1.55	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	TRAZODONE TAB 50MG	Generic	N	$2.68	30	30	$2.03	$0.65	$0.00	$2.68	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/11/2018	CYCLOBENZAPR TAB 10MG	Generic	N	$2.16	30	10	$1.51	$0.65	$0.00	$2.16	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/11/2018	IBUPROFEN TAB 600MG	Generic	N	$3.01	40	10	$2.36	$0.65	$0.00	$3.01	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/18/2018	TIMOLOL(T) SOL 0.5% OP	Generic	N	$5.04	5	20	$4.39	$0.65	$0.00	$5.00	$0.04	$0.00	$0.04
4929	ACTIVES GOLD	7/10/2018	HYDROC/APAP TAB 10-325MG	Generic	N	$25.19	150	30	$24.54	$0.65	$0.00	$5.00	$20.19	$0.00	$5.00
4929	ACTIVES GOLD	7/15/2018	FLUOXETIN(P) CAP 20MG	Generic	N	$12.04	180	90	$12.04	$0.00	$0.00	$12.04	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/5/2018	AMPHET/DEXTR TAB 5MG	Generic	N	$64.81	90	30	$64.16	$0.65	$0.00	$5.00	$59.81	$0.00	$5.00
4929	ACTIVES GOLD	7/14/2018	TRI-LINYAH TAB	Generic	N	$8.68	28	28	$8.03	$0.65	$0.00	$0.00	$8.68	$0.00	$0.00
4929	ACTIVES GOLD	7/13/2018	HYDROCHLOROT TAB 25MG	Generic	N	$4.63	180	90	$4.63	$0.00	$0.00	$4.63	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/13/2018	TRAZODONE TAB 50MG	Generic	N	$6.08	90	90	$6.08	$0.00	$0.00	$6.08	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/11/2018	AMOX/CLAVULA TAB 500/125	Generic	N	$7.93	14	7	$7.28	$0.65	$0.00	$5.00	$2.93	$0.00	$2.93
4929	ACTIVES GOLD	7/15/2018	ATORVASTATIN TAB 40MG	Generic	N	$6.18	16	16	$5.53	$0.65	$0.00	$5.00	$1.18	$0.00	$1.18
4929	ACTIVES GOLD	7/16/2018	RANITIDINE TAB 150MG	Generic	N	$3.05	30	30	$2.40	$0.65	$0.00	$3.05	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/18/2018	CELECOXIB CAP 200MG	Generic	N	$154.30	90	90	$154.30	$0.00	$0.00	$15.00	$139.30	$0.00	$15.00
4929	ACTIVES GOLD	7/5/2018	LEVOTHYROXIN TAB 0.025MG	Generic	N	$10.48	30	30	$9.83	$0.65	$0.00	$5.00	$5.48	$0.00	$5.00
4929	ACTIVES GOLD	7/17/2018	LEVOTHYROXIN TAB 0.175MG	Generic	N	$18.49	30	30	$18.13	$0.36	$0.00	$5.00	$13.49	$0.00	$5.00
4929	ACTIVES GOLD	7/19/2018	ESCITALOPRAM TAB 10MG	Generic	N	$12.53	90	90	$12.04	$0.00	$0.49	$12.53	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	METHADONE TAB 5MG	Generic	N	$12.35	60	30	$11.70	$0.65	$0.00	$5.00	$7.35	$0.00	$5.00
4929	ACTIVES GOLD	7/17/2018	MORPHINE SUL TAB 15MG	Generic	N	$35.65	90	15	$35.00	$0.65	$0.00	$5.00	$30.65	$0.00	$5.00
4929	ACTIVES GOLD	7/10/2018	SIMVASTATIN TAB 40MG	Generic	N	$7.73	90	90	$7.73	$0.00	$0.00	$7.73	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/12/2018	NITROFUR MAC CAP 100MG	Generic	N	$92.32	90	90	$92.32	$0.00	$0.00	$15.00	$77.32	$0.00	$15.00
4929	ACTIVES GOLD	7/19/2018	TOPIRAMATE TAB 25MG	Generic	N	$17.69	270	90	$17.69	$0.00	$0.00	$15.00	$2.69	$0.00	$2.69
4929	ACTIVES GOLD	7/5/2018	ALPRAZOLAM TAB 1MG	Generic	N	$0.78	3	3	$0.13	$0.65	$0.00	$0.78	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	GLIMEPIRIDE TAB 2MG	Generic	N	$12.39	90	90	$12.39	$0.00	$0.00	$12.39	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/9/2018	PIOGLITAZONE TAB 15MG	Generic	N	$105.26	90	90	$105.26	$0.00	$0.00	$15.00	$90.26	$0.00	$15.00
4929	ACTIVES GOLD	7/8/2018	CLOPIDOGREL TAB 75MG	Generic	N	$2.86	30	30	$2.21	$0.65	$0.00	$2.86	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/8/2018	ROSUVASTATIN TAB 40MG	Generic	N	$16.14	30	30	$15.49	$0.65	$0.00	$5.00	$11.14	$0.00	$5.00

4929	ACTIVES GOLD	7/11/2018	METRONIDAZOL TAB 500MG	Generic	N	$5.99	14	7	$5.34	$0.65	$0.00	$5.00	$0.99	$0.00	$0.99
4929	ACTIVES GOLD	7/9/2018	FEMYNOR (28) TAB 0.25/35	Generic	N	$10.47	28	28	$9.82	$0.65	$0.00	$0.00	$10.47	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	HEATHER TAB 0.35MG	Generic	N	$10.88	28	28	$10.23	$0.65	$0.00	$0.00	$10.88	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	LEVOTHYROXIN TAB 0.025MG	Generic	N	$26.89	90	90	$26.89	$0.00	$0.00	$15.00	$11.89	$0.00	$11.89
4929	ACTIVES GOLD	7/1/2018	FLUCONAZOLE TAB 150MG	Generic	N	$5.09	2	3	$4.44	$0.65	$0.00	$5.00	$0.09	$0.00	$0.09
4929	ACTIVES GOLD	7/14/2018	APAP/CODEINE TAB #3	Generic	N	$10.38	60	30	$9.73	$0.65	$0.00	$5.00	$5.38	$0.00	$5.00
4929	ACTIVES GOLD	7/14/2018	FENTANYL DIS 12MCG/HR	Generic	N	$131.12	10	30	$130.47	$0.65	$0.00	$5.00	$126.12	$0.00	$5.00
4929	ACTIVES GOLD	7/14/2018	FENTANYL DIS 25MCG/HR	Generic	N	$38.59	10	30	$37.94	$0.65	$0.00	$5.00	$33.59	$0.00	$5.00
4929	ACTIVES GOLD	7/12/2018	SULFASALAZIN TAB EC 500MG	Generic	N	$42.32	180	30	$41.67	$0.65	$0.00	$5.00	$37.32	$0.00	$5.00
4929	ACTIVES GOLD	7/11/2018	DULOXETINE CAP 60MG DR	Generic	N	$97.52	90	90	$97.52	$0.00	$0.00	$15.00	$82.52	$0.00	$15.00
4929	ACTIVES GOLD	7/10/2018	LEVOTHYROXIN TAB 0.2MG	Generic	N	$44.99	90	90	$44.99	$0.00	$0.00	$15.00	$29.99	$0.00	$15.00
4929	ACTIVES GOLD	7/10/2018	LIOTHYRONINE TAB 25MCG	Generic	N	$55.67	90	90	$55.67	$0.00	$0.00	$15.00	$40.67	$0.00	$15.00
4929	ACTIVES GOLD	7/11/2018	HYDROC/APAP TAB 5-325MG	Generic	N	$4.21	30	7	$3.56	$0.65	$0.00	$4.21	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/13/2018	TERBINAFINE TAB 250MG	Generic	N	$8.13	30	30	$7.48	$0.65	$0.00	$5.00	$3.13	$0.00	$3.13
4929	ACTIVES GOLD	7/7/2018	VIENVA (28) TAB 0.1/20	Generic	N	$9.67	28	28	$9.02	$0.65	$0.00	$0.00	$9.67	$0.00	$0.00
4929	ACTIVES GOLD	7/14/2018	SYEDA(28) TAB 3-0.03MG	Generic	N	$48.08	28	28	$47.43	$0.65	$0.00	$0.00	$48.08	$0.00	$0.00
4929	ACTIVES GOLD	7/6/2018	OMEPRAZOLE CAP 20MG	Generic	N	$5.45	90	90	$5.45	$0.00	$0.00	$5.45	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/12/2018	OMEPRAZOLE CAP 20MG	Generic	N	$5.38	90	90	$5.38	$0.00	$0.00	$5.38	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	DROS/EE (28) TAB 3/30	Generic	N	$142.29	84	84	$142.29	$0.00	$0.00	$0.00	$142.29	$0.00	$0.00
4929	ACTIVES GOLD	7/12/2018	ACETAZOLAMID TAB 250MG	Generic	N	$157.72	90	90	$157.72	$0.00	$0.00	$15.00	$142.72	$0.00	$15.00
4929	ACTIVES GOLD	7/16/2018	ALPRAZOLAM TAB 0.5MG	Generic	N	$1.80	30	10	$1.15	$0.65	$0.00	$1.80	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/13/2018	WERA TAB 0.5/35	Generic	N	$57.54	84	84	$57.54	$0.00	$0.00	$0.00	$57.54	$0.00	$0.00
4929	ACTIVES GOLD	7/7/2018	AMOXICILLIN CAP 500MG	Generic	N	$2.93	30	10	$2.28	$0.65	$0.00	$2.93	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/19/2018	AMPHET/DEXTR TAB 5MG	Generic	N	$32.38	45	30	$31.73	$0.65	$0.00	$5.00	$27.38	$0.00	$5.00
4929	ACTIVES GOLD	7/14/2018	TAMSULOSIN CAP 0.4MG	Generic	N	$31.35	90	90	$31.35	$0.00	$0.00	$15.00	$16.35	$0.00	$15.00
4929	ACTIVES GOLD	7/3/2018	VALACYCLOVIR TAB 1GM	Generic	N	$9.57	14	3	$8.92	$0.65	$0.00	$5.00	$4.57	$0.00	$4.57
4929	ACTIVES GOLD	7/8/2018	NORGEST/ETHI TAB 0.25/35	Generic	N	$10.47	28	28	$9.82	$0.65	$0.00	$0.00	$10.47	$0.00	$0.00
4929	ACTIVES GOLD	7/13/2018	BENZONATATE CAP 100MG	Generic	N	$20.01	90	30	$19.36	$0.65	$0.00	$5.00	$15.01	$0.00	$5.00
4929	ACTIVES GOLD	7/2/2018	VALACYCLOVIR TAB 1GM	Generic	N	$38.89	60	8	$38.24	$0.65	$0.00	$5.00	$33.89	$0.00	$5.00
4929	ACTIVES GOLD	7/9/2018	ATORVASTATIN TAB 80MG	Generic	N	$12.10	30	30	$11.45	$0.65	$0.00	$5.00	$7.10	$0.00	$5.00
4929	ACTIVES GOLD	7/9/2018	CLOPIDOGREL TAB 75MG	Generic	N	$2.86	30	30	$2.21	$0.65	$0.00	$2.86	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	OLOPATADINE SOL 0.2%	Generic	N	$175.34	5	22	$174.69	$0.65	$0.00	$5.00	$170.34	$0.00	$5.00

4929	ACTIVES GOLD	7/15/2018	LEVOTHYROXIN TAB 0.15MG	Generic	N	$15.91	30	30	$15.26	$0.65	$0.00	$5.00	$10.91	$0.00	$5.00
4929	ACTIVES GOLD	7/15/2018	AZITHROMYCIN TAB 500MG	Generic	N	$4.40	3	3	$3.75	$0.65	$0.00	$4.40	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/3/2018	DOXYCYCL HYC TAB 100MG	Generic	N	$9.46	10	5	$8.81	$0.65	$0.00	$5.00	$4.46	$0.00	$4.46
4929	ACTIVES GOLD	7/13/2018	BENZTROPINE TAB 0.5MG	Generic	N	$6.96	60	30	$6.31	$0.65	$0.00	$5.00	$1.96	$0.00	$1.96
4929	ACTIVES GOLD	7/13/2018	DIVALPROEX TAB 500MG ER	Generic	N	$49.33	60	30	$48.68	$0.65	$0.00	$5.00	$44.33	$0.00	$5.00
4929	ACTIVES GOLD	7/13/2018	LITHIUM CARB TAB 450MG ER	Generic	N	$15.07	60	30	$14.42	$0.65	$0.00	$5.00	$10.07	$0.00	$5.00
4929	ACTIVES GOLD	7/5/2018	CLINDAMY/BEN GEL 1-5%PUMP	Generic	N	$710.11	100	30	$709.46	$0.65	$0.00	$5.00	$705.11	$0.00	$5.00
4929	ACTIVES GOLD	7/4/2018	AMANTADINE CAP 100MG	Generic	N	$25.69	28	28	$25.69	$0.00	$0.00	$5.00	$20.69	$0.00	$5.00
4929	ACTIVES GOLD	7/4/2018	LEVOTHYROXIN TAB 0.05MG	Generic	N	$11.81	30	30	$11.16	$0.65	$0.00	$5.00	$6.81	$0.00	$5.00
4929	ACTIVES GOLD	7/1/2018	CLOBETASOL OIN 0.05%	Generic	N	$276.51	45	20	$275.86	$0.65	$0.00	$5.00	$271.51	$0.00	$5.00
4929	ACTIVES GOLD	7/16/2018	LEVOCETIRIZI TAB 5MG	Generic	N	$9.56	30	30	$8.91	$0.65	$0.00	$5.00	$4.56	$0.00	$4.56
4929	ACTIVES GOLD	7/2/2018	SYEDA(28) TAB 3-0.03MG	Generic	N	$143.86	84	84	$143.86	$0.00	$0.00	$0.00	$143.86	$0.00	$0.00
4929	ACTIVES GOLD	7/12/2018	DULOXETINE CAP 30MG DR	Generic	N	$192.91	180	90	$192.91	$0.00	$0.00	$15.00	$177.91	$0.00	$15.00
4929	ACTIVES GOLD	7/5/2018	CRYSELLE(28) TAB 0.3/30	Generic	N	$47.36	84	84	$47.36	$0.00	$0.00	$0.00	$47.36	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	LOSARTAN TAB 25MG	Generic	N	$9.27	90	90	$9.27	$0.00	$0.00	$9.27	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	ESCITALOPRAM TAB 20MG	Generic	N	$13.69	90	90	$13.69	$0.00	$0.00	$13.69	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/5/2018	BUPROP 12 SR TAB 200MG	Generic	N	$47.71	90	90	$47.71	$0.00	$0.00	$15.00	$32.71	$0.00	$15.00
4929	ACTIVES GOLD	7/5/2018	IBU TAB 800MG	Generic	N	$2.83	30	10	$2.18	$0.65	$0.00	$2.83	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/5/2018	NITROFUR MON CAP 100MG	Generic	N	$14.76	14	7	$14.11	$0.65	$0.00	$5.00	$9.76	$0.00	$5.00
4929	ACTIVES GOLD	7/19/2018	AMPHET/DEXTR CAP 25MG ER	Generic	N	$91.31	30	30	$90.66	$0.65	$0.00	$5.00	$86.31	$0.00	$5.00
4929	ACTIVES GOLD	7/19/2018	AMPHET/DEXTR CAP 20MG ER	Generic	N	$89.20	30	30	$88.55	$0.65	$0.00	$5.00	$84.20	$0.00	$5.00
4929	ACTIVES GOLD	7/11/2018	TESTOST CYP SDV 200MG/ML	Generic	N	$35.42	2	28	$34.77	$0.65	$0.00	$5.00	$30.42	$0.00	$5.00
4929	ACTIVES GOLD	7/3/2018	LEVOTHYROXIN TAB 0.05MG	Generic	N	$4.00	30	30	$4.00	$0.00	$0.00	$4.00	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/2/2018	AMOXICILLIN CAP 500MG	Generic	N	$2.25	21	7	$1.60	$0.65	$0.00	$2.25	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/14/2018	SPRINTEC TAB 0.25/35	Generic	N	$10.36	28	28	$9.71	$0.65	$0.00	$0.00	$10.36	$0.00	$0.00
4929	ACTIVES GOLD	7/13/2018	TECFIDERA CAP 240MG	Specialty	Y	$7,380.28	60	30	$7,380.28	$0.00	$0.00	$35.00	$7,345.28	$0.00	$265.00
4929	ACTIVES GOLD	7/9/2018	OXYCOD/APAP TAB 5-325MG	Generic	N	$2.11	10	2	$1.46	$0.65	$0.00	$2.11	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/6/2018	VIENVA (28) TAB 0.1/20	Generic	N	$9.67	28	28	$9.02	$0.65	$0.00	$0.00	$9.67	$0.00	$0.00
4929	ACTIVES GOLD	7/19/2018	PRAVASTATIN TAB 20MG	Generic	N	$42.22	90	90	$42.22	$0.00	$0.00	$15.00	$27.22	$0.00	$15.00
4929	ACTIVES GOLD	7/19/2018	SERTRALINE TAB 100MG	Generic	N	$8.33	90	90	$8.33	$0.00	$0.00	$8.33	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	ASPIR-LOW TAB 81MG EC	Generic	N	$1.42	90	90	$1.42	$0.00	$0.00	$0.00	$1.42	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	CARVEDILOL TAB 3.125MG	Generic	N	$3.10	60	15	$2.45	$0.65	$0.00	$3.10	$0.00	$0.00	$0.00

