PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

THIS AGREEMENT, effective as of the first day of January 2021 ("Effective Date") by and between CaremarkPCS Health, L.L.C., a Delaware limited liability company with its principal offices located at 2211 Sanders Road, Northbrook, IL 60062 ("Pharmacy Benefit Manager"), and the STATE OF MINNESOTA ("the State") (the State and Pharmacy Benefit Manager are collectively referred to as the "Parties" and individually as a "Party").

WITNESSETH

WHEREAS, the State maintains, or will maintain: (i) the State Employees Group Insurance Program ("SEGIP") that consists of one or more self-insured group health plans, including any high deductible health plan adopted by the State, which is available to eligible employees of the State, other eligible individuals, and their dependents, and to former employees and their dependents who are eligible for and elect continuation coverage; and (ii) the Minnesota Public Employees Insurance Program ("PEIP"), which is a self-insured group health plan administered by the State and which is available to eligible employees (as determined by State under Minn. Stat. § 43A.316, subd. 2(b)), other eligible individuals, and their dependents, and to former employees and their dependents who are eligible for and elect continuation coverage.

WHEREAS, Pharmacy Benefit Manager, provides its services in connection with the health care operations and payments of claims on behalf of their group health plans and consistent with the terms of this Agreement.

WHEREAS, the Parties desire to establish this Agreement for the management of pharmacy benefits under SEGIP and PEIP.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained in this Agreement, the Parties agree and covenant as follows:

SECTION 1 SCOPE

This Agreement applies to the management of pharmacy benefits under SEGIP and PEIP which Pharmacy Benefit Manager will provide to the Employee Plan pursuant to this Agreement.

SECTION 2 DEFINITIONS

The terms in this Section 2 will have the respective meanings set forth below whenever used in this Agreement, unless the context clearly requires otherwise, and when the defined meaning is intended, the term is capitalized.

To the extent that the definitions or provisions set forth in this Section 2 are in any way inconsistent with, or conflict with the definitions or provisions in the Summary of Benefits for the respective Employee Plan, the definitions and provisions in this Agreement will control for all purposes with respect to the operation and interpretation of this Agreement. Likewise, the definitions and provisions in the Summary of Benefits for the respective Employee Plan then in effect will control for all purposes with respect to the operation and interpretation of such Summary of Benefits.

2.1. Affiliate

Means any entity that directly or indirectly controls, is controlled by or is under common control with a Party.

2.2. AWP

Means the average wholesale price of a prescription drug as identified by a source recognized in the retail prescription drug industry designated by the Pharmacy Benefit Manager on the date the prescription was dispensed for that actual package size dispensed. AWP from two pricing sources will not be used simultaneously. The applicable AWP will be the 11-digit NDC for the product dispensed on the date dispensed. Pharmacy Benefit Manager will use Medi-Span for its retail, mail order and specialty drug pricing. Upon sixty (60) days' minimum prior written notice to the State, Pharmacy Benefit Manager may utilize an alternate nationally available and recognized reporting source of pharmaceutical pricing or drug classification, or a benchmark other than AWP, but only if such source is used for all of Pharmacy Benefits Manager's clients (i.e., Pharmacy Benefit Manager may not make ad hoc changes between multiple pricing sources).

2.3. Business Associate

Means a person assisting a Covered Entity in connection with its payment, treatment or health care operations, as more fully defined in 45 CFR § 160.103.

2.4. CFR

Means Code of Federal Regulations.

2.5. Claim

Means: (a) a contractual payment request submitted by a Participating Pharmacy dispensing one or more prescription drugs or Covered Products and transmitted in accordance with the electronic transaction standards set forth in 45 CFR Parts 160, 162 and 164; or (b) a direct reimbursement claim submitted by a Participating Pharmacy, another pharmacy, a Member or such Member's representative in connection with one or more prescription drugs or Covered Products dispensed to such Member.

2.6. Contract Year

Means the twelve (12) calendar month period beginning on each January 1 during the term of this Agreement.

2.7. Copayment

Means a fixed dollar portion of the charge for Covered Products which is to be paid by Members pursuant to the Summary of Benefits (or, for certain Participating Pharmacies, if less, the usual and customary charge "U&C" of the Covered Products).

2.8. Cost Share

Means the amount of money that a Member must pay to the Participating Pharmacy to obtain a Covered Product in accordance with the terms of the Employee Plan. The Cost Share may be a fixed amount (Copayment) or a percentage of the Covered Products

(coinsurance), or a Deductible that must be satisfied before a Covered Product are covered under the Employee Plan, which is to be paid by Members pursuant to the Summary of Benefits (or for certain Participating Pharmacies, if less, the U&C of the Covered Products).

2.9. Covered Entity

Means a health plan, a health care clearinghouse or a health care provider, as more fully defined in 45 CFR § 160.103.

2.10. Covered Product

Means a prescription drug, medication, supplies, device or other item that meets the requirements for coverage under the Employee Plan, after applying all conditions and exclusions set forth in the Employee Plan Guidelines, and which is dispensed to a Member pursuant to a written or electronic prescription order or allowable refill covered under the Employee Plan.

2.11. Deductible

Means a predetermined amount of money that a Member must pay before benefits are eligible for payment as indicated in the Summary of Benefits. The deductible applies to each Member each Contract Year.

2.12. Dependent

Means an individual who satisfies all the eligibility criteria through a Subscriber necessary to receive pharmacy benefits under the Employee Plan and is identified by State to Pharmacy Benefit Manager in accordance with the provisions of this Agreement as eligible for such benefits.

2.13. Direct Reimbursement Claim

Means a request for reimbursement of one or more Covered Products dispensed by a pharmacy and submitted by a Member in a pre-printed universal claim form acceptable to Pharmacy Benefit Manager.

2.14. Effective Date

Means January 1, 2021.

2.15. Employee Plan or Plans

Means each self-funded group health plan maintained by the State that provides pharmacy benefits to Members, individually or collectively as required by the context of this Agreement, and includes the State Employees Group Insurance Plan (SEGIP) Advantage Health Plan, and the Minnesota Public Employees Insurance Program (PEIP) Advantage Health Plan.

2.16. FDA

Means the United States Food and Drug Administration.

2.17. Formulary

Means the list of commonly prescribed drugs and supplies which has been reviewed by Pharmacy Benefit Manager's Pharmacy and Therapeutics (P&T) Committee (using evidence-based evaluation criteria for safety and efficacy in accordance with the Utilization Review Accreditation Commission "URAC" standards and, when applicable, Centers for Medicare and Medicaid Services "CMS" guidelines), subject to modification by State, to be used by State, Practitioners, Participating Pharmacies, and Members to guide the selection of cost effective Covered Products. The Formulary may be modified from time to time as new medications and/or new clinical information become available, is constantly updated to reflect any changes, and is accessible via Pharmacy Benefit Manager's website.