4929	ACTIVES GOLD	7/17/2018	ISOSORB MONO TAB 30MG ER	Generic	N	$7.01	30	30	$6.36	$0.65	$0.00	$5.00	$2.01	$0.00	$2.01
4929	ACTIVES GOLD	7/17/2018	LEVOTHYROXIN TAB 0.1MG	Generic	N	$11.99	30	30	$11.99	$0.00	$0.00	$5.00	$6.99	$0.00	$5.00
4929	ACTIVES GOLD	7/17/2018	LORAZEPAM TAB 0.5MG	Generic	N	$1.75	30	15	$1.10	$0.65	$0.00	$1.75	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	LOSARTAN TAB 50MG	Generic	N	$4.84	30	30	$4.19	$0.65	$0.00	$4.84	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/19/2018	BUPROP 12 SR TAB 150MG(W)	Generic	N	$15.61	90	90	$15.61	$0.00	$0.00	$15.00	$0.61	$0.00	$0.61
4929	ACTIVES GOLD	7/16/2018	POT CHLORIDE TAB 20MEQ ER	Generic	N	$8.51	30	30	$7.86	$0.65	$0.00	$5.00	$3.51	$0.00	$3.51
4929	ACTIVES GOLD	7/14/2018	FOLIC ACID TAB 1MG	Generic	N	$1.42	30	30	$0.77	$0.65	$0.00	$1.42	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/14/2018	PANTOPRAZOLE TAB 40MG DR	Generic	N	$5.37	30	30	$4.72	$0.65	$0.00	$5.00	$0.37	$0.00	$0.37
4929	ACTIVES GOLD	7/1/2018	GABAPENTIN CAP 300MG	Generic	N	$15.58	270	90	$15.58	$0.00	$0.00	$15.00	$0.58	$0.00	$0.58
4929	ACTIVES GOLD	7/12/2018	FLUOROMETHOL SUS 0.1% OP	Generic	N	$64.60	5	22	$63.95	$0.65	$0.00	$5.00	$59.60	$0.00	$5.00
4929	ACTIVES GOLD	7/12/2018	OLOPATADINE SOL 0.2% OP	Generic	N	$262.03	8	90	$262.03	$0.00	$0.00	$15.00	$247.03	$0.00	$15.00
4929	ACTIVES GOLD	7/6/2018	HYDROCHLOROT TAB 25MG	Generic	N	$1.43	30	30	$0.78	$0.65	$0.00	$1.43	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/6/2018	LISINOPRIL TAB 40MG	Generic	N	$3.47	30	30	$2.82	$0.65	$0.00	$3.47	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/3/2018	LEVOTHYROXIN TAB 0.088MG	Generic	N	$11.99	30	30	$11.99	$0.00	$0.00	$5.00	$6.99	$0.00	$5.00
4929	ACTIVES GOLD	7/19/2018	MONTELUKAST TAB 10MG	Generic	N	$18.88	90	90	$18.88	$0.00	$0.00	$15.00	$3.88	$0.00	$3.88
4929	ACTIVES GOLD	7/18/2018	APAP/CODEINE SOL 120-12/5	Generic	N	$2.31	100	5	$1.66	$0.65	$0.00	$2.31	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/12/2018	DULOXETINE CAP 60MG DR	Generic	N	$97.52	90	90	$97.52	$0.00	$0.00	$15.00	$82.52	$0.00	$15.00
4929	ACTIVES GOLD	7/5/2018	HYDROXYZ HCL TAB 10MG	Generic	N	$11.48	90	90	$11.48	$0.00	$0.00	$11.48	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	LEVOTHYROXIN TAB 0.075MG	Generic	N	$37.00	90	90	$37.00	$0.00	$0.00	$15.00	$22.00	$0.00	$15.00
4929	ACTIVES GOLD	7/12/2018	PAROXETINE TAB 10MG HCL	Generic	N	$8.15	90	90	$8.15	$0.00	$0.00	$8.15	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/10/2018	LISINOPRIL TAB 10MG	Generic	N	$1.70	30	30	$1.05	$0.65	$0.00	$1.70	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/5/2018	LEVOTHYROXIN TAB 0.1MG	Generic	N	$13.82	30	30	$13.17	$0.65	$0.00	$5.00	$8.82	$0.00	$5.00
4929	ACTIVES GOLD	7/10/2018	HYDROC/APAP TAB 7.5-325M	Generic	N	$23.26	120	30	$22.61	$0.65	$0.00	$5.00	$18.26	$0.00	$5.00
4929	ACTIVES GOLD	7/10/2018	OMEPRAZOL DR CAP 40MG RX	Generic	N	$6.28	30	30	$5.63	$0.65	$0.00	$5.00	$1.28	$0.00	$1.28
4929	ACTIVES GOLD	7/3/2018	OXYCOD/APAP TAB 5-325MG	Generic	N	$6.50	40	10	$5.85	$0.65	$0.00	$5.00	$1.50	$0.00	$1.50
4929	ACTIVES GOLD	7/2/2018	ALPRAZOLAM TAB 0.5MG	Generic	N	$1.81	30	30	$1.16	$0.65	$0.00	$1.81	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/3/2018	KETOCONAZOLE CRE 2%	Generic	N	$25.81	15	5	$25.16	$0.65	$0.00	$5.00	$20.81	$0.00	$5.00
4929	ACTIVES GOLD	7/13/2018	METOPROLOL TAB TAR 25MG	Generic	N	$2.43	60	30	$1.78	$0.65	$0.00	$2.43	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/9/2018	FENOFIBRATE TAB 160MG	Generic	N	$37.18	30	30	$36.53	$0.65	$0.00	$5.00	$32.18	$0.00	$5.00
4929	ACTIVES GOLD	7/5/2018	VENLAFAXINE TAB 75MG	Generic	N	$11.69	30	30	$11.04	$0.65	$0.00	$5.00	$6.69	$0.00	$5.00
4929	ACTIVES GOLD	7/16/2018	GABAPENTIN CAP 300MG	Generic	N	$4.08	60	30	$3.43	$0.65	$0.00	$4.08	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	PRAMIPEXOLE TAB 0.75MGER	Generic	N	$2,178.59	180	90	$2,178.59	$0.00	$0.00	$15.00	$2,163.59	$0.00	$15.00

4929	ACTIVES GOLD	7/18/2018	LEVALBUTEROL INH HFA 200	Generic	N	$54.99	15	16	$54.99	$0.00	$0.00	$5.00	$49.99	$0.00	$5.00
4929	ACTIVES GOLD	7/15/2018	HYDROCHLOROT TAB 12.5MG	Generic	N	$28.66	90	90	$28.66	$0.00	$0.00	$15.00	$13.66	$0.00	$13.66
4929	ACTIVES GOLD	7/15/2018	LISINOPRIL TAB 40MG	Generic	N	$8.37	90	90	$8.37	$0.00	$0.00	$8.37	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	AMITRIPTYLIN TAB 50MG	Generic	N	$40.64	90	90	$40.64	$0.00	$0.00	$15.00	$25.64	$0.00	$15.00
4929	ACTIVES GOLD	7/6/2018	LEVOFLOXACIN TAB 500MG	Generic	N	$3.25	7	7	$2.60	$0.65	$0.00	$3.25	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/2/2018	SPIRONOLACT TAB 25MG	Generic	N	$8.39	90	90	$8.39	$0.00	$0.00	$8.39	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/9/2018	ESTRA/NORETH TAB 1-0.5MG	Generic	N	$103.24	28	28	$102.59	$0.65	$0.00	$5.00	$98.24	$0.00	$5.00
4929	ACTIVES GOLD	7/1/2018	LEVOTHYROXIN TAB 0.112MG	Generic	N	$43.85	90	90	$43.85	$0.00	$0.00	$15.00	$28.85	$0.00	$15.00
4929	ACTIVES GOLD	7/18/2018	RANITIDINE TAB 300MG	Generic	N	$6.89	30	30	$6.24	$0.65	$0.00	$5.00	$1.89	$0.00	$1.89
4929	ACTIVES GOLD	7/12/2018	CHERATUSSIN SOL AC/SF	Generic	N	$18.78	240	6	$18.13	$0.65	$0.00	$5.00	$13.78	$0.00	$5.00
4929	ACTIVES GOLD	7/17/2018	LISINOPRIL TAB 20MG	Generic	N	$2.20	30	30	$1.55	$0.65	$0.00	$2.20	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/4/2018	BUTORPHANOL SPR NASAL	Generic	N	$69.58	5	30	$68.93	$0.65	$0.00	$5.00	$64.58	$0.00	$5.00
4929	ACTIVES GOLD	7/17/2018	BUPRENORPHIN SUB 2MG	Generic	N	$12.89	11	7	$12.24	$0.65	$0.00	$5.00	$7.89	$0.00	$5.00
4929	ACTIVES GOLD	7/11/2018	BUPRENORPHIN SUB 2MG	Generic	N	$20.69	18	7	$20.04	$0.65	$0.00	$5.00	$15.69	$0.00	$5.00
4929	ACTIVES GOLD	7/5/2018	BUPRENORPHIN SUB 2MG	Generic	N	$20.91	18	7	$20.26	$0.65	$0.00	$5.00	$15.91	$0.00	$5.00
4929	ACTIVES GOLD	7/2/2018	BUPRENORPHIN SUB 2MG	Generic	N	$13.03	11	7	$12.38	$0.65	$0.00	$5.00	$8.03	$0.00	$5.00
4929	ACTIVES GOLD	7/2/2018	CELECOXIB CAP 200MG	Generic	N	$156.01	90	90	$156.01	$0.00	$0.00	$15.00	$141.01	$0.00	$15.00
4929	ACTIVES GOLD	7/18/2018	ESTRADIOL(V) DIS 0.05/24	Generic	N	$82.21	8	30	$81.56	$0.65	$0.00	$5.00	$77.21	$0.00	$5.00
4929	ACTIVES GOLD	7/17/2018	LOSARTAN TAB 50MG	Generic	N	$4.84	30	30	$4.19	$0.65	$0.00	$4.84	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/19/2018	CYCLOBENZAPR TAB 5MG	Generic	N	$3.57	35	6	$2.92	$0.65	$0.00	$3.57	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/19/2018	KETOROLAC TAB 10MG	Generic	N	$20.72	20	5	$20.07	$0.65	$0.00	$5.00	$15.72	$0.00	$5.00
4929	ACTIVES GOLD	7/19/2018	OXYCOD/APAP TAB 5-325MG	Generic	N	$6.43	40	3	$5.78	$0.65	$0.00	$5.00	$1.43	$0.00	$1.43
4929	ACTIVES GOLD	7/18/2018	HYDROC/APAP TAB 10-325MG	Generic	N	$15.21	90	30	$14.56	$0.65	$0.00	$5.00	$10.21	$0.00	$5.00
4929	ACTIVES GOLD	7/15/2018	CARISOPRODOL TAB 350MG	Generic	N	$4.55	60	30	$3.90	$0.65	$0.00	$4.55	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/12/2018	DULOXETINE CAP 30MG DR	Generic	N	$96.45	90	90	$96.45	$0.00	$0.00	$15.00	$81.45	$0.00	$15.00
4929	ACTIVES GOLD	7/12/2018	DULOXETINE CAP 60MG DR	Generic	N	$97.52	90	90	$97.52	$0.00	$0.00	$15.00	$82.52	$0.00	$15.00
4929	ACTIVES GOLD	7/10/2018	VALACYCLOVIR TAB 1GM	Generic	N	$114.71	180	90	$114.71	$0.00	$0.00	$15.00	$99.71	$0.00	$15.00
4929	ACTIVES GOLD	7/9/2018	FENOFIBRIC CAP 45MG DR	Generic	N	$77.97	90	90	$77.97	$0.00	$0.00	$15.00	$62.97	$0.00	$15.00
4929	ACTIVES GOLD	7/9/2018	METFORMIN TAB 500MG	Generic	N	$2.95	180	90	$2.95	$0.00	$0.00	$2.95	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/3/2018	ESTRADIOL(V) DIS 0.025/24	Generic	N	$68.62	8	28	$67.97	$0.65	$0.00	$5.00	$63.62	$0.00	$5.00
4929	ACTIVES GOLD	7/4/2018	TOPIRAMATE TAB 50MG	Generic	N	$4.14	30	30	$3.49	$0.65	$0.00	$4.14	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/19/2018	BUPROP 24 XL TAB 300MG	Generic	N	$62.19	90	90	$62.19	$0.00	$0.00	$15.00	$47.19	$0.00	$15.00

4929	ACTIVES GOLD	7/8/2018	FEMYNOR (28) TAB 0.25/35	Generic	N	$10.47	28	28	$9.82	$0.65	$0.00	$0.00	$10.47	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	LACTULOS ORL SOL 10GM/15	Generic	N	$7.65	473	16	$7.00	$0.65	$0.00	$5.00	$2.65	$0.00	$2.65
4929	ACTIVES GOLD	7/3/2018	LACTULOS ORL SOL 10GM/15	Generic	N	$7.75	473	15	$7.10	$0.65	$0.00	$5.00	$2.75	$0.00	$2.75
4929	ACTIVES GOLD	7/13/2018	ALENDRONATE TAB 70MG	Generic	N	$4.11	4	28	$3.46	$0.65	$0.00	$4.11	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/9/2018	IPRATR/ALBUT SOL INH 60'S	Generic	N	$24.16	360	30	$23.51	$0.65	$0.00	$5.00	$19.16	$0.00	$5.00
4929	ACTIVES GOLD	7/5/2018	CAYSTON INH 75MG	Specialty	Y	$8,510.13	84	28	$8,509.48	$0.65	$0.00	$65.00	$8,445.13	$0.00	$265.00
4929	ACTIVES GOLD	7/5/2018	SYMDEKO TAB 100-150	Specialty	Y	$22,311.05	56	28	$22,310.40	$0.65	$0.00	$65.00	$22,246.05	$0.00	$265.00
4929	ACTIVES GOLD	7/19/2018	CYCLOBENZAPR TAB 10MG	Generic	N	$2.16	30	10	$1.51	$0.65	$0.00	$2.16	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/19/2018	IBU TAB 800MG	Generic	N	$2.81	30	10	$2.16	$0.65	$0.00	$2.81	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/14/2018	CEPHALEXIN CAP 500MG	Generic	N	$2.55	21	7	$1.90	$0.65	$0.00	$2.55	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/14/2018	MUPIROCIN OIN 2%	Generic	N	$7.46	22	10	$6.81	$0.65	$0.00	$5.00	$2.46	$0.00	$2.46
4929	ACTIVES GOLD	7/18/2018	DULOXETINE CAP 60MG DR	Generic	N	$97.52	90	90	$97.52	$0.00	$0.00	$15.00	$82.52	$0.00	$15.00
4929	ACTIVES GOLD	7/11/2018	FEMYNOR (28) TAB 0.25/35	Generic	N	$10.36	28	28	$9.71	$0.65	$0.00	$0.00	$10.36	$0.00	$0.00
4929	ACTIVES GOLD	7/8/2018	LEVO/EE (28) TAB 0.1/20	Generic	N	$9.67	28	28	$9.02	$0.65	$0.00	$0.00	$9.67	$0.00	$0.00
4929	ACTIVES GOLD	7/16/2018	ARIPIPRAZOLE TAB 5MG	Generic	N	$3.80	15	30	$3.15	$0.65	$0.00	$3.80	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/5/2018	TIMOLOL MAL TAB 5MG	Generic	N	$62.60	60	30	$61.95	$0.65	$0.00	$5.00	$57.60	$0.00	$5.00
4929	ACTIVES GOLD	7/3/2018	ERRIN TAB 0.35MG	Generic	N	$31.04	84	84	$31.04	$0.00	$0.00	$0.00	$31.04	$0.00	$0.00
4929	ACTIVES GOLD	7/14/2018	SMZ/TMP DS TAB 800-160	Generic	N	$2.07	14	7	$1.42	$0.65	$0.00	$2.07	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/9/2018	SMZ/TMP DS TAB 800-160	Generic	N	$2.08	14	7	$1.43	$0.65	$0.00	$2.08	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	TRIAMCINOLON CRE 0.5%	Generic	N	$25.35	60	14	$24.70	$0.65	$0.00	$5.00	$20.35	$0.00	$5.00
4929	ACTIVES GOLD	7/12/2018	OMEPRAZOLE CAP 20MG	Generic	N	$2.44	30	30	$1.79	$0.65	$0.00	$2.44	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/18/2018	CHLORHEX GLU SOL 0.12%	Generic	N	$3.68	473	16	$3.03	$0.65	$0.00	$3.68	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/18/2018	IBU TAB 800MG	Generic	N	$2.16	21	6	$1.51	$0.65	$0.00	$2.16	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/18/2018	OXYCOD/APAP TAB 7.5-325	Generic	N	$9.89	20	5	$9.24	$0.65	$0.00	$5.00	$4.89	$0.00	$4.89
4929	ACTIVES GOLD	7/17/2018	AZITHROMYCIN TAB 500MG	Generic	N	$4.40	3	3	$3.75	$0.65	$0.00	$4.40	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	LORAZEPAM TAB 2MG	Generic	N	$0.81	2	2	$0.16	$0.65	$0.00	$0.81	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/11/2018	LAMOTRIGINE TAB 100MG	Generic	N	$4.31	60	20	$3.66	$0.65	$0.00	$4.31	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/2/2018	ESCITALOPRAM TAB 10MG	Generic	N	$12.18	90	90	$12.18	$0.00	$0.00	$12.18	$0.00	$0.00	$0.00
4929	ACTIVES GOLD	7/17/2018	RANITIDINE TAB 150MG	Generic	N	$5.44	60	30	$4.79	$0.65	$0.00	$5.00	$0.44	$0.00	$0.44
4929	ACTIVES GOLD	7/5/2018	METHYLPRED TAB 4MG DPAK	Generic	N	$11.04	21	6	$10.39	$0.65	$0.00	$5.00	$6.04	$0.00	$5.00
4929	ACTIVES GOLD	7/5/2018	MULTI-VIT/FL DRO 0.25MG	Generic	N	$21.43	50	50	$20.78	$0.65	$0.00	$10.00	$11.43	$0.00	$10.00
4929	ACTIVES GOLD	7/12/2018	LORAZEPAM TAB 1MG	Generic	N	$7.19	120	30	$6.54	$0.65	$0.00	$5.00	$2.19	$0.00	$2.19