2.18. Full Claims Audit

Means an audit that includes both an operational assessment and a review of Claim transactions. The operational assessment will be comprised of structured interviews and Claim operation inspections of the various functional areas of Claims processing, both conducted on-site at Pharmacy Benefit Manager's place of business. The Claim transactions review will include random sample and/or targeted sample reviews of specific Claim transactions.

2.19. Funds Transfer

Means the amount deposited by the State to the bank account designed by Pharmacy Benefit Manager for the purpose of making payment for amounts due and owing under this Agreement pursuant to the procedure established in Section 5.2 (Covered Product Payment and Funds Transfer for Covered Product Claims).

2.20. Generic Covered Product

Means a Covered Product where the Generic Indicator (GI) field in Medi-Span contains a "Y".

2.21. HIPAA

Means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

2.22. HIPAA Privacy Rule

Means the federal regulations related to the use and disclosure of patients' PHI under 45 CFR Parts 160 and 164.

2.23. HIPAA Rule

Means the medical records, privacy, security, and standard transaction regulations under 45 CFR Parts 160 and 164.

2.24. Initial Term

Means the period of January 1, 2021 to December 31, 2021.

2.25. Mail Service Pharmacy

Means a pharmacy, where prescriptions are filled and delivered to Members via the United States Postal Service, United Parcel Service or other delivery service, and which has entered into an agreement with, or is owned and operated by, Pharmacy Benefit Manager or its Affiliate to dispense Covered Products to individuals including Members.

2.26. Manufacturer Derived Revenue

Means all discounts, Rebates, administrative fees, and any other compensation derived or received by Pharmacy Benefit Manager or its Affiliates from a manufacturer (whether as a result of the number of covered lives, other incentives or other amounts received). Manufacturer Derived Revenue shall consist of: (1) Rebates, including Manufacturer Administrative Fees, which Pharmacy Benefit Manager receives related to the State's Formulary adoption and utilization of the Members of the Employee Plans or Pharmacy Benefit Manager's relationship with the Employee Benefit Plans; and (2) other manufacturer revenues, consisting solely of (A) purchase discounts, and (B) Specialty Drug service fees; which amounts are received by Pharmacy Benefit Manager or its Affiliate as an operator of mail services pharmacies and Specialty drug pharmacies and which amounts are not directly associated with the utilization of the Members of the Employee Plans or Pharmacy Benefit Manager's relationship with the Employee Benefit Plans. Pharmacy Benefit Manager shall promptly disclose to the State any additional sources of revenue received from pharmaceutical manufacturers beyond those stated above in accordance with Section 3.12.1 of this Agreement, should any such additional revenue(s) be received at some point during the term of this Agreement.

2.27. Material Breach

Means any breach that includes, but is not limited to, events which may lead to the collapse of the Participating Pharmacy network, Pharmacy Benefit Manager's substantial failure to meet the Participating Pharmacy network goals described in Section 3.4.4 (Network Goals), Pharmacy Benefit Manager errors described in Section 3.1.4 (Pharmacy Benefit Administration Errors), the Pharmacy Benefit Manager's failure to comply with Sections 3.17 (Confidentiality) and 3.18 (Identity Theft Prevention and Mitigation), any representation or warranty in Section 12 (Representations, Warranties, and Covenants) was false when made, or has become false, the failure of either Party, financial or otherwise, to perform under this Agreement, specifically including Section 3.10, the failure of either Party to make a substantial payment to the other Party in accordance with the terms of this Agreement, the failure of either Party to comply with Section 11 (Privacy Protections and Compliance with Minnesota Government Data Practices Act), applicable federal or state laws and regulations, or any similar event or condition.

2.28. Member

Means a Subscriber in the Employee Plans and his or her enrolled Dependents.

2.29. MMB

Means Minnesota Management and Budget, which is the department of Minnesota State government that currently administers the Employee Plans, or its successors. For purposes of this Agreement, whenever communications or information is sent to State, or received from State by Pharmacy Benefit Manager, or must be authorized, approved or consented to by the

State, contact will be made through the persons within MMB's State Employees Group Insurance Program who administer the Employee Plans.

2.30. Net Paid Claim

Means the Claim amount paid by Pharmacy Benefit Manager to a pharmacy or Member which is net of Cost Share, duplicate payments, and any other adjustments realized.

2.31. Never Event

Means any of the adverse health care events identified under the Minnesota Adverse Health Care Reporting Act, Minnesota Statute §§ 144.706-144.7069 or Serious Reportable Events of the National Quality Forum, as amended from time to time.

2.32. Non-Participating Pharmacy

Means a pharmacy that does not have an agreement with Pharmacy Benefit Manager to dispense Covered Products to individuals including Members.

2.33. Participating Pharmacy

Means a pharmacy, or a company authorized to represent one or more subsidiary, affiliated, or franchised pharmacies, which has entered into an agreement with Pharmacy Benefit Manager to dispense Covered Products to individuals including Members, and includes the Mail Service Pharmacy and the Specialty Pharmacy. For purposes of this Agreement, a "Participating Pharmacy" will not be considered a representative, subcontractor, or agent of Pharmacy Benefit Manager, except that the Mail Service Pharmacy and the Specialty Pharmacy may be subcontractors of Pharmacy Benefit Manager.

2.34. Patient Protection and Affordable Care Act

Means the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Act and regulations promulgated or regulatory guidance issued in support thereof, as amended from time to time.

2.35. Pharmaceutical Care Incentive Program

Means a program, including specifically a Medication Therapy Management Program described in Section 3.9.3, furnished by a Participating Pharmacy to Members and that is intended to: (a) assure, with respect to such Members, that Covered Products are utilized in a manner that will optimize therapeutic outcomes through improved medication use; and (b) reduce costs through the use of generic Covered Products whenever safety and efficacy allow.

2.36. Pharmacy and Therapeutics Committee

Means a committee established and managed by Pharmacy Benefit Manager that is comprised of health care professionals who have knowledge of pharmaceutical products and the clinical use of such products, and which makes decisions related to programmatic decisions related to pharmaceutical therapies for the Employee Plans.

2.37. Plan Guidelines

Means a description of respective Employee Plans related to pharmacy benefits and limitations thereto, based on the applicable Summary of Benefits, and including the framework of policies, interpretations, rules, practices and procedures prepared by Pharmacy Benefit Manager and submitted to and approved by State that are applicable to the Summary of Benefits. The Plan Guidelines will not include any amendments, except as provided in Section 4.2 (Summary of Benefits) of this Agreement; provided, however, that State and Pharmacy Benefit Manager will cooperate in good faith to resolve any changes to the Plan Guidelines that State reasonably requests.

2.38. Practitioner

Means a physician or other health care provider authorized to prescribe medications to Members.

2.39. Prior Authorization

Means a prospective review to verify that certain criteria required by State and/or Employee Plans are satisfied for specific Covered Products prior to processing the Claim for such Covered Products.