4929	ACTIVES GOLD	7/12/2018	VENLAFAXINE TAB 75MG	Generic	N	$11.57	30	30	$10.92	$0.65	$0.00	$5.00	$6.57	$0.00	$5.00
4929	ACTIVES GOLD	7/12/2018	ZIPRASIDONE CAP 20MG	Generic	N	$30.77	30	30	$30.12	$0.65	$0.00	$5.00	$25.77	$0.00	$5.00
4929	RETIREES GOLD	7/10/2018	FLUOROMETHOL SUS 0.1% OP	Generic	N	$64.60	5	22	$63.95	$0.65	$0.00	$5.00	$59.60	$0.00	$5.00
4929	RETIREES GOLD	7/18/2018	LOSARTAN/HCT TAB 100-25	Generic	N	$19.99	90	90	$19.99	$0.00	$0.00	$15.00	$4.99	$0.00	$4.99
4929	RETIREES GOLD	7/11/2018	SOD CHLORIDE NEB 0.9% 3ML	Generic	N	$32.65	300	30	$32.00	$0.65	$0.00	$5.00	$27.65	$0.00	$5.00
4929	RETIREES GOLD	7/11/2018	VALSARTN HCT TAB 320/12.5	Generic	N	$19.61	30	30	$18.96	$0.65	$0.00	$5.00	$14.61	$0.00	$5.00
4929	RETIREES GOLD	7/5/2018	LATANOPROST SOL .005% OP	Generic	N	$8.91	3	25	$8.26	$0.65	$0.00	$5.00	$3.91	$0.00	$3.91
4929	RETIREES GOLD	7/16/2018	DULOXETINE CAP 60MG DR	Generic	N	$97.52	90	90	$97.52	$0.00	$0.00	$15.00	$82.52	$0.00	$15.00
4929	RETIREES GOLD	7/12/2018	PAROXETINE TAB 10MG HCL	Generic	N	$8.15	90	90	$8.15	$0.00	$0.00	$8.15	$0.00	$0.00	$0.00
4929	RETIREES GOLD	7/14/2018	ENOXAPARIN#1 SYN 40/0.4ML	Generic	N	$108.04	11	28	$108.04	$0.00	$0.00	$5.00	$103.04	$0.00	$5.00
4929	RETIREES GOLD	7/14/2018	HYDROC/APAP TAB 5-325MG	Generic	N	$5.40	40	5	$4.75	$0.65	$0.00	$5.00	$0.40	$0.00	$0.40
4929	RETIREES GOLD	7/14/2018	ONDANSETRON ODT 4MG	Generic	N	$5.37	20	7	$4.72	$0.65	$0.00	$5.00	$0.37	$0.00	$0.37
4929	RETIREES GOLD	7/19/2018	OFLOXACIN SOL 0.3% OP	Generic	N	$12.78	5	7	$12.13	$0.65	$0.00	$5.00	$7.78	$0.00	$5.00
4929	RETIREES GOLD	7/19/2018	PRED ACETATE SUS 1% OP	Generic	N	$36.79	5	23	$36.79	$0.00	$0.00	$5.00	$31.79	$0.00	$5.00
4929	RETIREES GOLD	7/2/2018	AMPHET/DEXTR CAP 30MG ER	Generic	N	$90.19	30	30	$89.54	$0.65	$0.00	$5.00	$85.19	$0.00	$5.00
4929	RETIREES GOLD	7/12/2018	GABAPENTIN CAP 100MG	Generic	N	$5.02	90	30	$4.37	$0.65	$0.00	$5.00	$0.02	$0.00	$0.02
4929	RETIREES GOLD	7/18/2018	LISINOPRIL TAB 5MG	Generic	N	$2.72	90	90	$2.72	$0.00	$0.00	$2.72	$0.00	$0.00	$0.00
4929	RETIREES GOLD	7/7/2018	RANITIDINE TAB 300MG	Generic	N	$18.94	90	90	$18.94	$0.00	$0.00	$15.00	$3.94	$0.00	$3.94
4929	RETIREES GOLD	7/16/2018	BUMETANIDE TAB 1MG	Generic	N	$56.47	90	90	$56.47	$0.00	$0.00	$15.00	$41.47	$0.00	$15.00
4929	RETIREES GOLD	7/16/2018	MIDODRINE TAB 5MG	Generic	N	$147.74	360	90	$147.74	$0.00	$0.00	$15.00	$132.74	$0.00	$15.00
4929	RETIREES GOLD	7/9/2018	PANTOPRAZOLE TAB 40MG DR	Generic	N	$14.30	90	90	$14.30	$0.00	$0.00	$14.30	$0.00	$0.00	$0.00
4929	RETIREES GOLD	7/18/2018	SIMVASTATIN TAB 20MG	Generic	N	$5.19	90	90	$5.19	$0.00	$0.00	$5.19	$0.00	$0.00	$0.00
4929	RETIREES GOLD	7/16/2018	NIFEDIPIN CC TAB 90MG ER	Generic	N	$98.95	90	90	$98.95	$0.00	$0.00	$15.00	$83.95	$0.00	$15.00
4929	RETIREES GOLD	7/11/2018	BETAMETH DIP OIN 0.05%AUG	Generic	N	$96.43	45	15	$95.78	$0.65	$0.00	$5.00	$91.43	$0.00	$5.00
4929	RETIREES GOLD	7/11/2018	KETOCONAZOLE CRE 2%	Generic	N	$42.63	30	10	$41.98	$0.65	$0.00	$5.00	$37.63	$0.00	$5.00
4929	RETIREES GOLD	7/11/2018	KETOCONAZOLE SHA 2%	Generic	N	$9.61	120	30	$8.96	$0.65	$0.00	$5.00	$4.61	$0.00	$4.61
4929	RETIREES GOLD	7/9/2018	LEVOTHYROXIN TAB 0.1MG	Generic	N	$37.93	90	90	$37.93	$0.00	$0.00	$15.00	$22.93	$0.00	$15.00
4929	RETIREES GOLD	7/4/2018	AMLOD/OLMESA TAB 10-40MG	Generic	N	$67.25	30	30	$66.60	$0.65	$0.00	$5.00	$62.25	$0.00	$5.00
4929	RETIREES GOLD	7/1/2018	PAROXETINE TAB 40MG HCL	Generic	N	$14.78	83	83	$14.13	$0.65	$0.00	$14.78	$0.00	$0.00	$0.00
4929	RETIREES GOLD	7/5/2018	ZOLPIDEM ER TAB 12.5MG	Generic	N	$135.95	90	90	$135.95	$0.00	$0.00	$15.00	$120.95	$0.00	$15.00
4929	RETIREES GOLD	7/17/2018	OMEPRAZOLE CAP 20MG	Generic	N	$5.38	90	90	$5.38	$0.00	$0.00	$5.38	$0.00	$0.00	$0.00
4929	RETIREES GOLD	7/2/2018	IRBESART/HCT TAB 150-12.5	Generic	N	$31.37	90	90	$31.37	$0.00	$0.00	$15.00	$16.37	$0.00	$15.00

4929	RETIREES GOLD	7/9/2018	TIZANIDINE TAB 4MG	Generic	N	$13.73	90	30	$13.08	$0.65	$0.00	$5.00	$8.73	$0.00	$5.00
						$49,334.40						$1,738.40			**$1,839.57**

Erin P. Collins & Associates, Inc.

Phone: 928.753.4700 x302
Fax: 877.866.5732
1115 Stockton Hill Rd., Ste. 101
Kingman, AZ 86401
jaimes@ecollinsandassociates.com

MEMORANDUM

TO: **LHSEBT Trustees**

FROM: **ERIN P. COLLINS & ASSOCIATES, INC. (ECA)**
Jaime Schulenberg, Sr. Account Manager

DATE: October 11, 2018

RE: Approval of July 19, August 20, August 29 and September 12, 2018 Regular and Executive Meeting Minutes

Attached are the minutes from the Trust meetings held on July 19, March 08, August 20 and 29 and September 12, 2018. Please note that Executive Meeting Minutes from August 20 and 29 will be distributed for your review at the meeting in accordance with guidance from legal counsel.

We would request approval of the minutes as presented.

If you should have any questions between now and the date of the meeting, feel free to call or email me at (928) 753-4700 x302 or jaimes@ecollinsandassociates.com.

Minutes Unconfirmed

LAKE HAVASU UNIFIED SCHOOL DISTRICT #1

EMPLOYEE BENEFIT TRUST

BOARD OF TRUSTEES MEETING – JULY 19, 2018

TRUST MEMBERS PARTICIPATING

Dr. Fadi Atassi, Amy Barney, Hal Christiansen, Marcia Cox, Pat Rooney

OTHERS PARTICIPATING

Mike Bonney, GDK
Joyce Perez, Gilsbar
Jaime Schulenberg - Erin P. Collins & Associates

OTHERS ATTENDING (PER SIGN IN SHEET)

Diana Asseier – LHUSD #1
Nichole Cohen
Kathy Cox
Nissa Harris
Andrea Helart
Ann Taffey

Meeting called to order at 5:04 p.m. Roll call was taken. Pledge to the flag followed with moment of silence.

Call to the Public:

None.

Introduction of New Trustees:

Vice Chairperson Marcia Cox announced that the Governing Board had appointed two new Trustees effective July 01, 2018: Amy Barney, a math teacher who has been with the District for 11 years; and Julie Sasseen, Business Development and Physician Relations Director at HRMC. Ms. Sasseen is on vacation and unable to attend the meeting. Vice Chairperson Cox welcomed the new Trustees.

Discussion and Possible Action re Interim Legal Counsel:

Jaime Schulenberg reminded Trustees that during the May 11, 2018 meeting, they had requested that the appointment of interim legal counsel be placed on a future agenda for consideration. Ms. Schulenberg had obtained a proposal and letter of engagement from Michael Hensley at Jones Skelton & Hochuli since Mr. Hensley is familiar with the Trust and able to provide the necessary services. She

reviewed the proposed rates as compared to current legal counsel, Cavanaugh Law Firm, which was $250/hr. for Mr. Hensley as compared to $350/hr. for Ms. Sellers.

ECA recommended that the Board approve Jones Skelton & Hochuli as interim legal counsel and authorize the Vice Chairperson to sign the engagement letter on behalf of the Trust.

Member Christiansen asked whether Mr. Hensley charges the Board for travel if he drives down to Lake Havasu City for meetings and Ms. Schulenberg confirmed that was accurate. It was suggested that where possible and practicable, the attorney attend meetings by phone.

Member Christiansen made a motion to approve Jones Skelton & Hochuli as interim legal counsel and authorize the Vice Chairperson to sign the letter of engagement.

Member Atassi seconds the motion.

Member Atassi: YES, Amy Barney: YES, Hal Christiansen: YES, Marcia Cox: YES

Motion unanimously approved by Trustees in attendance.

Update on Legal Request for Proposal:

Ms. Schulenberg reported on the RFP for Legal Services authorized by the Board at the May 11, 2018 meeting. Responses are due August 02, 2018 and were provided to 4 law firms: Cavanaugh, Fennemore Craig, Gust Rosenfield and Jones Skelton & Hochuli, all well-respected firms with a specialty in employee benefits. Once responses are received, ECA will analyze and prepare a report and recommendation to Trustees at a special meeting in August.

Vice Chairperson Cox asked whether the District would be provided with the original responses and Ms. Schulenberg responded that she would provide them with the original RFP and all responses since they are the custodian of records.

Ratification of Reinsurance:

Ms. Schulenberg advised Trustees that the reinsurance had been placed for the 2018-19 plan year with the incumbent carrier at the same specific level of $130,000. ECA had originally budgeted a 35% increase in premium based on the addition of prescriptions to the contract, however, the actual increase came in at approximately 59% over expiring. The significant increase was due to both the addition of prescription coverage as well as a number of high dollar claims. Ms. Schulenberg also pointed out that the reinsurance included 3 lasers, which she explained is a deductible assigned to a specific person that the carrier has identified as a higher level risk than the other plan members.

ECA recommended that the reinsurance renewal be ratified as of July 01, 2018.

Member Christiansen made a motion to ratify the reinsurance renewal effective July 01, 2018.

Member Atassi second the motion.

Fadi Atassi: YES, Amy Barney: YES, Hal Christiansen: YES, Marcia Cox: YES

Motion unanimously approved by Trustees in attendance.

Approval of Meeting Minutes from February 07, February 21, March 08, April 25, May 11 (as revised), and June 29, 2018:

Member Christiansen made a motion to approve the minutes as revised.

Member Atassi second the motion.

Fadi Atassi: YES, Amy Barney: ABSTAIN, Hal Christiansen: YES, Marcia Cox: YES

Motion approved by majority of Trustees in attendance.

Approval of December 2017 through June 30, 2018 Financial Reports:

Mike Bonney from GDK reviewed the financial reports through June 30, 2018, including the Statement of Activity. He reported that the Trust ended the year with $1.1M and is solvent with no concerns from an accounting or audit standpoint. He did point out that the contract with GDK had expired on June 30, 2018 and offered to continue to provide services under the existing agreement until such time as a new engagement could be discussed.

Mr. Bonney also recommended that the Board consider moving from a cash to accrual basis of accounting in order to provide a more accurate view of the financial status of the Trust.

Vice Chairperson Cox asked if there was any further information on the unrecognized amount of $144,000 from the period of time when the bank accounts weren't reconciled and Mr. Bonney indicated there is no way to find that. He did say, however, that he believes it was likely a double entry or something of that nature.

Nichole Cohen asked whether one of the Wells Fargo accounts was considered a "retiree" account and Ms. Schulenberg said that no such account existed but that her recollection was that at one time, the District had an account they labeled as "retiree," however, it was not actually used for the purpose of GASB liability. Ms. Schulenberg also noted that the GASB liability was the District's, not the Trust's and reported the actuary was already working with Mike Murray on the analysis. She anticipates discussion about the results and strategy at a future meeting.

Member Atassi made a motion to approve the financials as presented.

Member Christiansen seconds the motion.

Fadi Atassi: YES, Amy Barney: YES, Hal Christiansen: YES, Marcia Cox: YES

Motion unanimously approved by Trustees present.

Vendor Reports:

Joyce Perez from Gilsbar presented an overview of medical claims through June 30, 2018.

In the absence of Rich Hanna from Ameritas, Ms. Schulenberg gave a brief overview of dental claims through June 30, 2018.

Ms. Schulenberg also advised Trustees that Cerner had provided a report on H&W Center activities through June 30, 2018.

Administrative Update:

Ms. Schulenberg updated Trustees on a number of follow-up items from previous meetings, including:

- Jeff Goss Call to the Public - Mr. Goss was not in attendance so Trustees asked Ms. Schulenberg to contact him personally to provide requested information; and
- Stephanie Holmes Call to the Public – No further action required.

Ms. Schulenberg also noted the following items:

- LabCorp and Gilsbar found a solution to the Clinic billing issue, however, the system corrections will take 6-8 weeks on the LabCorp side. Once those are complete, the Clinic labs will be billed using the BCBSAZ rates.
- The co-pay changes implemented with CVS/Caremark effective July 01, 2018 are not currently effective. CVS contacted ECA the week on July 12, 2018 to notify them that required change documents had not been signed and provided; ECA immediately signed the documents and submitted for processing. ECA takes responsibility for not ensuring these documents had been submitted and has requested a report from CVS of underpaid co-payments and will make the Trust whole. EDITOR'S NOTE: Changes were implemented effective July 23, 2018; once a report has been provided of the underpaid co-payments, ECA will advise Trustees and write a check to the Trust.
- A copy of the final budget was provided to Trustees and Ms. Schulenberg reminded them that the premium rates on the budget were the adopted rates versus what the District was funding. Vice Chairperson Cox suggested adding a column to the budget to show the adopted versus funded for information; Ms. Schulenberg will update and get that out to Trustees.

Election of Officers:

Member Christiansen nominated Marcia Cox as Chairperson.

Member Atassi seconds the motion.

Fadi Atassi: YES, Amy Barney: YES, Hal Christiansen: YES, Marcia Cox: YES

Motion unanimously approved by Trustees present.

Chairperson Cox nominated Hal Christiansen as Vice Chairperson.

Member Atassi seconds the motion.

Fadi Atassi: YES, Amy Barney: YES, Hal Christiansen: YES, Marcia Cox: YES

Motion unanimously approved by Trustees present.

Chairperson Cox appoints ECA as Recording Secretary.

Future Agenda Items:

Jaime Schulenberg stated future agenda items:

- GDK Contract
- Cash v. Accrual Accounting Basis

- Legal Counsel RFP Recommendation

Vice Chairperson Christiansen made a motion to adjourn meeting.

Member Atassi second the motion.

Motion unanimously approved by Trustees in attendance.

Meeting adjourned at 6:44 p.m.

Respectfully Submitted: Jaime Schulenberg, Recording Secretary

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Minutes of the Regular Meeting of the LHUSD #1 Employee Benefit Trust meeting of July 19, 2018 are approved as submitted:

_____

Marcia Cox, Chairperson

LAKE HAVASU SCHOOLS EMPLOYEE BENEFIT TRUST
2200 Havasupai Blvd., Lake Havasu City, AZ 86403

Trust Board Minutes
August 20, 2018

SPECIAL MEETING:

1. Routine Opening of Meeting – Call to Order

The Special Meeting of the Board of Trustees of the Lake Havasu Schools Employee Benefit Trust was called to order by Trust Chairperson, Marcia Cox, in the District Boardroom, 2200 Havasupai Blvd., Lake Havasu City, Arizona at 5:04 p.m. on August 20, 2018.

2. Roll Call

BOARD MEMBERS PRESENT:	Marcia Cox, Chairperson
	Dr. Fadi Atassi (Arrived at 5:21 p.m.), Trustee
	Amy Barney, Trustee
	Hal Christiansen, Vice Chairperson
	Julie Sasseen, Trustee
BOARD MEMBERS ABSENT:	Pat Rooney, Trustee
GOVERNING BOARD MEMBERS	John Masden, President
PRESENT:	Nichole Cohen, Vice President
	Kathy Cox, Member
ADMINISTRATION PRESENT:	Diana Asseier, Superintendent
	Michael Murray, Director of Business Services
	Jaime Festa-Daigle, Director of Personnel & Technology
OTHERS:	Erin Collins, ECA – Broker/Consultant
	Jaime Schulenberg, ECA – Broker/Consultant
	5 Others

3. Pledge of Allegiance/Moment of Silence

4. Call to the Public – None

5. Discussion and Possible Action re Legal Counsel Request for Proposal

Ms. Schulenberg summarized the recent Request for Proposal process for Legal Counsel, which included two responses. Both firms who responded are able to provide the requested services, however, ECA recommends retention of Jones, Skelton & Hochuli because Mr. Hensley has been working with the Trust so is familiar with its operations; in addition, their rates were lower than those presented by the other respondent.

Mr. Christiansen moved, seconded by Ms. Cox, to award a contract for legal services to Jones Skelton & Hochuli.
ROLL CALL VOTE: Barney: YES, Christiansen: YES, Cox: YES, Sasseen: YES

6. Update on End to End Plan Review

Ms. Cox requested that the Board move into Executive Session for legal advice on the End to End Review as well as the Cerner Management Contract.

Mr. Christiansen moved, seconded by Ms. Sasseen, to adjourn to Executive Session at 5:12 p.m.

Regular session resumed at 6:11 p.m.

Mr. Collins presented an update on the End to End Review conducted by ECA and presented to the Board December 06, 2017. To summarize, a number of items identified have been addressed, including:

A) Consolidated financial reporting;
B) Premium rate-setting done by an actuary and including all related expenses;
C) Banking and Investment Services were moved from Morgan Stanley;
D) An Incurred But Not Paid (IBNP) liability analysis will be conducted by the actuary;
E) Retiree liabilities (GASB 75) is underway with the District and actuary;
F) Public meetings are conducted in accordance with Open Meeting Law;
G) Trustees will receive education on various topics including fiduciary liability, conflict of interest, HIPAA, etc.;
H) Vendor Contracts are being re-negotiated to comply with Open Meeting Law, align with the plan year and are being signed by the appropriate personnel and housed at the District;
I) Fiduciary Liability insurance was purchased; and
J) Prescriptions claims were added to the reinsurance contract.

Several items are still in process, including:

A) Closing the gap in funding between the actuarially set rates and District/Employee contributions;
B) Negotiating void vendor contracts; and
C) Clinic operations.

With regard to the Clinic, Mr. Collins reported that the Trust was in negotiations with Cerner regarding costs, noting that the negotiation period expires 08/31/18 and if no agreement is reached, the Clinic would close 12/31/18. Should that occur, ECA is working in the background on plan design changes for January-June 2019 and July 2019 forward to provide a more traditional plan with lower co-pays, deductibles, etc. That will be presented as soon as ECA receives those numbers from the actuary.

Several members of the public commented with questions concerning the clinic lease and how that would work (ECA's assumption is that the Trust will continue to pay the lease unless the owner can sell or rent the building prior to the term date) and physicians who might be

interested in partnering with the Trust to provide services to members. Ms. Cox commented that all of that will be studied as part of any re-design.

Ms. Cohen asked for clarification on the Incurred But Not Paid (IBNP) report and the GASB 75 liabilities. Ms. Schulenberg noted that the data to prepare the IBNP for 06/30/18 was being gathered and would be presented as soon as it was available. Mr. Collins indicated that he felt that the previous GASB liabilities may be undervalued if the under-funded premiums were used as the basis.

7. Discussion and Possible Action re Cerner Management Contract

Mr. Collins summarized the proposal received from Cerner, which included an overview of the cost comparison conducted by the Trust's actuary as well as the proposal to reduce the management fee by cutting the NP staff to 1 and reducing the hours to 40 per week. He noted that Cerner's philosophy was never to compete against the community cost, period. Mr. Collins said Cerner's was a primary care structure and their intent is to spend more time with individuals seeking care whereas a local visit might be 15 minutes, Cerner's would be an hour.

The current contract negotiation period ends August 31, 2018 so Mr. Collins indicated that from his perspective, the current options were:

A) Request an extension of 30 days to continue negotiations, which would give ECA time to receive pricing from the actuary on alternative benefit designs. He noted that if Cerner refuses to provide additional time, Trustees would need to understand that would mean a closure of the Clinic as of 12/31/18; or
B) Accept or reject the current proposal.

Members of the public commented that they felt Cerner had been dishonest and not treated members or the Trust properly, not provided requested information and suggested that the Board not consider further negotiations.

Ms. Barney wants to take into account staff who use the clinic and make sure she has all the information available before she is comfortable making a decision. Ms. Sasseen agreed.

Ms. Cohen said she appreciates the staff concerns, however, the Trustees have a fiduciary duty to manage the Trust and if the Clinic is driving costs upwards, making the benefits unsustainable, they have a duty to act in the best interest of all the employees.

Ms. Cox said that the Trust is committed to providing a stable and fiscally sound plan and they have made great strides so far, but there is a lot still to do.

Mr. Masden asked whether the Trust was fiscally sound today? Mr. Collins said yes, but with a "limited shelf life," which he defined as an inability to maintain the current level of benefits with the current revenue for more than 18 months at best.

Ms. Barney moved, seconded by Ms. Sasseen, to request a 30-day extension from Cerner to continue negotiating the contract. Mr. Christiansen asked that legal counsel request that Cerner consider keeping Saturday hours (perhaps by eliminating Mondays or adjusting hours during the week) as part of any ongoing negotiation.
ROLL CALL VOTE: Atassi: YES, Barney: YES, Christiansen: YES, Cox: NO, Sasseen: YES

8. Future Agenda Items – Cerner Clinic Negotiation, Alternative Benefit Design

9. Future Meeting Dates: September 06, 2018

10. Adjournment
Dr. Atassi moved, seconded by Mr. Christiansen, to adjourn at 7:34 p.m.
ROLL CALL VOTE: Atassi: YES, Barney: YES, Christiansen: YES, Cox: YES, Sasseen: YES

Video of the entire meeting may be seen on the District website (www.havasu.k12.az.us) under EBT Documents.

Minutes of the Special Trust Board Meeting of August 20, 2018 are approved as submitted.

Marcia Cox, Chairperson

Hal Christiansen, Vice Chairperson

LAKE HAVASU SCHOOLS EMPLOYEE BENEFIT TRUST
2200 Havasupai Blvd., Lake Havasu City, AZ 86403

Trust Board Minutes
August 29, 2018

SPECIAL MEETING:

1. Routine Opening of Meeting – Call to Order

The Special Meeting of the Board of Trustees of the Lake Havasu Schools Employee Benefit Trust was called to order by Trust Chairperson, Marcia Cox, in the District Boardroom, 2200 Havasupai Blvd., Lake Havasu City, Arizona at 4:01 p.m. on August 29, 2018.

1.1 Roll Call

BOARD MEMBERS PRESENT:	Marcia Cox, Chairperson
	Dr. Fadi Atassi (Arrived at 4:04 p.m.), Trustee
	Amy Barney, Trustee
	Hal Christiansen, Vice Chairperson (Via Phone)
	Pat Rooney, Trustee
	Julie Sasseen, Trustee
GOVERNING BOARD MEMBERS	John Masden, President
	Nichole Cohen, Vice President
	Kathy Cox
ADMINISTRATION PRESENT:	Diana Asseier, Superintendent
	Michael Murray, Director of Business Services
	Jaime Festa-Daigle, Director of Personnel & Technology
OTHERS:	Erin Collins, ECA – Broker/Consultant
	Michael Hensley, Jones Skelton & Hochuli – Legal Counsel (Via Phone)
	Jaime Schulenberg, ECA – Broker/Consultant (Via Phone)
	26 Others

1.2 Pledge of Allegiance/Moment of Silence

2. Call to the Public – None

3. Old Business (Editor's Note: This item was mis-numbered on the Agenda as #4)

3.1 Review and Update re Status of Negotiations with Cerner for Management and Operation of the H&W Clinic

Ms. Cox requested that the Board move into Executive Session for legal advice on the contract negotiations with Cerner.

Dr. Atassi moved to adjourn to Executive Session, seconded by Ms. Sasseen, to adjourn to Executive Session at 4:07 p.m.

Regular session resumed at 4:36 p.m.

Mr. Collins gave a presentation on the status of ongoing negotiations with Cerner regarding the management and operation of the Health & Wellness Clinic. During the presentation, Mr. Collins provided background on the discovery of numerous contracts which were considered void and how that resulted in negotiations with Cerner to try and reduce the overall expenditures of the Trust to eliminate a projected deficit in funds. He went on to describe the options available to the Trust, which are to accept a revised proposal from Cerner or allow the Clinic to wind-down operations and close as of 12/31/18 if an agreement could not be reached by 08/31/18.

The presentation included an overview of the pros and cons of both options as well as projected budget impacts for both keeping and closing the Clinic. Mr. Collins also noted that ECA had begun a process to redesign benefits as of January 01, 2019 in the event an agreement with Cerner could not be reached.

Mr. Christiansen acknowledged that there would be no way to find a new manager or provider for the Clinic prior to 12/31/18 and asked whether it would make sense to extend the contract with Cerner through March 2020 and spend the next 18 months trying to find other solutions to provide a clinic-like model for employees. Mr. Collins commented that he was unsure as to whether 18 months was a long enough timeframe to conduct such an analysis as he felt that the initial process to review on- or near-sight clinics lacked substantive metrics including goal-setting, care directed at the reduction of medical claims, performance guarantees, and billing systems that would allow for necessary reporting, among a myriad of other things. He stressed that this was not a reflection on Cerner but rather, in the initial research and implementation phase. Mr. Collins simply feels that the process is very complex and could take up to two years to do it properly.

Ms. Cox noted that the Board had been trying to work with Cerner for over three years in an effort to understand costs and benefits and still had not received a lot of the requested data. She said that Cerner's solution, instead of reducing their fee, was to reduce staffing and hours, which would have a negative impact on members trying to use the Clinic. She reiterated that the Board has a fiduciary duty to maintain a fiscally sound Plan that is able to provide affordable benefits to its members over the long-term. She feels that continued operation of the Clinic will cause increased premiums year over year. Ms. Cox did note that a decision not to agree to Cerner's proposal did not mean that the Trust could not look at other alternatives in the future.

Mr. Collins added that he did not believe that with the current contract and structure the Clinic would ever break even and that he thought the Trust and District would be better off

re-distributing any savings in such a way that all employees would benefit (by reducing co-pays, deductibles, maximum out-of-pocket amounts, etc.).

A number of members of the public addressed the Board, primarily with concerns regarding the loss of the Clinic, availability of providers in Lake Havasu City, and what was perceived to be a "quick" decision by the Board to close the Clinic. Many members understood the financial issues, but felt that the overall model of the Clinic should not be compared to the community model. Some specific comments and responses included:

- Question regarding whether the projected surplus (if the Clinic closes) was truly a "surplus" since presumably members would move their care to community providers. Mr. Collins indicated that ECA had assumed no savings for movement of care from the Clinic to the community, and that, in fact, he felt we had underestimated the savings the Trust will realize.
- A concern about increasing the Urgent Care co-pay to $75; $50 is already difficult based on teacher salaries.
- Question regarding a wellness clinic operated by NAPEBT in Flagstaff – has ECA contacted them about their program? Mr. Collins replied that we had not reached out to them but knows they are losing $3M per year based on their Department of Insurance audits.
- Question regarding the option to close the current Trust and join ASBAIT. Ms. Cox and Ms. Cohen noted that they had applied to ASBAIT in the past and ASBAIT had declined to quote and would not indicate why. Ms. Cox said the decline letter from ASBAIT was included in the most recent bids for insurance completed by the previous consultant.
- Question as to whether claims costs have declined with the implementation of the changes in July; Mr. Collins said that we only have one month of data so it is too early to tell. However, he noted that estimated savings were taken into account when the premiums were developed.
- Comments regarding the perception that this decision was being made "too quick." Ms. Cox explained that although she understood there might be that perception, that the Board had been in discussions with Cerner for several years and it wasn't until they hired a new consultant and attorney that they were finally able to get the data they needed in order to make an informed decision. Ms. Cohen added that when the Clinic was implemented, it was estimated to save the Trust $1.6M in claims. She also mentioned that in previous minutes that there was talk about increasing premiums, that we couldn't afford it and even talk about eliminating staff as a way to keep the Center open.

With no further public comment, Ms. Barney requested that if the Clinic closes, Personnel assist employees ahead of open enrollment by verifying the list of available providers is up to date and accurate, taking new patients, etc.

Mr. Hensley advised Trustees that they had the option to either make a motion to accept the proposal from Cerner to keep the Clinic open beyond 12/31/18, or with no motion, that the current Agreement would wind-down the Clinic with a closure date of 12/31/18. No motion was made; as such, Cerner will be advised that their proposal was not accepted and ECA and Trustees will begin employee education, benefit re-structuring, and work with Cerner on the wind-down of Clinic operations.

4. Adjournment (Editor's Note: This item was mis-numbered on the Agenda as #5)
   Dr. Atassi moved, seconded by Ms. Barney, to adjourn at 6:00 p.m.

Video of the entire meeting may be seen on the District website (www.havasu.k12.az.us) under EBT Documents.

Minutes of the Special Trust Board Meeting of August 29, 2018 are approved as submitted.

Marcia Cox, Chairperson

Hal Christiansen, Vice Chairperson

LAKE HAVASU SCHOOLS EMPLOYEE BENEFIT TRUST
2200 Havasupai Blvd., Lake Havasu City, AZ 86403

Trust Board Minutes
September 12, 2018

SPECIAL MEETING:

1. Routine Opening of Meeting – Call to Order

The Special Meeting of the Board of Trustees of the Lake Havasu Schools Employee Benefit Trust was called to order by Trust Chairperson, Marcia Cox, in the District Boardroom, 2200 Havasupai Blvd., Lake Havasu City, Arizona at 6:00 p.m. on September 12, 2018.

1.1 Roll Call

BOARD MEMBERS PRESENT:	Marcia Cox, Chairperson
	Amy Barney, Trustee
	Hal Christiansen, Vice Chairperson
	Pat Rooney, Trustee
	Julie Sasseen, Trustee
BOARD MEMBERS ABSENT:	Dr. Fadi Atassi, Trustee
GOVERNING BOARD MEMBERS	John Masden, President
PRESENT:	Nichole Cohen, Vice President
ADMINISTRATION PRESENT:	Diana Asseier, Superintendent
OTHERS:	Susan Betz, ECA – Broker/Consultant
	Erin Collins, ECA – Broker/Consultant
	Courtney Heeley, Teladoc
	Storm Kinion, ECA – Broker/Consultant
	Joyce Perez, Gilsbar
	Jaime Schulenberg, ECA – Broker/Consultant
	10 Others

1.2 Pledge of Allegiance/Moment of Silence

2. Call to the Public – Deferred to the end of the meeting regarding the closure of the clinic.

3. Old Business

3.1 Update on Void Contracts

Ms. Schulenberg updated the Board on the review of contracts found to be void, including American Health Group, Ameritas, Gilsbar and National Cooperative/CVS. ECA is working with the Trust's legal counsel and the respective vendors and the contracts will be brought back to the board on 10/18/18 to either ratify or renew.

4. New Business

4.1 Teladoc Presentation

Mr. Collins introduced Courtney Heeley from Teladoc, who gave a presentation on a proposal to add telemedicine services to the Plan effective January 01, 2019. Teladoc is primarily in place for acute illnesses such as UTI's, pink eye, strep throat, etc. The providers are able to write prescriptions for non-narcotic medications and are available 24/7/365. The current proposal would provide Teladoc at no charge to the member.

The current proposal is for medical services only, however, there are three other options that will be researched further for consideration during the 2019-20 renewal:

- Dermatology;
- Sexual Health; and
- Behavioral Health.

Members can pre-register with Teladoc via a Smartphone (Android/Apple) or computer and access services through those same options. Members also have the choice to select a Spanish speaking physician.

Trustees had several questions, including:

- What age ranges are eligible to use Teladoc and what the physician requirements are to be contracted with Teladoc. Ms. Heeley confirmed that all age ranges are eligible to use Teladoc. The physicians are all board certified in their specialty and are required to have a minimum of 5 years practicing medicine.
- Whether Teladoc is available internationally; the patient can connect with a doctor, however, prescriptions are not available internationally at this time.
- Does Teladoc have the ability to peer review physicians if there are complaints/issues? Per Ms. Heeley, yes.
- Criteria for diagnosing illnesses; Ms. Heeley explained that each illness has a certain set of criteria and offered to provide some specifics for strep throat. She also reiterated that members could face time with a provider so that they could see the throat or any other areas of concern and that members could also provide pictures.
- How long Teladoc has been in business; 15 years with 1.5M consultations in 2017.
- The charge to the Trust for services - $4.25/PEPM based on active employees. Ms. Heeley also noted that members could add family members to the portal even if they are not on the District's medical plan.

4.2 Discussion and Possible Action re Alternative Benefit Plan Design for January – June 2019

Mr. Collins presented recommended plan changes for January 2019 through June 2019 in conjunction with the closure of the Health & Wellness Clinic. Those recommended changes include:

- Reduce Office Visit co-payment from $55 to $25 PCP / $50 Specialist;
- Break out Lab/X-Ray* from 80% after Deductible to:
    - Free-Standing - $50 Co-Pay then 100% and
    - Hospital-Based – Deductible and Coinsurance

  *NOTE: Advanced Imaging (MRI, CT Scan, PET Scan, etc.) remains payable under deductible and coinsurance.
- Add Teladoc with No Cost to Members;
- Change Sterilization to cover Vasectomy at 100% with no member cost-share;
- Reduce Retail 90/Mail Order Prescription co-payments from $25/Generic, $105/Preferred Brand and $195/Non-Preferred Brand to $20/$70/$130.

Mr. Collins also provided Trustees with preliminary numbers and potential benefit changes for fiscal year 2019-2020. He reiterated that the 2019-2020 numbers are very preliminary and most likely will change due to claims, etc. The renewal meeting for 2019-2020 is tentatively set for 02/04/2019-02/05/2019.

A member of the public expressed concerns about her plan being paid at 100% when she retires. She advised the Trust that when she was hired she signed a contract and it was also part of the board policy, at the time, designating teachers to have their benefits paid at 100%. Ms. Barney communicated that it was board policy for all teachers hired prior to 2005 to have their benefits paid at 100% after retirement. There was discussion about possibly keeping the Silver plan for retirees.

Chairperson Cox requested any Call to the Public comments related to this item. She first read an email she received from a teacher regarding a High Deductible Health Plan option which expressed concern over being “forced” to enroll, as well as a concern over a proposed increase to the Urgent Care co-payment. Ms. Cox noted that if an HDHP was offered, the intent was that it would be an option and not replace the existing Gold Plan. She also noted that there was no recommendation to increase the Urgent Care co-pay through June 30, 2019.

Judy McClintock stood and read a prepared statement regarding the closure of the clinic. In her statement she said that on 03/06/18 the Governing Board approved an employee compensation package including an EBT contribution. Ms. McClintock said no such contribution had been made and that if it had, there might not be a $472,000.00 deficit. At the 03/29/18 District Meeting with ECA it was discussed that the Trust had a contractual agreement with Cerner. At no time was there discussion of closing the clinic; then, the Friday before the Fourth of July holiday, there was an executive session during which the contract with Cerner was determined to be null and void. If Cerner would not lower the costs, there would be a 120-day wind down. Ms. McClintock says she now only has 4-months to find a PCP and come up with co-pays. According to Ms. McClintock 400 out of 800 employees use the clinic, which is not a small amount. Ms. McClintock also stated that it is clear for 3-years there were board members trying to get information on the clinic and that the goal was to close it. Ms. McClintock feels betrayed, sad, angry and feels the

Trustees let them down. She also questioned why there needed to be an EBT, brokers, attorneys, consultants, etc.

Governing Board members John Masden and Nichole Cohen commented on Ms. McClintock's statement, including:

- That the statement was about feelings, not facts;
- That in August, no one knew about the potential closure of the Clinic;
- That if employees are unhappy with the current plan, the Board could consider moving to the marketplace; and
- Reiterated that the Trust Board has a fiduciary responsibility to maintain the Trust in a responsible manner while the Governing Board's responsibility was to fund the plan.

Mr. Christiansen moved to accept the benefit plan changes for January 2019 – June 2019 as recommended, seconded by Ms. Barney and unanimously approved.

Ms. Cox presented information about scheduling an appointment for lab work online with LabCorp or Sonora Quest as well as information about locating a primary care physician.

5. Adjournment
   Vice Chairperson Christiansen moved, seconded by Ms. Sasseen, to adjourn at 8:06 p.m.

Video of the entire meeting may be seen on the District website (www.havasu.k12.az.us) under EBT Documents.

Minutes of the Special Trust Board Meeting of September 12, 2018 are approved as submitted.

Marcia Cox, Chairperson

Hal Christiansen, Vice Chairperson

Erin P. Collins & Associates, Inc.

Phone: 928.753.4700 x302
Fax: 877.866.5732
1115 Stockton Hill Rd., Ste 101
Kingman, AZ 86401
jaimes@ecollinsandassociates.com

MEMORANDUM

TO: **LHSEBT TRUSTEES**

FROM: **ECA Inc.**
Jaime Schulenberg, Sr. Account Manager

DATE: September 5, 2018

RE: Financial Summary for July 2018

Attached please find the LHSEBT financial reports for the month ending July 31, 2018 for your review and information.

Below is a summary for your quick reference and information.

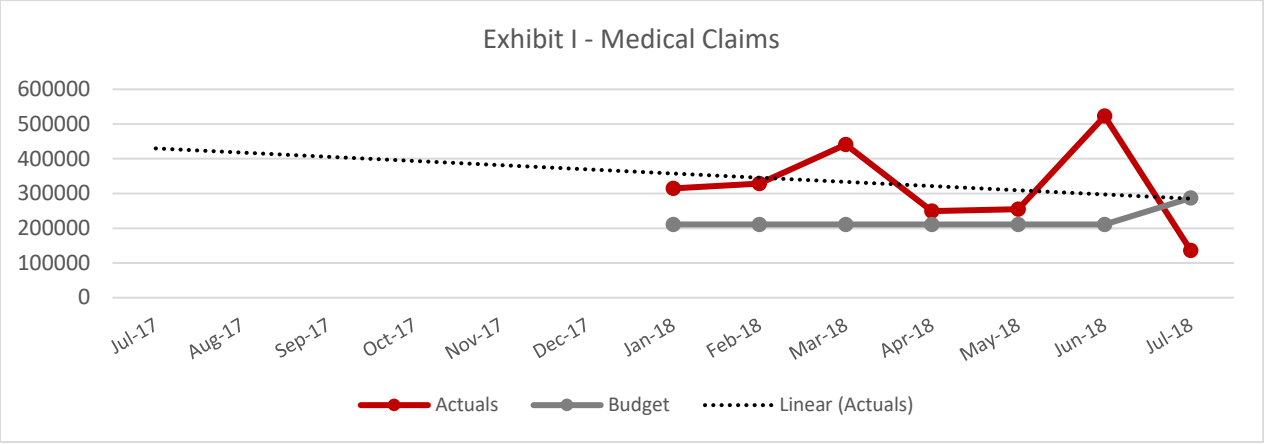
	July 2018
REVENUE	$73,084
EXPENSES	
- Claims	$58,061
- Premiums	$47,124
- Claims Administration	$14,632
- General Operating	$74,025
Expense Total:	**$193,843**
Monthly Financial Position	**($120,759)**
YTD Cash Position	**($120,759)**
All Years Cash Position	**$3,463,872**
Estimated IBNP Liability	**($0)**
All Years Surplus/Deficit Position[1]	**$3,463,872**

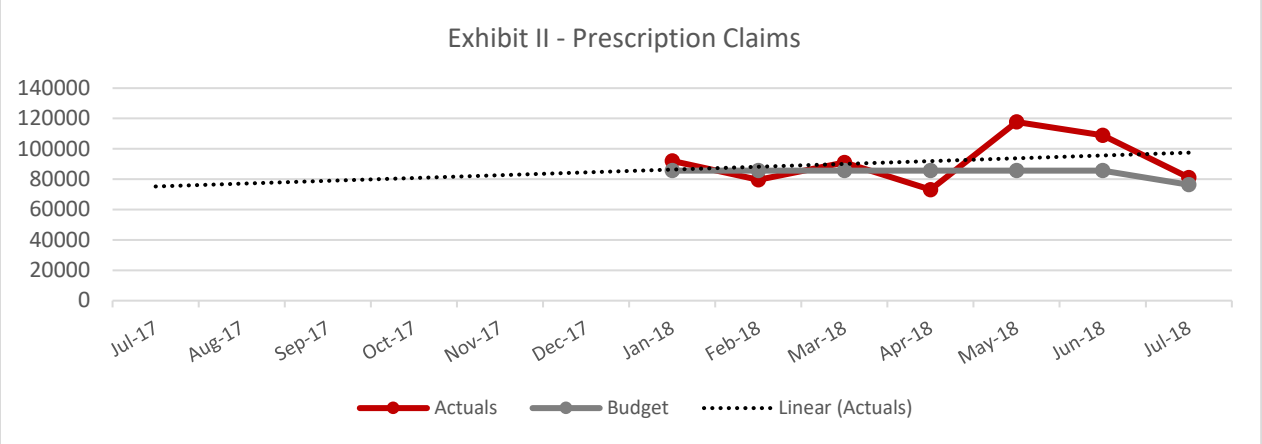
[1] The LHSEBT Incurred But Not Paid analysis for 06/30/18 is underway; the All Year's Surplus/Deficit Position will be updated to reflect that reduction as soon as it is received.