2.40. Protected Health Information ("PHI")

Means individually identifiable health information related to the past, present, or future physical or mental health or condition of a Member; the provision of health care to a Member; or the past, present or future payment for the provision of health care to a Member, as more fully defined in 45 CFR § 164.501 or otherwise deemed confidential under federal or state law.

2.41. Public Employees Insurance Program ("PEIP")

Means the Minnesota Public Employees Insurance Program, which is a self-insured group health plan administered by the State and which is available to eligible employees (as determined by State under Minnesota Statute § 43A.316, subd. 2(b)), other eligible individuals, and their dependents, and to former employees and their dependents who are eligible for and elect continuation coverage.

2.42. Rebates

Means all formulary and price protection rebates, including base and market share rebates, including, but not limited to, those received for Specialty Pharmaceuticals, collected from a manufacturer by Pharmacy Benefit Manager, or its Affiliates, in its capacity as a group purchasing organization for the Employee Benefit Plans that are attributable to the utilization of Covered Drugs by Members. Rebates will specifically include: (a) revenue or compensation payable by a manufacturer for "Manufacturer Administrative Fees", which are paid by manufacturers to Pharmacy Benefit Manager for administrative services performed by Pharmacy Benefit Manager in relation to the processing, invoicing for or collection of any Rebates; and (b) any and all amounts paid to Pharmacy Benefit Manager by a manufacturer as a result of increases in the reported AWP for a Covered Drug dispensed to a Member, which amounts are generally referred to as "price protection rebates". To the extent Pharmacy Benefit Manager receives any

funding from a manufacturer for Practitioner education programs, health research, compliance and persistency programs, and health education programs for Members, such amounts shall be included in Rebates. Rebates will not include the purchase discount and Specialty Service fee revenues described in section (2) of the definition of Manufacturer Derived Revenue, above.

2.43. Renewal Term

Means the period as defined in Section 16.1 (Term) of this Agreement.

2.44. Significant Event

Means an event described in Section 17.5 (Significant Events) of this Agreement.

2.45. Specialty Pharmaceuticals List

Means the standard list of Specialty Pharmaceuticals and their reimbursement rates applicable to the Employee Plan and maintained and updated by Pharmacy Benefit Manager from time to time. The Specialty Pharmaceuticals List is and will be available to Employee Plan and its Members on Pharmacy Benefit Manager's website.

2.46. Specialty Pharmaceuticals

Means those injectable and non-injectable drugs on the Specialty Pharmaceuticals List. Specialty Pharmaceuticals, which may be administered by any route of administration, are typically used to treat chronic or complex conditions, and typically have one or more of several key characteristics, including frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; intensive patient training and compliance assistance to facilitate therapeutic goals; limited or exclusive product availability and distribution (if a drug is only available through limited specialty pharmacy distribution it is always considered a Specialty Pharmaceuticals); specialized product handling, administration requirements and/or high cost.

2.47. Specialty Pharmacy

Means a pharmacy which is owned and operated by Pharmacy Benefit Manager or its Affiliate or has entered into an agreement with Pharmacy Benefit Manager or its Affiliate, and which is licensed and qualified to provide services created to manage the handling and service requirements of Specialty Pharmaceuticals, including dispensing, distribution, case management and other services specific to patients with rare and/or chronic conditions.

2.48. State Employees Group Insurance Program ("SEGIP")

Means the Minnesota State Employees Group Insurance Program, which is a self-insured group health plan administered by State and which is available to eligible employees of State, other eligible individuals, and their dependents, and to former employees and their dependents who are eligible for and elect continuation coverage.

2.49. Subscriber

Means, for purposes of SEGIP and/or PEIP, an employee or other person who, pursuant to the terms of SEGIP and/or PEIP, is eligible to and has elected to participate in the respective Employee Plan and is identified by State to Pharmacy Benefit Manager in accordance with the provisions of this Agreement as eligible for such benefits. An individual ceases to be a Subscriber as of the earlier of the date that the individual: (a) for any reason provided by law or the terms of the respective Employee Plan ceases to be eligible to participate in that Employee Plan; or (b) has elected not to participate in the respective Plan.

2.50. Summary of Benefits

Means that document prepared by State which provides a written description of all aspects of SEGIP or PEIP, including any amendments thereto, and which is delivered to Members in the applicable Employee Plan. The prescription drug portions of the respective Summary of Benefit for the initial Contract Year of this Agreement is attached to this Agreement as Exhibit D, and made a part of this Agreement. The prescription drug portion of the Summary of Benefits for any subsequent Contract Year will be incorporated into this Agreement upon notice by the State to Pharmacy Benefit Manager.

2.51. Runoff Claims ("ROC")

Means claims paid after the settlement cutoff date. Funds to reimburse Pharmacy Benefit Manager for ROC will be transferred pursuant to Section 5 (Payments to Pharmacy Benefit Manager).

SECTION 3 OBLIGATIONS OF PHARMACY BENEFIT MANAGER

Pharmacy Benefit Manager will furnish the following services to the State and the Employee Plans during the term of this Agreement.

3.1. General Description of Duties and Obligations

Pharmacy Benefit Manager will act as the Pharmacy Benefit Manager for the Employee Plans according to the terms of the Summary of Benefits, the Plan Guidelines, and this Agreement. Pharmacy Benefit Manager will process Claims, render clinical and Formulary services and provide State standard management reports and consultative services, all in connection with Members' Covered Product utilization and as more fully set forth in this Agreement. In connection with these services, Pharmacy Benefit Manager will evaluate the status and performance of State's pharmacy benefit program and advise State on a regular basis of the results of each evaluation.

3.1.1. Never Event

To the extent that Pharmacy Benefit Manager obtains knowledge from any source of the occurrence of a Never Event, Pharmacy Benefit Manager will use commercially reasonable efforts to ensure that Participating Pharmacies do not bill the Employee Plans or Members and the Pharmacy Benefit Manager will deny payment, offset against future claims or reverse claims for Covered Products related to a Never Event. Pharmacy Benefit Manager will not propose or agree to any provisions in any agreement that limits or prohibits the Pharmacy Benefit Manager from using commercially reasonable efforts to ensure that Participating

Pharmacies do not bill the Employee Plans or Members, including denying payment, offsetting against future claims or reversing claims for Covered Products, for claims related to Never Events.

3.1.2. Material Adverse Change

Pharmacy Benefit Manager, during the term of this Agreement will notify the State in writing and consult with the State prior to implementing a Material Adverse Change. For purposes of this Agreement, "Material Adverse Change" means any change that is materially adverse to the financial condition of the Employee Plans or the financial and medical conditions of the Members, taken as a whole, but will exclude changes that Pharmacy Benefit Manager makes in the ordinary course of business such as formulary changes and day-to-day pricing changes on individual Covered Products. Examples of a change that may constitute a Material Adverse Change include significant changes to the pricing methodology used by Pharmacy Benefit Manager for determining prices for Covered Products that would result in materially different prices than those set forth under Exhibit A, Exhibit B, and Exhibit C, and significant Participating Pharmacy deletions within a geographic area that reduce availability of Covered Products to Members. Pharmacy Benefit Manager and State will meet and confer to resolve issues related to any such Material Adverse Change.