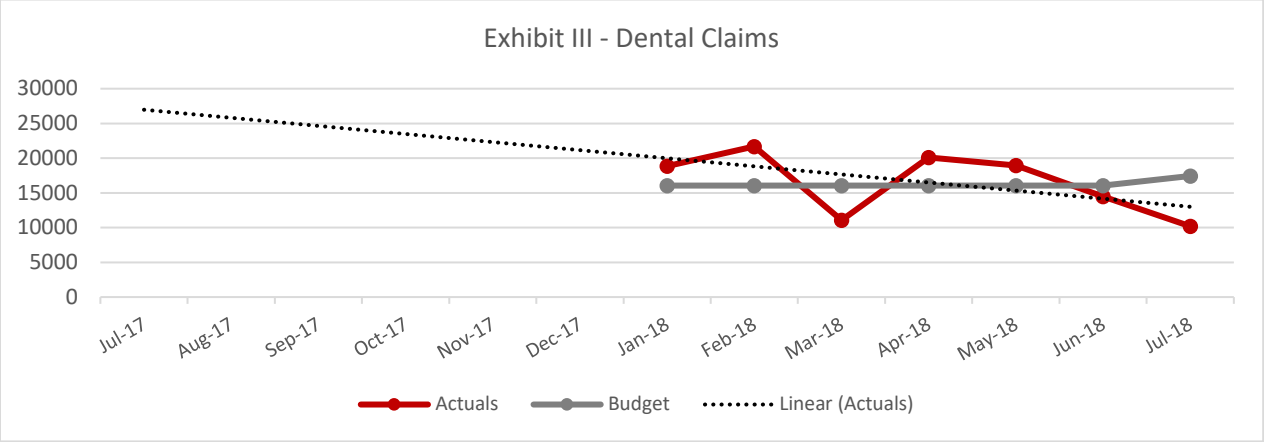
With regard to the financial report, the following items merit your attention:

1. Gross Revenue came in at just 14% due to the District making one of the July deposits on 06/29/18 and the other coming in well below what was budgeted. Although this appears to be the "norm" for July, we are still researching this and will provide additional information when we report on this at the next quarterly meeting.
    a. Interest & Investment Income came in at 755% due to the Trust's ability to invest more funds that earned interest than originally anticipated.
    b. Had the 06/29/18 deposit been applied to the June financial report, the Trust's deficit for the month would have reduced from ($120,759) to ($74,720).
    c. The overall deficit is attributable to the revenues received.

2. Claim Funds include Medical, Rx and Dental claims as well as the Health & Wellness Center Lab and Rx charges, less any stop loss reimbursements and Rx rebates. This line item is running at 15% of budget for the month. More specifically, claims are running as follows (See Exhibits I, II and III below):
    a. Gold Plan Medical claims at 49%;
    b. Silver Plan Medical claims at 3%;
    c. H&W Center Labs at 0%:
        i. The Trust has not received a bill for July transactional services, which includes lab and Rx;
    d. Gold Plan Rx claims at 115%:
        i. Gold Plan Rx claims are running over budget due to CVS/Caremark not being able to break out the Silver claims from the Gold claims;
    e. Silver Plan Rx claims at 0%:
        i. Silver Plan Rx claims are running at 0% of budget as noted above. We are trying to work with the PBM to see if this can be corrected;
    f. H&W Center Rx claims at 0% as described in 2(d)(i) above; and
    g. Dental claims at 58%.
    h. Overall, the Claims line is low due to receipt of both a reinsurance reimbursement as well as an Rx Rebate.







3. Premiums are running at 91% for the year. Please note the following:
    a. VTL and STD are running over budget at 137% and 103% respectively due to additional enrollments and changes that occurred during open enrollment.
    b. Vision is (.09%) due to the discovery of a credit during an ECA reconciliation in June (it appears that the June 2017 or a previous month was overpaid/double paid).

4. Claim Administration came in at 71%. Please note the following:
    a. Dental Admin is running at (171%) due to the correction of an accrual amount entered by ECA's CPA based on information we had regarding payments made prior to January 2018.

5. General Operating is running at 95%; please note the following:
    a. Legal is 396% for July due to services rendered through June. This item will come in line as the year progresses; and
    b. PCORI is 931% due to payment of the required fee. As noted above, this item will also come in line as the year progresses.

6. The Trust does not have any large claims that exceed 50% of the specific deductible, or $65,000, as of July 31, 2018.

Please note that figures used in this overview have been taken from the financial reports attached. The numbers are rounded, and therefore may not calculate to the penny.

If you have any questions on anything included here, please don't hesitate to contact me. I can be reached at your convenience at 928.753.4700 x302 or via email at jaimes@ecollinsandassociates.com.

c: Michael Murray, Director of Business Services

LHSEBT - Lake Havasu Schools Employee Benefit Trust

2018-19

Jul-18

	Annual Budget	MTD Budget	MTD Actual	YTD Budget	6 Month YTD Actual	% Total MTD	% Total YTD
GROSS REVENUE	*$6,374,085*	*$531,173.72*	*$73,084*	*$531,174*	*$73,084*	*13.76%*	*13.76%*
Contributions	*$6,245,881*	$520,490	$59,362	$520,490	$59,362	11.40%	11.40%
Interest & Investment Income	*$16,932*	$1,411	$10,651	$1,411	$10,651	754.84%	754.84%
COBRA/ASRS	*$111,271*	$9,273	$3,071	$9,273	$3,071	33.12%	33.12%
CLAIM FUNDS	*$4,571,912*	*$380,993*	*$58,061*	*$380,993*	*$58,061*	*15.24%*	*15.24%*
Medical (Gold)	*$3,306,366*	$275,530	$136,242	$275,530	$136,242	49.45%	49.45%
Medical (Silver)	*$38,677*	$3,223	$110	$3,223	$110	3.41%	3.41%
Medical (Clinic Labs)	*$101,065*	$8,422	$0	$8,422	$0	0.00%	0.00%
Stop Loss Reimbursement		$0	($127,973)	$0	($127,973)		
Rx (Gold)	*$845,572*	$70,464	$81,101	$70,464	$81,101	115.09%	115.09%
Rx (Silver)	*$0*	$0	$0	$0	$0		
Rx (Clinic)	*$71,007*	$5,917	$0	$5,917	$0	0.00%	0.00%
Rx Rebates		$0	($41,610)	$0	($41,610)		
Dental	*$209,225*	$17,435	$10,192	$17,435	$10,192	58.45%	58.45%
PREMIUMS	*$619,302*	*$51,609*	*$47,124*	*$51,609*	*$47,124*	*91.31%*	*91.31%*
Specific Stop Loss (American Fidelity)	*$446,533*	$37,211	$34,759	$37,211	$34,759	93.41%	93.41%
Aggregate Stop Loss (American Fidelity)	*$17,082*	$1,424	$1,290	$1,424	$1,290	90.61%	90.61%
Basic Life Insurance (Guardian)	*$26,486*	$2,207	$2,040	$2,207	$2,040	92.44%	92.44%
VTL (Guardian)	*$59,639*	$4,970	$6,819	$4,970	$6,819	137.20%	137.20%
STD (Guardian	*$25,891*	$2,158	$2,220	$2,158	$2,220	102.90%	102.90%
Vision (United Health Care)	*$43,670*	$3,639	($3)	$3,639	($3)	-0.09%	-0.09%
CLAIM ADMINISTRATION	*$247,222*	*$20,602*	*$14,632*	*$20,602*	*$14,632*	*71.02%*	*71.02%*
Medical Admin (Gilsbar)	*$106,541*	$8,878	$7,894	$8,878	$7,894	88.91%	88.91%
Cobra Admin (Gilsbar)	*$9,523*	$794	$708	$794	$708	89.22%	89.22%
% of Savings	*$2,831*	$236	$488	$236	$488		
Dental Admin (Ameritas)	*$19,773*	$1,648	($2,813)	$1,648	($2,813)	-170.71%	-170.71%
FSA Admin (Gilsbar)	*$672*	$56	$44	$56	$44	78.57%	78.57%
Utilization Review (AHG)	*$11,904*	$992	$880	$992	$880	88.71%	88.71%
Case Management (AHG)	*$3,900*	$325	$675	$325	$675		
Medical Network (BCBSAZ)	*$89,280*	$7,440	$6,600	$7,440	$6,600	88.71%	88.71%
Rx Admin (CVS Caremark/WI Rx)	*$2,797*	$233	$157	$233	$157	67.43%	67.43%
GENERAL OPERATING	*$935,649*	*$77,971*	*$74,025*	*$77,971*	*$74,025*	*94.94%*	*94.94%*
Benefit Administrator (ECA)	*$72,019*	$6,002	$6,000	$6,002	$6,000	99.97%	99.97%
Management Fee (Cerner)	*$662,696*	$55,225	$54,896	$55,225	$54,896		
Clinical Operating Expenses	*$85,709*	$7,142	$5,648	$7,142	$5,648	79.08%	79.08%
Wellness Programs	*$0*	$0	$0	$0	$0	#DIV/0!	#DIV/0!
Actuary (Cheiron)	*$12,559*	$1,047	$0	$1,047	$0		
Actuary - GASB (Cheiron)	*$17,558*	$1,463	$0	$1,463	$0	0.00%	0.00%
Accountant (GDK)	*$3,631*	$303	$300	$303	$300		
Auditor (Henfeld Meech)	*$6,012*	$501	$0	$501	$0	0.00%	0.00%
Legal	*$12,142*	$1,012	$4,011	$1,012	$4,011	396.45%	396.45%
PCORI	*$2,024*	$169	$1,571	$169	$1,571	931.39%	931.39%
General Administration	*$61,300*	$5,108	$1,599	$5,108	$1,599	31.29%	31.29%
GRAND TOTAL BUDGET	*$6,374,085*	*$531,174*	*$193,843*	*$531,174*	*$193,843*	*36.49%*	*36.49%*

Gold Active/Cobra Census

	EE	ES	EC1	EC1+	EF
Budget	304	43	20	24	64
Actual	281	39	43	0	58
% Budget	92.4%	90.7%	215.0%	0.0%	90.6%

Gold Retiree Census

	EE	ES	EC1	EC1+	EF
Budget	26	8	0	0	0
Actual	28	10	0	0	0
% Budget	107.7%	125.0%	0.0%	0.0%	0.0%

Silver Census

	EE	ES	EC1	EC1+	EF
Budget	6	1	0	0	0
Actual	7	1	0	0	0
% Budget	116.7%	100.0%	0.0%	0.0%	0.0%

Total Medical Census

	EE	ES	EC1	EC1+	EF
Budget	336	52	20	24	64
Actual	316	50	43	0	58
% Budget	94.0%	96.2%	215.0%	0.0%	90.6%

Active/ Cobra Dental Census

	EE	ES	EC1	EC1+	EF
Budget	362	44	18	25	58
Actual	301	35	44	0	52
% Budget	83.1%	79.5%	244.4%	0.0%	89.7%

Retiree Dental Census

	EE	ES	EC1	EC1+	EF
Budget	0	0	0	0	0
Actual	31	8	0	0	1
% Budget	0.0%	0.0%	0.0%	0.0%	0.0%

Active/ Cobra Vision Census

	EE	ES	EC1	EC1+	EF
Budget	369	54	16	20	49
Actual	320	38	36	0	48
% Budget	86.7%	70.4%	225.0%	0.0%	98.0%

Retiree Vision Census

	EE	ES	EC1	EC1+	EF
Budget	369	54	16	20	0
Actual	25	8	0	0	1
% Budget	6.8%	14.8%	0.0%	0.0%	0.0%

Cash Position As Of June 30, 2018		$3,584,631
Cash Position MTD	July-18	($120,759)
Cash Position YTD	July-18	($120,759)
Cash Position All Years		$3,463,872

Prior Year	Cash Position	June 30, 2018	$3,584,631
	IBNP	June 30, 2018	$0
	Surplus Position	June 30, 2018	$3,584,631
Current Year	Cash Position	July 2018	$3,463,872
	IBNP	July 2018	$0
	Surplus Position	July 2018	$3,463,872

YTD Aggregate Calculations

Contracted Aggregate Factors

	EE	ES	EC1	EC1+	EF
	$550	$1,095	$969	$969	$1,645
Total	$365,479.25				
Med/Rx	$217,452.22				
Difference	$148,027.03				
Estimated % Attachment Point			59.50%		

General Administration Expenses Detail
LHSEBT

	July	August	September	October	November	December	January	February	March	April	May	June	YTD
Expenses													
Bank Fees													**$0.00**
Cobra Dental Fees													**$0.00**
Depreciation													**$0.00**
Investment Management	$1,598.51												**$1,598.51**
Meeting Expenses													**$0.00**
Misc. Expenses													**$0.00**
Printing													**$0.00**
Trustees E&O													**$0.00**
	$1,598.51	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$1,598.51**

Clinic General Administration Expenses Detail
LHSEBT

	July	August	September	October	November	December	January	February	March	April	May	June	YTD
Expenses													
Cleaning	$1,170.00												**$1,170.00**
Electric													**$0.00**
Gas	$22.83												**$22.83**
Landscaping	$200.00												**$200.00**
Misc. Expenses													**$0.00**
Pest Control													**$0.00**
Phone	$748.66												**$748.66**
Property Insurance													**$0.00**
Property Taxes													**$0.00**
Rent	$3,275.00												**$0.00**
Repairs and Maintenance													**$0.00**
Security													**$0.00**
Trash													**$0.00**
Water	$155.35												**$155.35**
Western Alarm	$76.50												**$76.50**
	$5,648.34	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$5,648.34**

Erin P. Collins & Associates, Inc.

Phone: 928.753.4700 x302
Fax: 877.866.5732
1115 Stockton Hill Rd., Ste. 101
Kingman, AZ 86401
jaimes@ecollinsandassociates.com

MEMORANDUM

TO: **LHSEBT Trustees**

FROM: **ERIN P. COLLINS & ASSOCIATES, INC. (ECA)**
Jaime Schulenberg, Sr. Account Manager

DATE: October 11, 2018

RE: Emergency Checks at District Office

With the change in Chairperson effective July 19, it was necessary for District staff to facilitate updating signature cards on the LHSEBT bank accounts. During that process, it was learned that the District had previously kept a supply of signed LHSEBT checks in the event of an emergency.

This practice brings up a number of concerns in terms of general accounting practices, in addition to misappropriation. ECA would recommend against such a practice. In the event of an unforeseen need, ECA is able to purchase items or pay invoices using our corporate credit card, after which we would seek reimbursement from the Trust by providing a request with appropriate documentation of the expenditure. However, ultimately it is up to the Board to determine whether to authorize the Chairperson to sign blank checks to be kept at the District Office for emergencies.

If you have any questions between now and the date of the meeting, I can be reached at (928) 753-4700 ext. 302 or via email at jaimes@ecollinsandassociates.com.

Erin P. Collins & Associates, Inc.

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Kingman, AZ 86401
jaimes@ecollinsandassociates.com

MEMORANDUM

TO: **LHSEBT Trustees**

FROM: **ERIN P. COLLINS & ASSOCIATES, INC. (ECA)**
Jaime Schulenberg, Sr. Account Manager

DATE: October 11, 2018

RE: Health & Wellness Center 2018 Annual Program Health Performance Review

Attached is the 2018 Annual Program Health Performance Review provided by Cerner. As of the date of this memo, we have not received confirmation as to whether someone from Cerner will be available to present this report; if not, we would recommend tabling this item to the next meeting.

If you have any questions between now and the date of the meeting, I can be reached at (928) 753-4700 ext. 302 or via email at jaimes@ecollinsandassociates.com.