3.1.3. Implementation Services

Pharmacy Benefit Manager will facilitate the accurate implementation of any changes in design or other program changes to the pharmacy benefits under the Employee Plans requested by State and as mutually agreed, including as necessary or appropriate, the following standard implementation services that may be applicable:

(a) Loading eligibility files that do not require conversion;

(b) Encoding State's Plan Guidelines for the Employee Plans within the information services and claims processing systems of Pharmacy Benefit Manager;

(c) Creating and encoding Plan Guidelines for the Employee Plans within the Pharmacy Benefit Manager's Participating Pharmacy network;

(d) Initiating for State a standard reporting package;

(e) Implementing standard Pharmacy Benefit Manager system edits;

(f) Producing standard teslin identification cards as described in Section 3.2.3 (Identification Cards). and displaying the logos of Employee Plans, State, and Pharmacy Benefit Manager, or at State's option, providing files to State for production of a combined identification card by State;

(g) Enabling State's, or its designated representative's, connectivity through a virtual private network or file transfer protocol to Pharmacy Benefit Manager's system;

(h) Implementing standard Prior Authorization guidelines required by State (when prior authorization services are purchased without customization);

(i) Producing standard prior authorization letters, from Pharmacy Benefit Manager's standard library (when prior authorization services are purchased without customization);

(j) Cooperation and coordination with health plan administrators during transition;

(k) Setting up transfer of Claim files to health plan administrators and data warehouse; and

(l) Participation in health plan open enrollment activities for the Employee Plans, subject to the limitations in Section 3.2.1 (Open Enrollment) below.

3.1.4. Pharmacy Benefit Administration Errors

A breach of this Agreement will have occurred whenever Pharmacy Benefit Manager fails to routinely administer the Employee Plans according to the terms of the respective Summary of Benefits, Plan Guidelines, or this Agreement. Such breach will be considered a Material Breach whenever a pattern of errors relating to a specific Participating Pharmacy or claim type results in incorrect claim payments affecting the claims of more than one-half of one percent (0.5%) of the claims processed by Pharmacy Benefit Manager in a calendar year. Pharmacy Benefit Manager will notify State in writing within five (5) business days of discovery of the occurrence of any such administration error.

3.1.5. Prompt Claims Payment

Pharmacy Benefit Manager will pay or deny clean Claims within thirty (30) days of receipt by Pharmacy Benefit Manager, provided the State has funded the claims in accordance with this Agreement.

3.1.6. Administration of ROC from Previous Contract Years

The State will fund Pharmacy Benefit Manager for the payment of Runoff Claims that are not Member-submitted paper Claims under the Funds Transfer procedure described in Section 5 (Payments to Pharmacy Benefit Manager) for ROC incurred during the immediate prior Contract Year covered under this Agreement and submitted to State by the earlier of (a) six (6) months of date of fill, or (b) the deadline for the Pharmacy to submit a Clean Claim under the pharmacy network agreement, but no later than twelve (12) months after the date of fill. Pharmacy Benefit Manager will not receive any additional fees beyond those specified in Section 5 (Payments to Pharmacy Benefit Manager) of this Agreement for providing this service.

3.2. Enrollment and Eligibility

3.2.1. Open Enrollment

Pharmacy Benefit Manager will participate in the open enrollment process for all eligible individuals in the Employee Plans. This includes preparation of materials to describe the pharmacy benefits under the respective Employee Plans, participation in open enrollment meetings as designated by State, and other related activities.

3.2.2. Positive Identification System

Pharmacy Benefit Manager will maintain a positive identification system including Member identification cards and a method for pharmacies to verify benefit coverage at the point of sale. Pharmacy Benefit Manager will maintain separate subgroup files in the Employee Plans for the various subgroups of persons in the Employee Plans as defined on an annual basis by the State so as to aid in the administration and reporting for such subgroups.

3.2.3. Identification Cards

Pharmacy Benefit Manager will provide and mail, at its own expense, an identification card for each Subscriber of a design approved by both State and Pharmacy Benefit Manager. Provided that State delivers complete enrollment information gathered during the annual open enrollment to Pharmacy Benefit Manager no less than thirty (30) calendar days prior to the beginning of each Plan Year, Pharmacy Benefit Manager will issue membership cards to each new Subscriber prior to the first day of coverage of such new Plan Year. If State does not deliver complete enrollment information by such deadline, Pharmacy Benefit Manager will issue membership cards for the new Plan Year as soon as reasonably practicable following receipt of such enrollment information, but in no event later than thirty (30) days following receipt by Pharmacy Benefit Manager. For new Subscribers at times other than the beginning of a new Plan Year, Pharmacy Benefit Manager will issue a new identification card(s) no more than ten (10) calendar days after Pharmacy Benefit Manager's receipt of a completed application. Pharmacy Benefit Manager will distribute up to two (2) cards to each Subscriber including names of all Dependents, if any, upon enrollment of a new Subscriber. Additional cards may be available to a Subscriber upon request.

3.2.4. Miscellaneous Enrollment Duties

Pharmacy Benefit Manager will perform such other duties relating to the eligibility and enrollment of individuals in the Employee Plans as may be mutually agreed upon by the Parties either in writing or in practice.

3.2.5. Eligibility Determinations and Eligibility Files

Pharmacy Benefit Manager will establish and maintain eligibility files related to Members and their Covered Product utilization. Maintenance of eligibility files (additions, terminations and updates) will generally be performed weekly, according to the following process: (a) MMB will transmit an eligibility file to Pharmacy Benefit Manager by the close of business on Wednesday; (b) Pharmacy Benefit Manager will process the file and update the records in the eligibility file system within an average of twenty-four (24) hours from receipt of file from the State (Load reports containing a summary and exceptions will be provided to MMB within an average of twelve (12) hours from completion of the file load. Files that exceed agreed

upon thresholds (Terms, New Additions, Demographic Changes), will suspend file processing, requiring MMB approval); (c) if applicable, Pharmacy Benefit Manager will supply to MMB a list of these discrepancies that exceeded the agreed upon thresholds within two (2) business days from receipt of the file; (d) if applicable, within two (2) business days of receipt of such a list of discrepancies, MMB will provide Pharmacy Benefit Manager one of the following: (i) Approval to advance the file for processing and apply the discrepancies, or (ii) Direction to cancel the file in suspense, and MMB will provide a new file for processing, and (e) Pharmacy Benefit Manager, on request from MMB (typically monthly or quarterly), will provide a compare report within two (2) business days following receipt of a file from MMB. MMB will provide instructions to Pharmacy Benefit Manager as to whether the compare file needs to be loaded into Pharmacy Benefit Manager' eligibility file system or held for reporting purposes only. Pharmacy Benefit Manager will be liable for any Claims paid on behalf of individuals who are specifically listed as a termination by MMB in a processable file per the above describe process, whom Pharmacy Benefit Manager fails to terminate within forty-eight (48) hours of receipt of such a processable file.