LHSEBT Health & Wellness Center
brought to you by the Employee Benefit Trust

2018 Annual Program Health Performance Review

Reporting Date Range:
(7/1/2017 – 6/30/2018)
Sources:
Eligibility, PHA, Labs & Biometrics

Wellness Review

- Program Overview
- PHA Summary
- Labs & Biometrics Summary
- Top Condition Risks
  - Hypertension
  - Hyperlipidemia
  - Obesity
- Cohort Condition Migration
- Discussion and Next Steps

Cerner

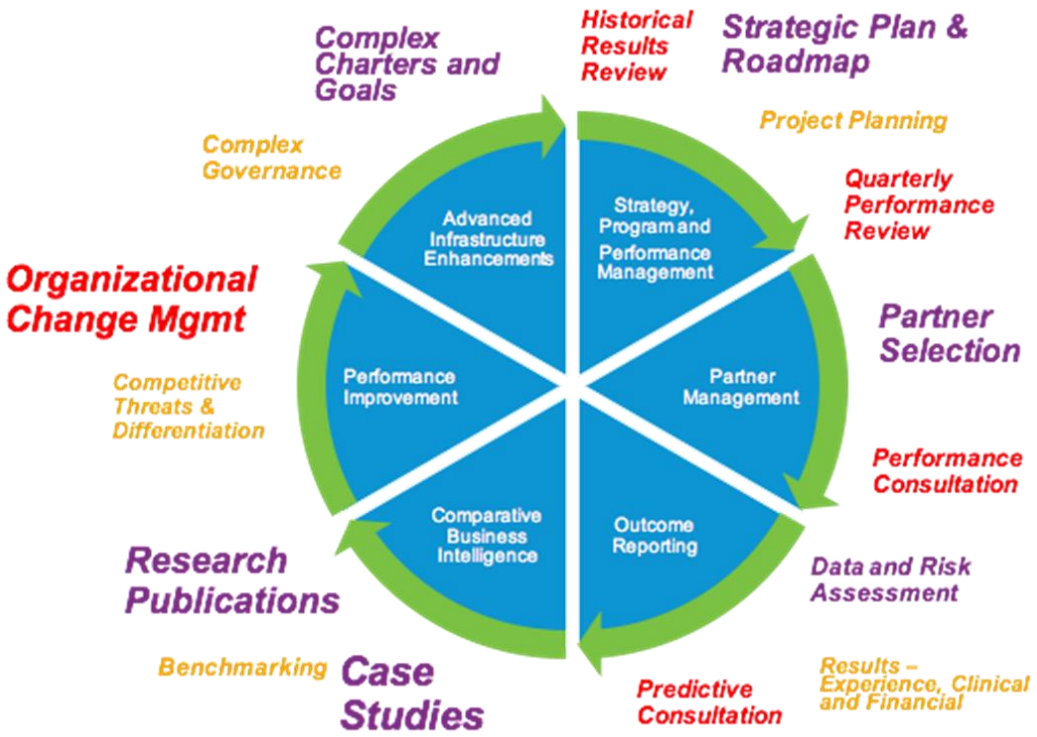
Christa Roberts	Director – Client and Performance Management
Stephanie Lewis	Manager, Sr. Strategist – Client and Performance Management
Dakota Zeit	Sr. Client Results Analyst – Client and Performance Management
Sharon Radetic	Regional Operations Manager – Population Health Services
Dalton Jones	Data Visualization Analyst – Client and Performance Management

Creating a System for Health

A ***System for Health*** is defined by:

- **Experience it creates** (seamless and coordinated),
- **Intelligent and personal health programming it provides** (90+ percent of the time evidence-based measures are met)
- **Overall investment value related to results** (population health investment dollars and results are tracked connected to social determinants of health)

Creating the environment and obtaining desired results requires client and performance management team members to work within a new, six category model of consultation and client management.

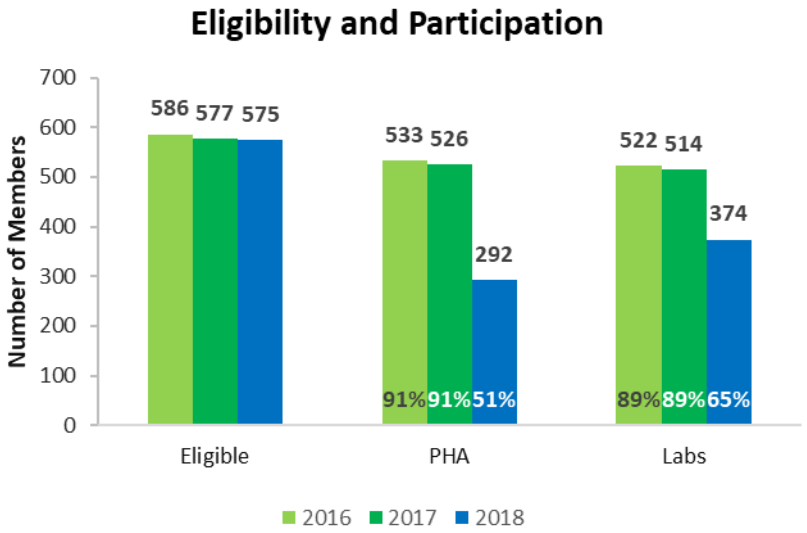


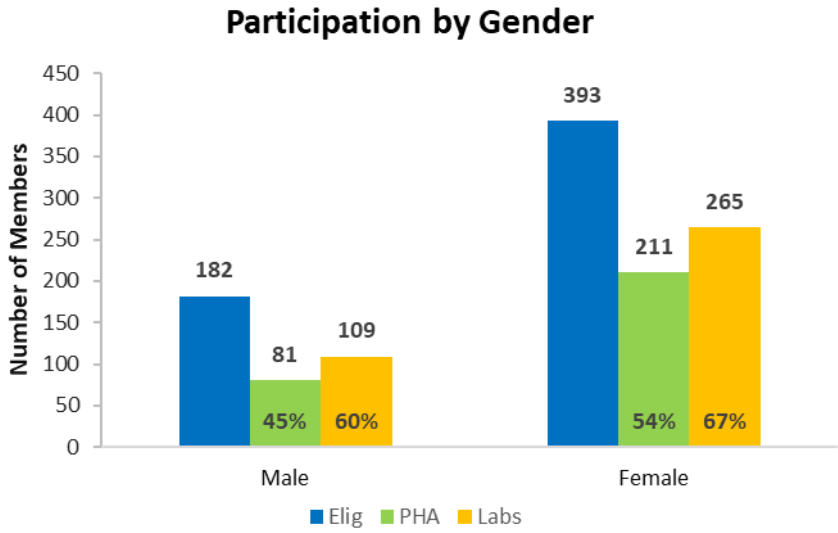
Program Participation Overview

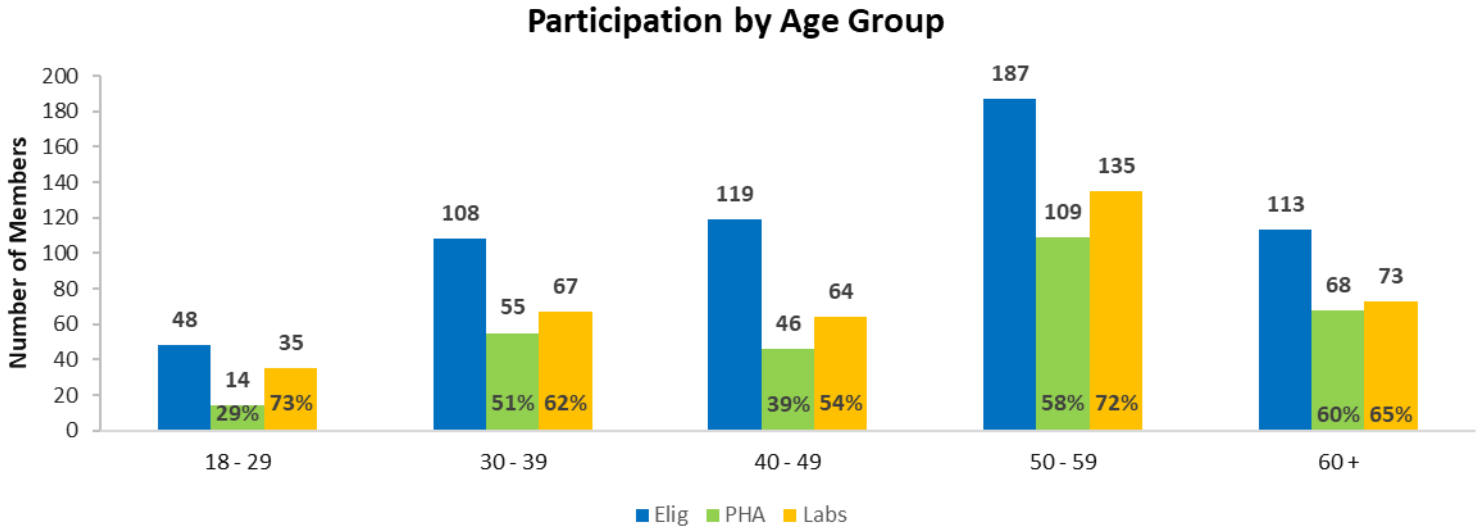
Key Insights

Source: Eligibility, PHA and Wellness Screenings (7/1/2017 – 6/30/2018 for PHA / Labs & Biometrics)

- 292 members have completed the PHA (51%)
- 374 members have completed a screening (65%)
- Average age of members:
  - Eligible – 48
  - Participant – 50
- Highest participation by percentage falls within the 60+ age group

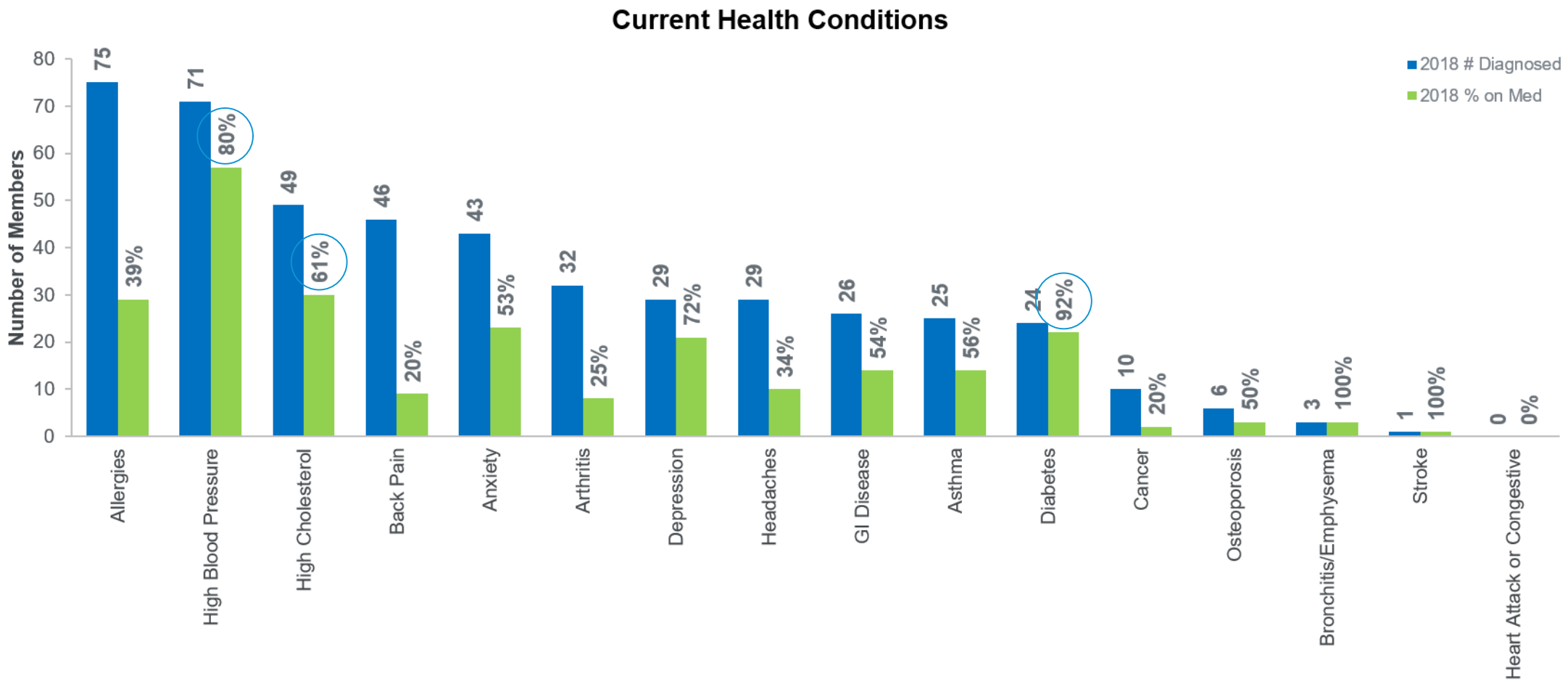






Current Health Conditions – PHA (Self Reported)

Source: PHA (7/1/17 – 6/30/18)

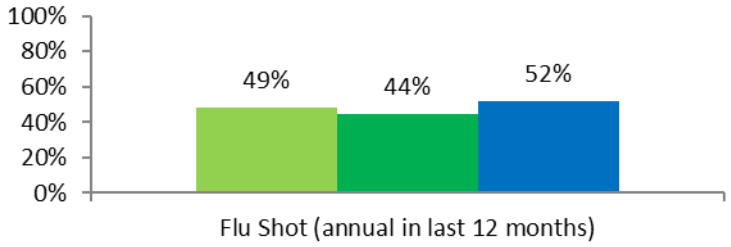


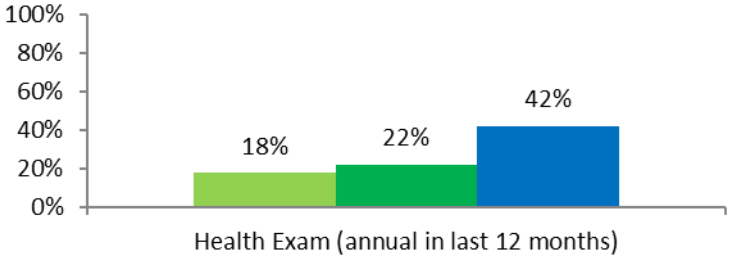
Preventive Care Trends

Source: PHA (7/1/17 – 6/30/18)

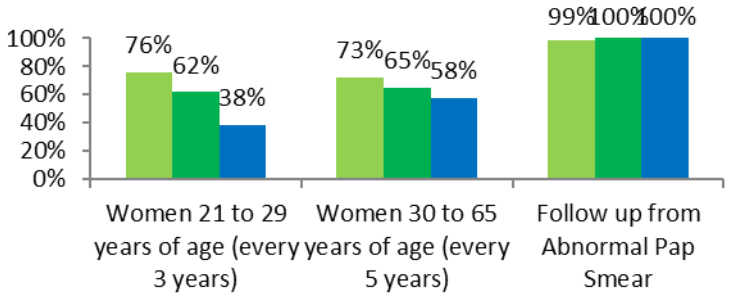
2016 2017 2018

Flu Shot



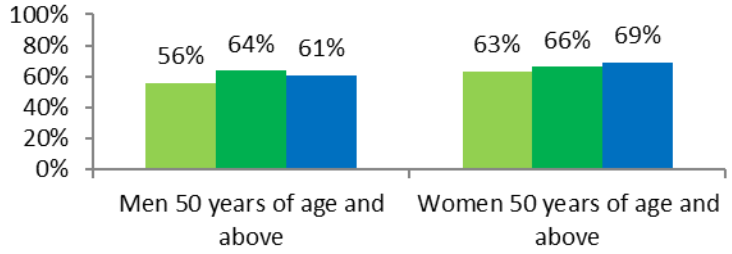


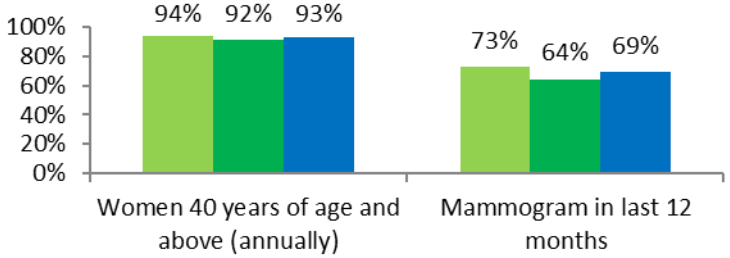
Health Exam



Pap Smear

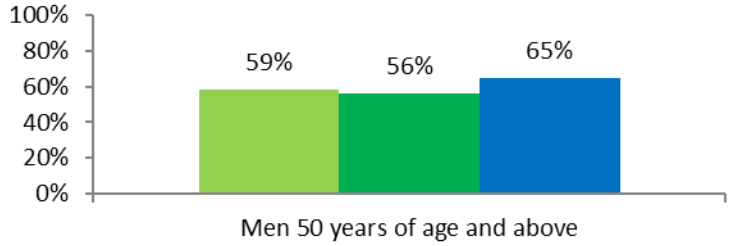
Colonoscopy





Mammogram

Prostate Exam



Lab & Biometric Averages – Aggregate

Source: Wellness Screenings (7/1/17 – 6/30/18)

- 374 total participants have completed Labs and Biometrics
- 6 averages fall within clinical low risk ranges
- 5 averages improved from 2017
- Two high risk averages

Cerner	Lab & Biometric Stratification		
Lab or Biometric	Low	Moderate	High
Hemoglobin (HbA1c)	< 5.7 mmol/L	5.7 - 6.4 mmol/L	>= 6.5 mmol/L
Glucose	< 100 mg/dL fasting, < 140 mg/dL random	100 - 125 mg/dL fasting, 140 - 199 mg/dL random	>= 126 mg/dL fasting, >= 200 mg/dL random
Total Cholesterol	< 200 mg/dL	200 - 239 mg/dL	>= 240 mg/dL
HDL Cholesterol	> 60 mg/dL	40 - 60 mg/dL Male, 50 - 60 mg/dL Female	< 40 mg/dL Male, < 50 mg/dL Female
LDL Cholesterol	< 100 mg/dL	100 - 159 mg/dL	>= 160 mg/dL
Triglycerides	< 150 mg/dL	150 - 199 mg/dL	>= 200 mg/dL
Blood Pressure	< 120 Systolic and < 80 Diastolic mm Hg	120-129 Systolic and < 80 Diastolic mm Hg	**High (Stage 1)** 130-139 Systolic or 80-89 Diastolic mm Hg / **High (Stage 2)** >= 140 Systolic or >= 90 Diastolic mm Hg
Body Mass Index	>= 18.5 - < 25 mg/m2	>= 25 - < 30 mg/m2	>= 30 mg/m2
Waist Circumference	< 31 inches Female, < 37 inches Male	>= 31 - <= 35 inches Female, >= 37 - <= 40 inches Male	> 35 inches Female, > 40 inches Male

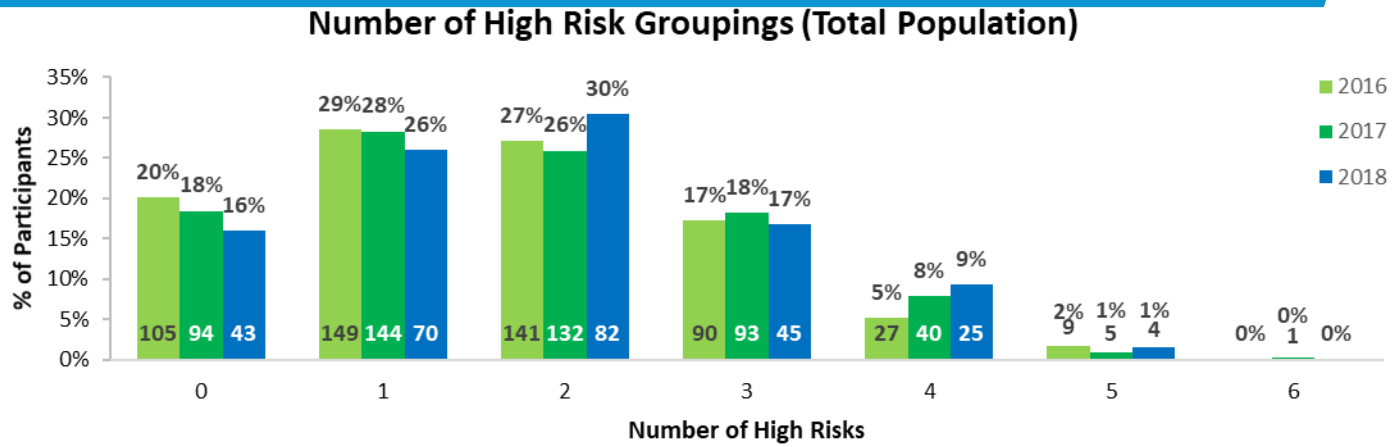
Demographics Averages	2016	2017	2018
Total Participants	522	514	374
Female	68%	68%	71%
Male	32%	32%	29%
Age (Average in Years)	49	48	49
Height (Average in Inches)	67	67	67
Weight (Average in pounds)	182	185	186
HbA1c (mmol/L)	5.6	5.5	5.5
Glucose - Non-Fasting (mg/dL)	95	106	96
Glucose - Fasting (mg/dL)	98	101	99
Total Cholesterol (mg/dL)	194	196	192
HDL (mg/dL)	58	58	56
LDL (mg/dL)	109	113	111
Triglycerides (mg/dL)	132	148	145
Total Cholesterol/HDL Ratio	3.6	3.7	3.8
Blood Pressure Systolic (mm/Hg)	119	120	121
Blood Pressure Diastolic (mm/Hg)	78	78	78
Body Mass Index (kg/m2)	29	29	29
Waist - Females (inches)	35	35	36
Waist - Males (inches)	40	40	41