3.3. Member Communication and Account Management

3.3.1. General Duties

Pharmacy Benefit Manager will provide Subscribers with the information set forth in this Section, and as may be mutually agreed upon by the Parties. Pharmacy Benefit Manager will follow the guidelines established by the State and all laws applicable to Pharmacy Benefit Manager's activities under this Agreement, specifically including the Americans with Disabilities Act and to the extent applicable, the HHS Final Rule to implement Section 1557 of the Affordable Care Act, when preparing or providing information to Subscribers.

3.3.2. Advance Approval and Routine Correspondence

Pharmacy Benefit Manager will obtain MMB's prior approval for any communication with Members related to significant policy or interpretation issues of the respective Employee Plans or unauthorized access of Member information, including PHI. Pharmacy Benefit Manager is not required to seek MMB's prior approval for routine Member communications. However, Pharmacy Benefit Manager must send to the attention of the State's representative identified in Section 17.6 (Notices), an advance copy of any general mailing sent to or generally made available to all or a subgroup of Members. Pharmacy Benefit Manager will provide to MMB within one (1) week of original distribution, copies of all Member promotional and educational communications. Pharmacy Benefit Manager must identify itself as the Pharmacy Benefit Manager for the Employee Plan on all communications with Member as well as contact information.

3.3.3. Special Purpose Communications

Pharmacy Benefit Manager's Member communication program must address utilization review procedures, health promotion and education.

3.3.4. Open Enrollment Literature

Pharmacy Benefit Manager must obtain State's prior approval of open enrollment literature and other marketing materials to be used in connection with the Employee Plans.

3.3.5. Plan Identity

Except as otherwise authorized by State, Pharmacy Benefit Manager will incorporate the respective service marks "Minnesota Advantage Health Plan℠" or "Advantage Health Plan℠" (for SEGIP) or Minnesota PEIP, Advantage Health Plan (for PEIP) into all mailings of literature and communications for distribution to Members. All communications must also display the MMB, Employee Insurance Division service mark and logo, which the State will provide to Pharmacy Benefit Manager in camera-ready form. All graphics and visuals intended to be used in any communication materials must be approved by the State. Pharmacy Benefit Manager will secure the State's prior approval of any use of the above-referenced service marks not specifically set forth in Section 15.2.1 (Ownership Service Marks). Pharmacy Benefit Manager will use the symbol "SM" any time the above-referenced service marks are utilized.

3.3.6. Dedicated Account Management Unit

Pharmacy Benefit Manager will assign to State and the Employee Plans, a designated account management unit within its organization comprised of persons or groups responsible for account management, customer service, pharmacy relations, and pharmacy contracting to manage the pharmacy benefits under the applicable Employee Plan. In order to allow for prompt decision-making and response to the State's inquiries, these designated persons or groups will have direct access to senior leadership in Pharmacy Benefit Manager's organization. The designated account management service unit will administer pharmacy benefits for Members, will staff the State's annual open enrollment meetings, will process new enrollment and changes to enrollment, and will respond directly to Member inquiries regarding pharmacy benefits and claim status. The designated account management unit will also include an outreach coordinator to assist Members who have special health care needs.

3.3.7. Key Personnel

Pharmacy Benefit Manager will notify the State within three (3) working days of any permanent or temporary (greater than ten (10) consecutive working days) changes to or deletions from Pharmacy Benefit Manager's key personnel. For these purposes, key personnel are:

- Kyle Smith, Strategic Account Executive
- Kurt Neuenfeld, Clinical Advisor
- Amanda Fish, Senior Account Manager

During the course of this Agreement, the State reserves the right to approve or disapprove of the members of Pharmacy Benefit Manager's (and any subcontractor's) key personnel assigned to the Agreement and to approve or disapprove any proposed changes to the key personnel. Pharmacy Benefit Manager will, upon request, provide the State with a resume of any member of its staff or a subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Agreement. Upon the written request of the State, any employee of the Pharmacy Benefit Manager who, in the opinion of the State, is unacceptable will be removed as a key person. In the event that an employee is removed pursuant to a written request from the State, Pharmacy Benefit Manager will have thirty (30) days in which to fill the vacancy with an acceptable employee. Replacement of any personnel,

including those who have terminated employment, will be with personnel of equal or greater ability and qualifications as those previously approved by the State.

3.3.8. Toll-Free Telephone Number

Pharmacy Benefit Manager will provide Members with dedicated toll-free and local telephone numbers for coverage and claims related questions. Pharmacy Benefit Manager will maintain a call center, which will be accessible through a toll-free telephone line, responsible for responding to inquiries from Participating Pharmacies, other pharmacies, and Members regarding the services provided by Pharmacy Benefit Manager under this Agreement. Call center personnel will respond to questions related to eligibility of individuals, the applicable Summary of Benefits, Deductible status, Coinsurance and Copayment levels, maximum benefit status, direct reimbursement, and in the case of Participating Pharmacies, on-line adjudication instruction. Pharmacy Benefit Manager's toll-free helpline will be available to the State and all Participating Pharmacies and nonparticipating Pharmacies twenty-four (24) hours a day, seven (7) days a week.

3.4. Pharmacy Network

3.4.1. General Duty

Pharmacy Benefit Manager will, in good faith, establish and maintain the Preferred Pharmacy network for the Employee Plans, which may include State-specific pharmacy contracts. Pharmacy Benefit Manager has created and will maintain a network of Participating Pharmacies. Pharmacy Benefit Manager will cause Participating Pharmacies to perform pharmacy services for Members according to their Participating Pharmacy agreement. Although the composition of the Participating Pharmacy network may change due to the addition or withdrawal of specific Participating Pharmacies, Pharmacy Benefit Manager will use commercially reasonable efforts to ensure that the network includes Participating Pharmacies such that the network will provide reasonable access and availability to the Members.

3.4.2. Listing of Participating Pharmacies

Pharmacy Benefit Manager will make available to Members and the State an updated list of Participating Pharmacies in its network on-line via its website. Pharmacy Benefit Manager will cooperate with State to ensure that such network list is available in a format that allows State to establish links between MMB's website and the Pharmacy Benefit Manager's website. In addition, Pharmacy Benefit Manager will make printed versions of relevant portions of the list of Participating Pharmacies available upon request to Members through its Customers Service Call Center representatives.

3.4.3. Discretion to Determine Participating Pharmacy Reimbursement

Pharmacy Benefit Manager will negotiate the Participating Pharmacy reimbursement terms of all network participation agreements for Claims Incurred under the Employee Plans. Pharmacy Benefit Manager will include in all network participation agreements a provision precluding Pharmacies from seeking payment from Members for any portion of Claims (other than the applicable Member Cost Share) incurred under the Employee Plan that the Pharmacy fails to submit to Pharmacy Benefit Manager by the earlier of (a) six (6) months of the Incurred Date, or (b) the deadline for the Pharmacy to submit a Clean Claim under the Pharmacy agreement.

3.4.4. Network Goals

The following network goals are established for the Employee Plans:

(a) Quality Goals. Pharmacy Benefit Manager will credential each pharmacy or network of pharmacies which becomes a Participating Pharmacy under this Agreement, and will re-credential such Participating Pharmacies every two (2) years. All such credentialing will comply with the requirements of the URAC. Pharmacy Benefit Manager will also take commercially reasonable steps to respond to any quality issues that come to its attention regarding any Participating Pharmacy.

(b) Size Goals. Pharmacy Benefit Manager will cooperate with the State and use commercially reasonable efforts to ensure that the network of Participating Pharmacies meets the geographic access needs of the Members. Pharmacy Benefit Manager will cooperate with the State to add pharmacy locations as directed by the State; provided, however, that if the negotiated pharmacy discount from a State-directed pharmacy is less favorable than the then-current average network discount, then the addition of that pharmacy will not count toward the Pharmacy Benefit Manager network discounts set forth in Exhibit C.

(c) Changes. If Pharmacy Benefit Manager desires to vary network goals for a given geographic area in exceptional circumstances depending on factors such as the number of Members in the geographic area, the number of alternative health care pharmacies in the geographic area, the type of health care pharmacies (e.g., hospitals or physicians) in the geographic area, or to ensure that quality care is available, then Pharmacy Benefit Manager must provide the State sixty (60) days prior written notice of any such proposed change. Pharmacy Benefit Manager and the State will meet and confer to establish a variance that is mutually agreeable. Pharmacy Benefit Manager will establish the network in accordance with the goals set forth in this Agreement or with amended goals as mutually agreed. Pharmacy Benefit Manager and the State will meet and confer if, in the opinion of the State, any Pharmacy Network change will adversely affect the access or availability to the Members. Pharmacy Benefit Manager will notify the State of any change in the pharmacy network, not initiated by Pharmacy Benefit Manager, promptly after Pharmacy Benefit Manager becomes aware of that change.

(d) Notice of Change. Pharmacy Benefit Manager will notify the State, in writing and as soon as practicable, but not later than ten (10) days after receiving written notice of any such change, of any significant change in access to the network of Participating Pharmacies [redacted]

3.4.5. Audits

Pharmacy Benefit Manager will maintain a pharmacy audit program, the criteria of which may be amended from time to time. The audit may be conducted by Pharmacy Benefit Manager's internal auditors or its outside auditors, and at the Participating Pharmacy or at Pharmacy Benefit Manager by a review of electronically submitted Claims. Pharmacy Benefit Manager will periodically report in writing a summary of the findings of these pharmacy audits to the State to the extent that any such audit identifies issues of material concern related to a Participating Pharmacy. One-hundred percent (100%) of overpayments made to a Participating Pharmacy attributable to State's Claims will be offset against future payments to that Participating Pharmacy from State's account within ninety (90) days after the overpayment is discovered; if offset is not available, then any overpayment recovered from the Participating Pharmacy will be promptly remitted to State. Pharmacy Benefit Manager will make commercially reasonable efforts to pursue overpayments to pharmacies. Pharmacy Benefit Manager will not be required to commence any litigation to recover any such overpayments. For purposes of this section, "overpayments" will generally include overpayments based on pharmacy errors or based on payments at rates higher than agreed rates, but will generally not include payments made for a prescription for a former Subscriber who has become ineligible, but who appeared in the current eligibility file at the time the Claim was processed.

3.5. Claims Processing

3.5.1. General

Pharmacy Benefit Manager will promptly process Claims with dates of fill on or after the Effective Date, through and including Claims with dates of fill prior to the termination of this Agreement. Pharmacy Benefit Manager will process all Claims according to the Prescription Pricing Schedule in Exhibit C, the Summary of Benefits, Plan Guidelines and HIPAA-required transaction code sets. Pharmacy Benefit Manager will check all Claims for eligibility, benefit design, Cost Share requirements, and exclusions to determine which Claims are successfully processed, pended for prior authorization, or rejected for ineligibility or other factors in the specifications of the Employee Plans. Notwithstanding the foregoing, if State requests that Pharmacy Benefit Manager encourage a pharmacy to become a Participating Pharmacy by offering such a pharmacy reimbursement rates that exceed the rates set forth in Exhibit C, then Pharmacy Benefit Manager will use such revised reimbursement rates for such pharmacy. Pharmacy Benefit Manager will review all contractual Claims transmitted by Participating Pharmacies and the Mail Service Pharmacy and notify such pharmacies on-line of the reason or reasons for denial of such Claims, including, but not limited to, missing or erroneous information. Likewise, Pharmacy Benefit Manager will report to submitting persons the status of all denied Direct Reimbursement Claims. Participating Pharmacies must submit Claims to Pharmacy Benefit Manager within six (6) months of the fill date.

Additionally, if State, a Member, or a State third-party administrator notifies Pharmacy Benefit Manager that a Member has a primary insurer other than the Employee Plan, through a process agreed to by Pharmacy Benefit Manager and State, then after receipt of that notice Pharmacy Benefit Manager will pay Claims for such Member as a secondary payer other than as a primary payer.

3.5.2. Direct Reimbursement Claim

Pharmacy Benefit Manager will provide, via its website, a direct reimbursement claim form, for use by Members to obtain reimbursement for amounts paid out-of-pocket (other than Cost Share) for Covered Products (e.g. Covered Products dispensed at a Non-Participating Pharmacy). Pharmacy Benefit Manager will accept, process, and adjudicate Claims for direct reimbursement consistent with applicable Employee Plan Guidelines within ten (10) business days of receipt of the direct reimbursement claim form. Members should submit completed direct reimbursement claim forms to the address indicated on the Pharmacy Benefit Manager website, which shall also be included on the preprinted form and available via Pharmacy Benefit Manager's toll-free customer service phone line.

3.5.3. Discretion to Determine Member's Entitlement to Pharmacy Benefits

Pharmacy Benefit Manager will make pharmacy benefit claims determination decisions within the benefit plan design established by the State for the Employee Plans under the same methodology and standards for approval or denial that it applies in doing claims administration for its other pharmacy benefits plans. In the event of a conflict between the benefit plan design established by the State and the methodology and standards applied by Pharmacy Benefit Manager for its administration of other pharmacy benefit plans the benefit plan designed by the State will control. Further, in any benefit claims determination where Pharmacy Benefit Manager would depart from the terms of the Summary of Benefits to approve a claim or drug as an "exception," it will make its determination by applying the same methodology and rules of interpretation that it applies to its other pharmacy benefit Plans.