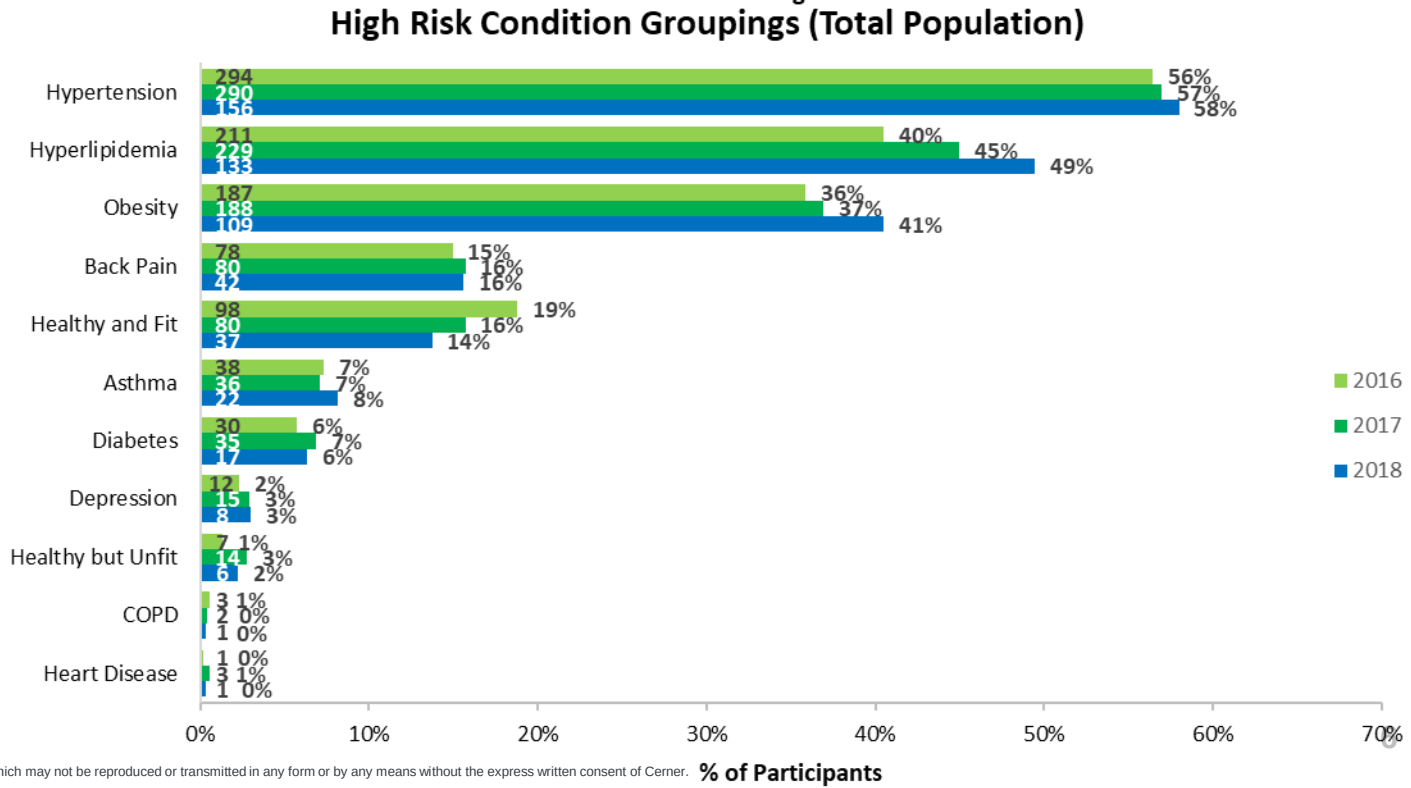
Health Risks - Aggregate

Key Insights

Source: PHA and Wellness Screenings (7/1/17 – 6/30/18)

- Top 3 High Risk conditions
  - Hypertension
  - Hyperlipidemia
  - Obesity
- 84% of participating members are classified in 1 or more high risk categories
- More than one-third (58%) classified in 2 or more comorbid high risk condition categories
- 58% with high risk Hypertension
- 49% with high risk Hyperlipidemia





Lab & Biometric Averages – 3 Year Cohort

Source: Wellness Screenings (7/1/17 – 6/30/18)

- 201 total participants completed Labs and Biometrics YOY
- 5 averages fall within clinical low risk ranges
- 3 averages improved from 2017
- One high risk average

Cerner	Lab & Biometric Stratification		
Lab or Biometric	Low	Moderate	High
Hemoglobin (HbA1c)	< 5.7 mmol/L	5.7 - 6.4 mmol/L	>= 6.5 mmol/L
Glucose	< 100 mg/dL fasting, < 140 mg/dL random	100 - 125 mg/dL fasting, 140 - 199 mg/dL random	>= 126 mg/dL fasting, >= 200 mg/dL random
Total Cholesterol	< 200 mg/dL	200 - 239 mg/dL	>= 240 mg/dL
HDL Cholesterol	> 60 mg/dL	40 - 60 mg/dL Male, 50 - 60 mg/dL Female	< 40 mg/dL Male, < 50 mg/dL Female
LDL Cholesterol	< 100 mg/dL	100 - 159 mg/dL	>= 160 mg/dL
Triglycerides	< 150 mg/dL	150 - 199 mg/dL	>= 200 mg/dL
Blood Pressure	< 120 Systolic and < 80 Diastolic mm Hg	120-129 Systolic and < 80 Diastolic mm Hg	**High (Stage 1)** 130-139 Systolic or 80-89 Diastolic mm Hg / **High (Stage 2)** >= 140 Systolic or >= 90 Diastolic mm Hg
Body Mass Index	>= 18.5 - < 25 mg/m2	>= 25 - < 30 mg/m2	>= 30 mg/m2
Waist Circumference	< 31 inches Female, < 37 inches Male	>= 31 - <= 35 inches Female, >= 37 - <= 40 inches Male	> 35 inches Female, > 40 inches Male

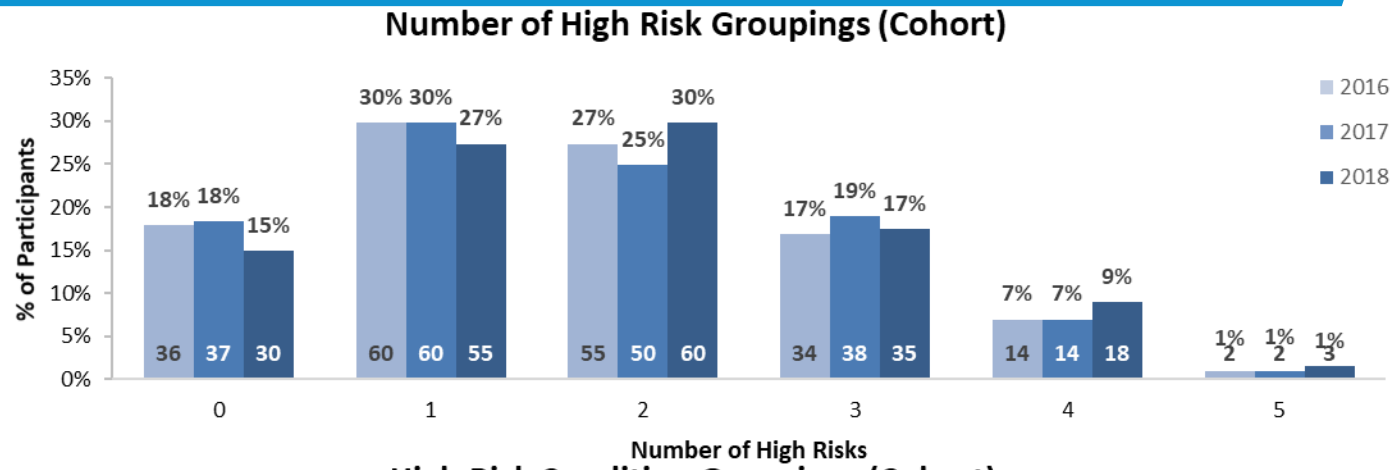
Demographics Averages	2016	2017	2018
Total Participants	201	201	201
Female	74%	74%	74%
Male	26%	26%	26%
Age (Average in Years)	50	51	52
Height (Average in Inches)	67	67	66
Weight (Average in pounds)	181	182	184
HbA1c (mmol/L)	5.7	5.6	5.6
Glucose - Fasting (mg/dL)	99	101	99
Total Cholesterol (mg/dL)	195	203	199
HDL (mg/dL)	59	58	57
LDL (mg/dL)	108	120	116
Triglycerides (mg/dL)	134	138	145
Total Cholesterol/HDL Ratio	3.6	3.8	3.8
Blood Pressure Systolic (mm/Hg)	120	120	123
Blood Pressure Diastolic (mm/Hg)	79	78	79
Body Mass Index (kg/m2)	29	29	29
Waist - Females (inches)	35	36	36
Waist - Males (inches)	39	39	40

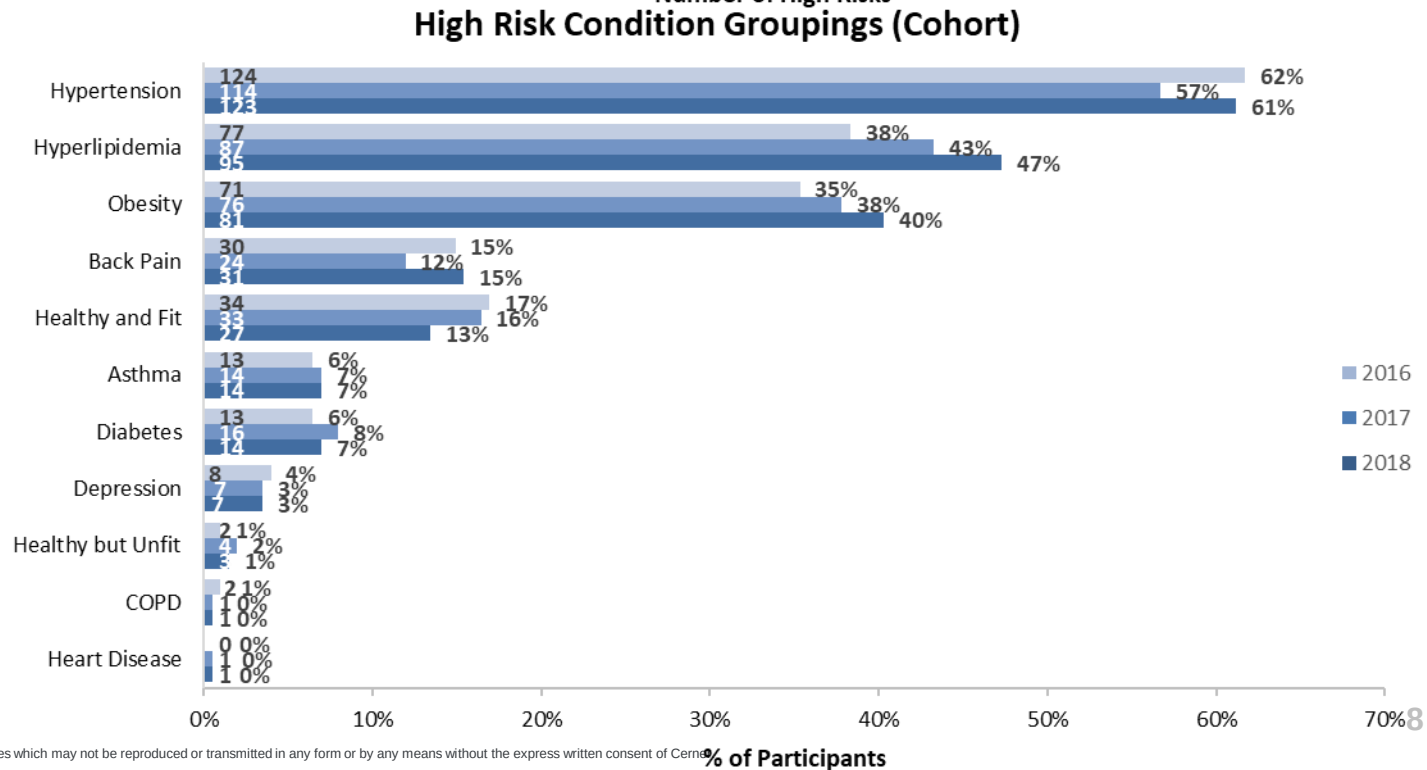
Top Health Conditions – 3 year Cohort

Key Insights

Source: PHA and Wellness Screenings (7/1/17 – 6/30/18)

- Top 3 High Risk conditions
  - Hypertension
  - Hyperlipidemia
  - Obesity
- On average, 85% of participating members are classified in 1 or more high risk categories
- Wellness Initiatives that were done to target top health conditions:
  - Onsite Biometric Screenings
  - Distribute Healthy Recipes
  - Ongoing WAVE cooking classes
  - Member education through monthly wellness newsletters and wellness workshops



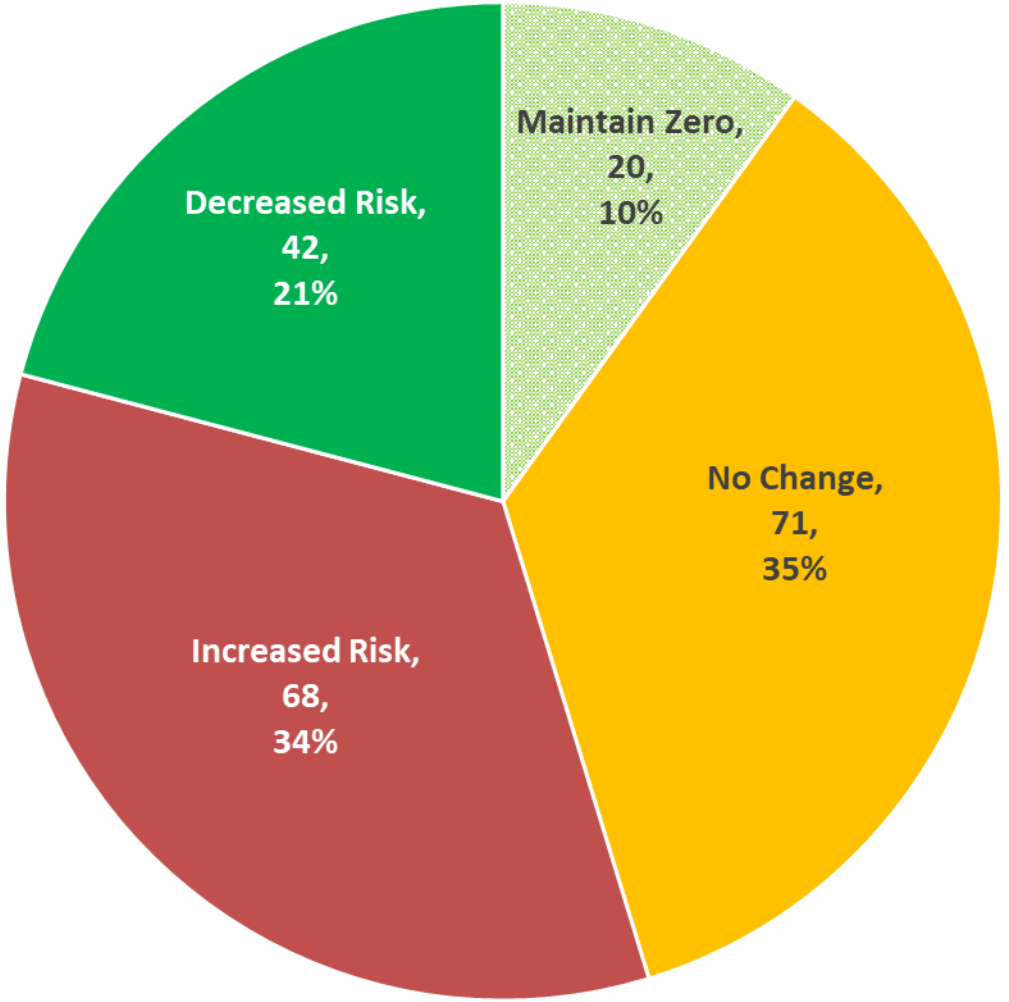


Cohort Risk Migration – PHA & Screenings

Source: PHA and Wellness Screenings (7/1/17 – 6/30/18)

Cohort Health Condition Risk Shift

- From 2016 to 2018, 62 members or 31% of the cohort **reduced their number of high risk factors or maintained zero high risk factors**
  - 42 members or 21% **decreased** high risk condition count from 2016 to 2018
  - 71 members or 35% had **no change** in high risk conditions from 2016 to 2018
  - 20 members or 10% **maintained zero** high risk conditions from 2016 to 2018
  - 68 members or 34% **increased** high risk conditions from 2016 to 2018



2017-2018 Annual Health Center Review

Cerner

2017-2018 Utilization

2016-2017	
Eligible Population	704

2017-2018 Utilization					
	July 2017-Sept 2017	Oct 2017-Dec 2017	Jan 2018- March 2018	April 2018-June2018	Annual Total
Total Visits	494	644	1110	713	2,961
Unique Patients	349	434	586	496	1,035
New Patients	55	69	70	104	298
Returning Patients	301	374	539	397	686
HC as PCP	185	226	333	247	508

2017-2018 Utilization			
	2016-2017	2017-2018	% Change
Total Visits	3,220	2,961	-8.04%
Unique Patients	1,054	1,035	-1.80%
New Patients	305	298	-2.29%
Return Rate	45.40%	31.40%	-20%
HC as PCP	496	508	2.36%

Quality Management & Patient Outcomes

Cerner

2017-2018: Patient Satisfaction

Cerner Patient Satisfaction Rate

99%

vs

National Rate

80%

- **It might seem like I just went through and clicked all the highest marks, but I didn't. They really deserve them. I would not go to the dr. Other than here or an emergency. But it s good here**
- **Diane also did my vitals before seeing Chrissy. Always receive great care from Chrissy, Robert and Diane**
- **Staff and Laura are very professional and treat you with courtesy and a positive attitude**
- **So glad to have this as my primary care provider. Always a pleasure to deal with**
- **Thank you for the great care. Love the wellness center**
- **I could not have had any better of care than at our Wellness Center. They are the best.**

NCQA/AHRQ CAHPS Physician & Group Survey National Results

2017-2018 Health Center Highlights

Increased Wellness Center Utilization

- **3,774** total visits
- Retention of professional, knowledgeable center staff
- Quality care focus (patient experience) rather than quantity
- Focus on monthly wellness theme with newsletters, classes and handouts
- PCP rate of **72%**

Exceptional WOW Program Participation

- **65%** participation rate in the WOW program without incentivizing participants
- Appointment at no cost to patient
- Face to face goal setting & coaching with a provider