Except with respect to eligibility determinations as provided in Section 4.1 (Eligibility and Enrollment), Pharmacy Benefit Manager will determine a Member's entitlement to pharmacy benefits, construe the terms of the Summary of Benefits, and determine the amount of payment for pharmacy benefit claims submitted, all in accordance with this Agreement, subject to the review processes set forth in Section 3.5.7 (Coordination of Benefits and Subrogation). Subject to the HIPAA Privacy Rule, Pharmacy Benefit Manager and the State will consult with each other, upon request, in the event of a disputed claim or when a claim presents a question of policy. Pharmacy Benefit Manager will notify, in writing consistent with applicable laws and the Summary of Benefits, the affected Member, and/or dependent whenever it denies payment of all or a portion of any claim for benefits, identifying the specific provision of the Summary of Benefits relied upon for the denial.

3.5.4. Modification

Except as provided in Section 3.5.1 (General), Pharmacy Benefit Manager will not grant exceptions or make modifications to the Employee Plan. It is understood and acknowledged by both Parties, however, that claim adjustments made as part of the normal customer services functions performed by Pharmacy Benefit Manager's Member Services department in the administration of the Employee Plan are not considered modifications or exceptions to the Employee Plan under this paragraph.

3.5.5. Collection of Deductible, Copayment, or Coinsurance by Pharmacies

Pharmacy Benefit Manager will contractually require Participating Pharmacies to collect from Members or their representatives the amount of any applicable Cost Share prior to providing such persons any Covered Products to which such Member is or may be

entitled. Pharmacy Benefit Manager will also contractually require Participating Pharmacies to agree not to recover from Members any unpaid balances due from Pharmacy Benefit Manager and/or the Employee Plan.

3.5.6. Prior Authorizations

Pharmacy Benefit Manager will, as required by State, confirm with Practitioners whether certain Covered Products are prescribed for medical conditions consistent with FDA-approved indications and labeling, or are appropriate for the diagnosis in the judgment of the Practitioner. In providing any or all such services, Pharmacy Benefit Manager may rely upon information provided by the Member or such person's representative, the Practitioner, the dispensing pharmacist and other sources deemed reliable by Pharmacy Benefit Manager. Pharmacy Benefit Manager will not determine medical necessity or appropriateness of treatment, although Pharmacy Benefit Manager may rely upon protocols established and maintained by its Pharmacy and Therapeutics Committee (consisting of pharmacists and physicians) based upon factors such as safety, availability, potential for misuse and cost in its review of Claims submitted for payment of such prescription drugs. The Pharmacy Benefit Manager's standard prior authorization list will be made available to State along with any Pharmacy Benefit Manager approved criteria for use. The Pharmacy Benefit Manager will communicate any changes to the prior authorization list in advance to State. Drug prior authorizations will be submitted and accessible by Practitioners and accepted by the Pharmacy Benefit Manager and the Employee Plan, electronically through secure electronic submissions consistent with all applicable laws. Facsimile does not constitute electronic transmissions. State acknowledges that Pharmacy Benefit Manager may suspend processing of Claims for Covered Products subject to prior authorization in the event the Practitioner fails to provide missing information necessary for the processing of such Claims in compliance with such protocols.

3.5.7. Coordination of Benefits and Subrogation

Pharmacy Benefit Manager will perform and bear the cost of any and all services and activities necessary to perform the services described under this Agreement. If the State or a third-party administrator notifies Pharmacy Benefit Manager that a Member has a primary insurer other than the Employee Plan, then Pharmacy Benefit Manager will pay Claims for such Member as a secondary payor other than as a primary payor. Pharmacy Benefit Manager does not assume responsibility for establishing coordination of benefits filing orders for subsequent coverages, nor responsibility for coordination of benefits investigational efforts, subrogation, or coordination with Worker's Compensation. In addition, Pharmacy Benefit Manager will promptly provide the State, the Employee Plans, and their respective agents with such information as may be reasonably requested to pursue subrogation or reimbursement of Claims processed by Pharmacy Benefit Manager under this Agreement.

Government Agency Submitted Claims. The State acknowledges that government agencies that have issued payment for prescription drug claims may seek eligibility or similar data from Pharmacy Benefit Manager regarding Members, and such government agencies may submit to Pharmacy Benefit Manager claims for reimbursement for prescription drug benefits provided by such government agencies to Members ("Government Claims"). The State authorizes Pharmacy Benefit Manager to provide such eligibility or similar data as lawfully requested by government agencies and further authorizes Pharmacy Benefit Manager to process such Government Claims. The State acknowledges that Pharmacy Benefit Manager may advance payment for Government Claims on behalf of the State, and the State will reimburse Pharmacy Benefit Manager for all amounts advanced by Pharmacy Benefit Manager for payment

of Government Claims. 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. The State shall also reimburse Pharmacy Benefit Manager for any adjustments or reconciliations to previously processed Government Claims that may be payable to government agencies in accordance with applicable laws and regulations. Pharmacy Benefit Manager reserves the right to terminate these services upon ninety (90) days' prior notice to the State upon a change in applicable law governing Government Claims.

3.5.8. Denial of Claims

In its conduct of internal and external reviews as described in this Section, Pharmacy Benefit Manager will comply with all applicable federal and Minnesota laws and regulations.

(a) Internal Review. Pharmacy Benefit Manager will conduct reviews of all appeals from denied Claims and will notify the affected Member in writing of the Member's right to seek external review in accordance with guidance issued by the Minnesota Departments of Health and Commerce as well as applicable federal law.

(b) External Review. Pharmacy Benefit Manager will comply with the provisions of federal law and Minnesota Statutes 62Q.73 and rules issued thereunder when a Member seeks external review of an adverse determination after the internal appeals process has either been exhausted or shortened by the initiation of an independent external review of the adverse determination. Pharmacy Benefit Manager's obligations will include the furnishing of medical records and other relevant documents and the payment of the appropriate filing fee. An adverse determination may include the refusal to preauthorize a procedure, drug or medical device, as well as the denial of a claim for benefits. Pharmacy Benefit Manager will notify the State in writing within five (5) days of receipt of a Member's request for an external review of an adverse determination.

(c) State Review. State will maintain an appeals process for review of Claims that have been denied by Pharmacy Benefit Manager and appealed by Member after such exhaustion of any appeals processes available to such Member that are maintained by Pharmacy Benefit Manager.

3.5.9. Cost of Legal Defense on Claim Determination

Pharmacy Benefit Manager will provide and bear the cost of any legal defense required in any lawsuit brought by or on behalf of a Member, beneficiary or legal representative of either, with respect to a dispute over pharmacy claims administration services provided by Pharmacy Benefit Manager.