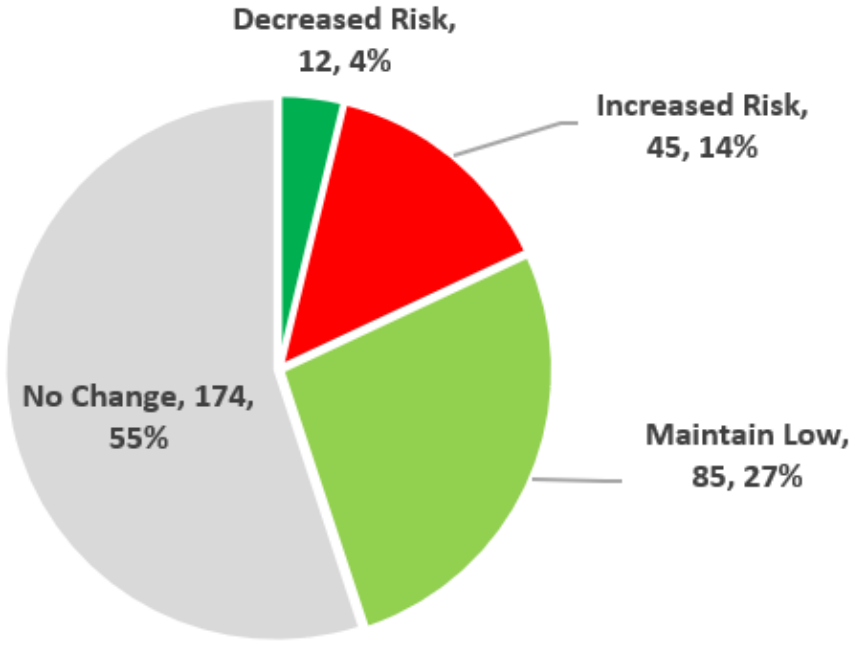
Quality Improvement Goals

- Improving cervical cancer screening
- Improving blood pressure outcomes

Health Center Cohort Analysis 2016-2018

Cerner

2016-2018 Cohort Analysis - ***Obesity***

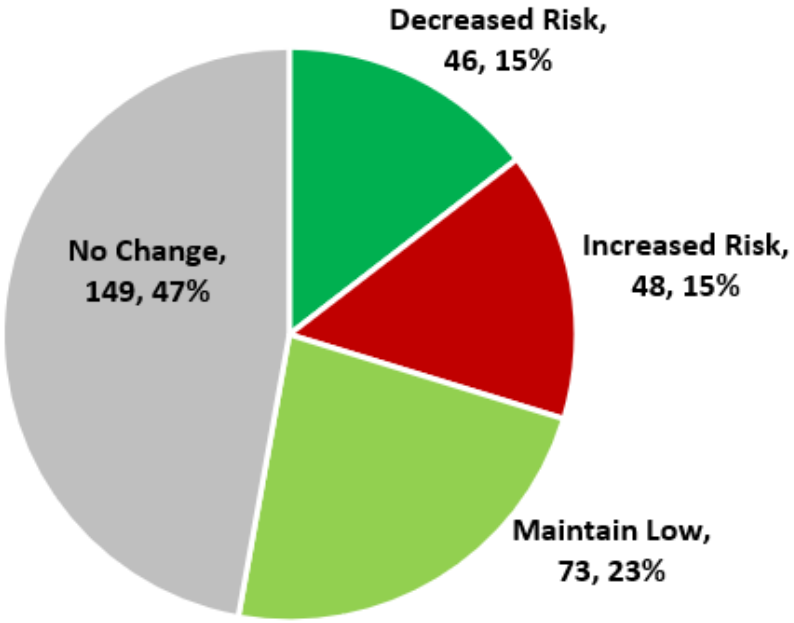


Row Labels	Count of Person - MPI
Decreased Risk	12
Increased Risk	45
Maintain Low	85
No Change	174

1.9% (6 Members)	High to Moderate	**2.5% Total High Risk Reduction**		
0.6% (2 Members)	High to Low			
1.3% (4 Members)	Moderate to Low	316 Member Cohort Group from 2016 to 2018		
Year 3 Metric Improvements	Member Count	% of Cohort	Avg. Change (lbs. or mg/m2)	Max Improvement (lbs. or mg/m2)
Body Weight (lbs.)	84	27%	-7.1	-42
Body Mass Index (mg/m2)	77	24%	-1.2	-6.6

2016-2018 Cohort Analysis - ***Hypertension***

Hypertension Risk Migration (2016 - 2018)

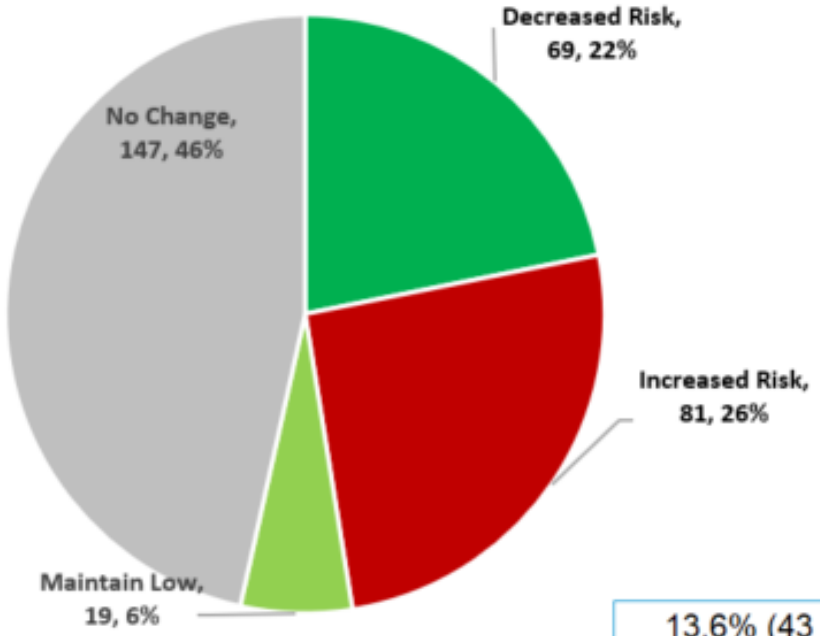


Row Labels	Count of Person - MPI
Decreased Risk	46
Increased Risk	48
Maintain Low	73
No Change	149
Grand Total	316

4.4% (14 Members)	High to Moderate	**12.7% Total High Risk Reduction**		
8.2% (26 Members)	High to Low			
1.9% (6 Members)	Moderate to Low	316 Member Cohort Group from 2016 to 2018		
Year 3 Metric Improvements	Member Count	% of Cohort	Avg. Change (mm/Hg)	Max Improvement (mm/Hg)
Systolic Blood Pressure (mm/Hg)	111	35%	-9.7	-30
Diastolic Blood Pressure (mm/Hg)	133	42%	-6.7	-24

2016-2018 Cohort Analysis - ***Hyperlipidemia***

Cohort Hyperlipidemia Risk Migration (2016 - 2018)



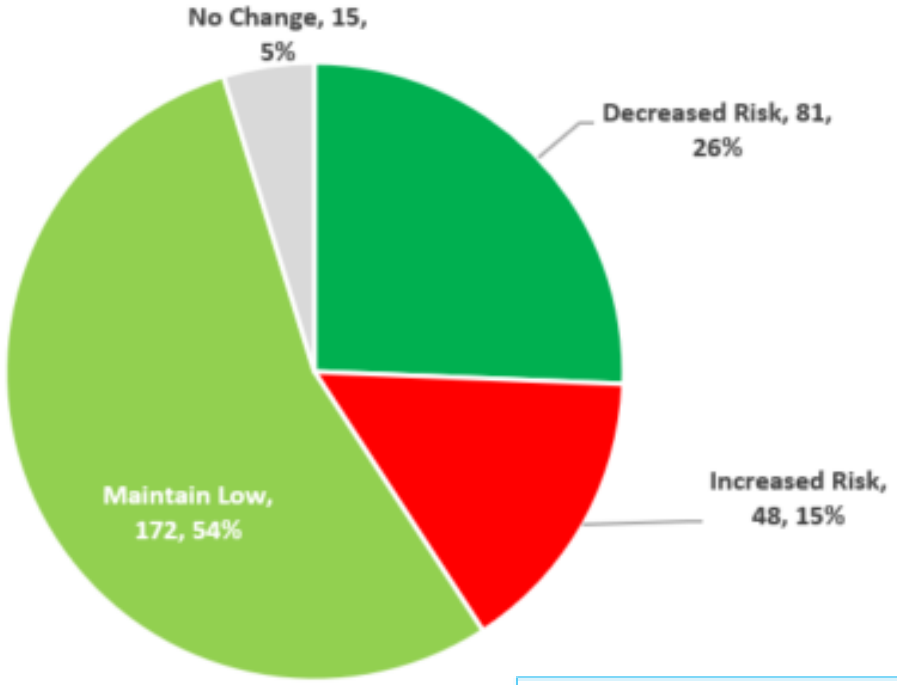
Risk Change	Count of Members
Decreased Risk	69
Increased Risk	81
Maintain Low	19
No Change	147

13.6% (43 Members)	High to Moderate	**17.7% Total High Risk Reduction**
4.1% (13 Members)	High to Low	
4.1% (13 Members)	Moderate to Low	316 Member Cohort Group from 2016 to 2018

Year 3 Metric Improvements	Member Count	% of Cohort	Avg. Change (mg/dL)	Max Improvement (mg/dL)
LDL Cholesterol (mg/dL)	131	41%	-34.2	-139
HDL Cholesterol (mg/dL)	166	53%	-9.2	-46
Triglycerides	142	45%	-88.0	-472
Total Cholesterol (mg/dL)	154	49%	-39.5	-160

2016-2018 Cohort Analysis - ***Diabetes***

Cohort Diabetes Risk Migration (2016 - 2018)



Row Labels	Count of Person - MPI
Decreased Risk	81
Increased Risk	48
Maintain Low	172
No Change	15

1.6% (5 Members)	High to Moderate	**5.4% Total High Risk Reduction**		
3.8% (12 Members)	High to Low			
20.3% (64 Members)	Moderate to Low	316 Member Cohort Group from 2016 to 2018		
Year 3 Metric Improvements			Avg. Change (mmol/L)	Max Improvement (mmol/L)
	Member Count	% of Cohort		
HbA1c (mmol/L)	168	53%	-0.64	-8.6

2017-2018: Population Engagement

Monthly Wellness Themes

- 12 monthly wellness themes marketed
- Marketing materials produced, displayed and distributed
- Health workshop offered on the wellness dashboard

WAVE Cooking Classes

- Small Group Healthy Cooking Classes
- Exposure to non-traditional healthy foods
- Offered 3 interactive cooking classes
  - **12-16** participants per class

Full Plate Diet Session #1

- 8 week weight loss jump start program
- Emphasized healthy eating habits to gradually lose or maintain weight
- 19 total participants
  - **15 participants lost 81 pounds for an average of 5.4 pounds/person**
  - **2 normal BMI participants remained in the healthy range**
  - **2 participants gained weight for a total of 7 pounds**

2017-2018: Population Engagement

On-site Flu Clinic

- Offered **9** off-site clinics during October 2017
- **220** vaccinations given

Career Day at Thunderbolt

- After hour wellness class offered
- **22** participants

Holiday Nutrition Class

- **4** Free Skin Screening Days offered
- **122** screenings completed

Raffle for Breast Cancer

- **2** free blood pressure clinics offered
- **18** screenings completed

Value on investment:

Creating healthier stories one patient at a time.

2017-2018: Value on Investment

The Situation

Patient presented with generalized complaints of fatigue, difficulty sleeping, etc. Labs from another provider revealed an elevated iron level. Further workup conducted by us as her primary care provider

The Result

Found to have a blood disorder that is genetic. Referred to the appropriate specialist and treatment is underway. Patient comforted to have a correct diagnosis that explained her symptoms and able to notify her family of the disorder

2017-2018: Value on Investment

The Situation

53 year old female treated for obesity and chronic pain with mildly elevated blood pressure.
Started on a high-fiber, low carb diet and an exercise regimen with gentle stretching and strengthening exercises.

The Result

Weight loss of 9.5 pounds in 3 months and her blood pressure is now normal. Her pain has improved with exercise and other treatments. She plans to continue her regimen towards better health.

Closing & Next Steps

Strengths

- **Medication Adherence** – good self reported condition specific medication adherence for high blood pressure, high cholesterol and diabetes
- **Healthy & Fit** – 14% of the population falls within this category meaning they have no identified high risks
- **Physical Activity** – 61% of participants are active three or more days per week

Risks

- **Hypertension** – 58% of participants fall into the high risk category
- **Hyperlipidemia** – 49% of participants are high risk
- **Obesity** – 41% of participants are obese with a BMI > or = 30
- **Sleep 8 hours/night** – 30% of participants sleep 8 hours/night or more “less than half the time or never”

Opportunities

- Device integration (application & device connectivity)
- Offer onsite fitness classes
- Improve Nutrition Offerings: Fresh Fruit Fridays, color code vending machines, wellness classes geared around cooking techniques either at WAVE or have a dietician come onsite quarterly
- Promote tobacco cessation resources through marketing and wellness classes
- Emphasize steps and weight challenges and add wellness classes around nutrition and fitness/ Encourage walking meetings when on breaks or before/after school and map out walking paths in school for staff
- HealtheIntent

Questions?

Appendix

Top 11 Conditions

- Risk Stratification

Cerner	Risk Stratification		
Condition	Low	Moderate	High
Cardiovascular (Heart) Disease	< 1% cardiac risk score Based on the Framingham Risk Score	> 1% - < 29% cardiac risk score Based on the Framingham Risk Score	> 29% cardiac risk score Based on the Framingham Risk Score
Depression, Anxiety and Stress Management	Answers no on questions *5.1 and **5.2 on PHA, or yes to either question, and no personal health history of depression or anxiety	Answers no on both questions *5.1 and **5.2 on PHA, but has a personal health history of depression or anxiety; Answers yes to either PHA question and has a personal health history of depression or anxiety; Answers yes to both PHA questions but does not have a personal health history of depression or anxiety	Answers yes on both questions *5.1 and **5.2 on PHA, and yes to personal health history of depression or anxiety
	*PHA Question 5.1: During the last 2 weeks has feeling down, depressed or hopeless bothered you? A) yes B) no **PHA Question 5.2: During the last 2 weeks, has little interest or little pleasure in doing things bothered you? A) yes B)		
Asthma	Negative for history of smoking, allergies, or family history of asthma	Past history of smoking, current history of allergies, or family history of asthma	Positive for smoking and personal health history of asthma
COPD	No history of chronic bronchitis, COPD and have never smoked	No history of chronic bronchitis, COPD and quit smoking OR No history of chronic bronchitis, COPD and current smoker OR Yes to history of chronic bronchitis, COPD and have never smoked	Yes to history of chronic bronchitis, COPD and quit smoking OR Yes to history of chronic bronchitis, COPD and current smoker
Hypertension	< 120 Systolic and < 80 Diastolic mm Hg	120-129 Systolic and < 80 Diastolic mm Hg	**High (Stage 1)** 130-139 Systolic or 80-89 Diastolic mm Hg **High (Stage 2)** >= 140 Systolic or >= 90 Diastolic mm Hg
Diabetes	Glucose (fasting) 70-79 (random) 80-139 Hemoglobin A1c non-diabetic < 5.7, diabetic <= 6.9	Glucose (fasting) 120-125 (random) 140-199 Hemoglobin A1c non-diabetic 5.7 - < 6.5	Glucose (fasting) >= 126 (random) >= 200 Hemoglobin A1c non-diabetic >= 6.5, diabetic >= 7.0
Hyperlipidemia/Dyslipidemia	Total Cholesterol: <= 199 mg/dL HDL Cholesterol: >= 60 mg/dL LDL Cholesterol: <= 129 mg/dL Triglycerides: <= 149 mg/dL	Total Cholesterol: 200-239 mg/dL HDL Cholesterol: 40-59 mg/dL LDL Cholesterol: 130-159 mg/dL Triglycerides: 150-199 mg/dL	Total Cholesterol: >= 240 mg/dL HDL Cholesterol: <= 39 mg/dL LDL Cholesterol: >= 160 mg/dL Triglycerides: >= 200 mg/dL
Back and Neck Pain	Does not select back pain on current health PHA question	N/A	Selects back pain on current health PHA question
Obesity	Body Mass Index between 18.5 - 24.9	Body Mass Index between 25 - 29.9	Body Mass Index >= 30
Healthy but Unfit	Body Mass Index < 25, chooses anything other than never smoked on PHA or answered yes to chewing tobacco	Body Mass Index between 25 - 27.9, Moderate risk for Nutrition or Exercise based on wellness scoring	Body Mass Index between 28 - 29.9, High risk for Nutrition or Exercise based on wellness scoring
Healthy and Fit	No major life changes and all labs and biometrics in ideal range Life Events: Marriage, Divorce, Pregnancy/Adoption, Loss or addition of job, Death	1 life event change identified Life Events: Marriage, Divorce, Pregnancy/Adoption, Loss or addition of job, Death	2 life event changes identified Life Events: Marriage, Divorce, Pregnancy/Adoption, Loss or addition of job, Death

Erin P. Collins & Associates, Inc.

Phone: 928.753.4700 x302
Fax: 877.866.5732
1115 Stockton Hill Rd., Ste. 101
Kingman, AZ 86401
jaimes@ecollinsandassociates.com

MEMORANDUM

TO: **LHSEBT Trustees**

FROM: **ERIN P. COLLINS & ASSOCIATES, INC. (ECA)**
Jaime Schulenberg, Sr. Account Manager

DATE: October 11, 2018

RE: Administrative Update

Mid-Year Plan Changes and Open Enrollment

ECA notified Gilsbar and CVS of the January 01, 2019 benefit changes approved by the Board and both vendors are working to implement those changes in their systems. We have confirmed with Gilsbar that these changes will not require new ID cards for members.

We are also working with District staff to schedule a mid-year open enrollment which we assume will include employee meetings. In addition, we drafted a memo to go to all employees advising them of the upcoming benefit changes, which included attachments from the H&W Clinic (memo and Records Release) and the list of BlueCross BlueShield of AZ primary care providers in Lake Havasu City currently accepting new patients. That memo should have been distributed as of the date of the Trust meeting.

We will continue to keep the Board apprised of this process as it continues.

Teladoc Implementation

The Teladoc agreement has been signed and set-up forms provided so that implementation can begin. In addition, ECA reached out to Gilsbar to ensure they could facilitate eligibility file feeds, which they confirmed. Our next step is to develop a marketing strategy to encourage members to download the app, complete medical history paperwork, etc.

Development of Incurred But Not Paid (IBNP) Calculation for 06/30/18

Claims data has been provided to the actuary, Mike Schionning from Cheiron, to develop the Incurred But Not Paid (IBNP) liability for the plan year ending 06/30/18; as soon as we have the report, we will schedule it for presentation to Trustees. As a reminder, this calculation estimates the outstanding liability owed by the Trust for claims that were incurred by beneficiaries as of 06/30/18, but which have not been presented for payment. It also includes an administrative expense component which is contingent on closing the

Trust down and winding up its operations. The IBNP liability will be reflected in future financial reports as a reduction of available "cash" since those dollars must be reserved for payment of those claims as they present. Further, this calculation will be updated annually after the plan year closes.

If you have any questions between now and the date of the meeting, I can be reached at (928) 753-4700 ext. 302 or via email at jaimes@ecollinsandassociates.com.