3.5.10. Claims Fraud

Pharmacy Benefit Manager will continually monitor Claims during processing for the purpose of identifying instances of claim fraud from any source. Pharmacy Benefit Manager will use its best efforts to prevent and identify claim fraud through system design, monitoring, and any other method commonly utilized in the Pharmacy Benefit Management industry. Pharmacy Benefit Manager will bear full responsibility for curing any instance of confirmed claim fraud, including recoupment, reversing, offsetting or denying Claims, on behalf of the affected Employee Plan of payments made by that Employee Plan not arising out of the failure of the State to fulfill its obligations in this Agreement, if Pharmacy Benefit Manager recovers the amount of the Claim, which Pharmacy Benefit Manager will pursue using commercially reasonable efforts including denying payment, offsetting or reversing or recoupment of Claims, or if the Pharmacy Benefit Manager should have reasonably known that the Claim was fraudulent prior to the payment of the Claim based on industry standards in place at the time such fraud occurred. Additionally, Pharmacy Benefit Manager will use commercially reasonable efforts to assist in the recovery of amounts paid in error and coordinate with Participating Pharmacies to correct errors identified after Claims are submitted. Pharmacy Benefit Manager will notify State's designated representative, in writing, within five (5) business day of its discovery of eligibility or confirmed claim fraud by or on behalf of an individual seeking benefits under the Employee Plan.

Pharmacy Benefit Manager will provide State a written report of identified claim fraud each year, including special investigations unit cases.

3.5.11. Miscellaneous Claims Processing Duties

Pharmacy Benefit Manager will perform such other claims processing duties as may be mutually agreed upon by the Parties either in writing or in practice.

3.6. Utilization Review

3.6.1. Concurrent Drug Utilization Review

Pharmacy Benefit Manager will provide concurrent on-line drug utilization review to Participating Pharmacies for all Claims submitted on-line. The claims adjudication system will include edits applied to Claims during the adjudication process to identify the following: duplicate prescriptions; over-utilization/refill too soon; under-utilization; drug interactions; pediatric warnings; geriatric warnings; acute/maintenance dosing; formulary compliance; therapeutic duplication; drug inferred health state; drugs exceeding maximum dose; drugs below minimum daily dosage, and other financial and cost limitations which are specified by State. The claims adjudication system will provide the dispensing pharmacy with appropriate messaging to advise the dispensing pharmacy of concurrent drug utilization review issues.

3.6.2. Retrospective Drug Utilization Review

Pharmacy Benefit Manager will retrospectively review previously approved Claims for potential fraud or abuse, clinical appropriateness, and as requested by State. Pharmacy Benefit Manager will analyze Members' drug profiles and review one or more specific therapeutic categories or issues. Automatic algorithms will be employed to identify Members receiving the profiling and targeted drug therapy. Pharmacy Benefit Manager also will contact Practitioners and Participating Pharmacies as needed to discuss therapeutic issues and to offer

suggestions for alternative therapy. Pharmacy Benefit Manager will provide State, or its designated representative, retrospective drug utilization review reports that include, but are not limited to, high cost/high utilization of a particular drug class, or therapeutic appropriateness of a drug for a particular disease state, or other reports requested by State.

3.6.3. Clinical Pharmacy Management Programs

At such times and under such procedures as agreed by the Parties, Pharmacy Benefit Manager will offer monitoring and reporting related to: (a) controlled substances; (b) use of multiple pharmacies by a Member to obtain the same Covered Products; (c) fraud, waste and abuse; (d) use of multiple prescribers by a Member to obtain the same Covered Products; and (e) filling of multiple prescriptions for the same Covered Products by a Member.

3.7. Treatment Alternatives

Consistent with the HIPAA Privacy Rule, Pharmacy Benefit Manager may contact Members to provide refill reminders or information about treatment alternatives, including, but not limited to, brand and generic drugs, or other health-related benefits and services that may be of interest to such Members. In connection with these services, Pharmacy Benefit Manager also may provide Participating Pharmacies and Practitioners information, electronic messaging, and communications about such alternatives and services.

3.8. Formulary Management and Support

3.8.1. Formulary Management

Pharmacy Benefit Manager will provide a recommended Formulary to State, subject to modification by State. Pharmacy Benefit Manager may modify the Formulary from time to time as a result of decisions of its Pharmacy and Therapeutics Committee and new therapeutic agents that become available, subject to modification by State. Pharmacy Benefit Manager will notify State in advance of modifications to the Formulary. State will implement, administer, and cooperate with Pharmacy Benefit Manager and facilitate Members' utilization of the Formulary. Pharmacy Benefit Manager will maintain the Plan's Formulary on-line via its website and cooperate with State to ensure that it is in a format that facilitates State's ability to establish links between MMB's website and the internet version of that Formulary.

3.8.2. Formulary Support Programs

Pharmacy Benefit Manager will offer State Formulary support programs intended to assist in the transition of Members from their current drug utilization mix to a new mix of utilized products, which are better aligned with the Formulary. According to procedures established by agreement of Pharmacy Benefit Manager and State from time to time, Pharmacy Benefit Manager will provide sixty (60) days prior written notice to adversely impacted Members when removing a covered drug from the formulary or making any changes to the preferred or tiered cost sharing status of a covered drug.

3.9. Other Services

3.9.1. Medications Therapy Management

Pharmacy Benefit Manager will provide a Medication Therapy Management program as further described in Exhibit F.

3.9.2. Ninety Day at Retail

Pharmacy Benefit Manager will provide State a ninety (90) day at retail program through which retail pharmacies will fill prescriptions for Members subject to the terms in Exhibit C.

3.9.3. Pharmaceutical Care Incentive Program

Pharmacy Benefit Manager will provide a Pharmaceutical Care Incentive Program as follows:

This program forms a unique partnership between Participating Pharmacies, Practitioners, and Pharmacy Benefit Manager to improve the overall level of care and, therefore, the outcome for each Member. Inherent in the program are incentives to maximize the education of the Member as well as to promote the use of generics whenever safety and efficacy allow. Reimbursement will be made to those Participating Pharmacies who provide the outlined interventions to those Members eligible for the Pharmaceutical Care Incentive Program as identified on the prescription drug card.

3.10. Mail Order Pharmacy Program

Pharmacy Benefit Manager will provide a Mail Order Pharmacy Program as further described in Exhibit A.

3.11. Specialty Drug Program

Specialty Benefit Manager will provide a Specialty Pharmaceuticals program, including the following:

(a) Dispense new or refill prescription orders for Specialty Drugs upon receipt from a Plan member of (i) a prescription and a completed order or refill order form or electronic prescription from a licensed prescriber, and (ii) the applicable cost share/copayment;

(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 members via the United States postal service or other appropriate carriers consistent with Pharmacy Benefit Manager's standard policies to the address provided by the State's third party vendor and/or the Plan member. Shipping shall include all necessary temperature control packaging per manufacturer's guidelines; and

(d) Bill the State's medical benefits provider when appropriate, and pursuant to instructions from the State's medical benefits provider, for ancillary supplies and services associated with the Specialty Drug dispensed.

3.12. Manufacturer Derived Revenue/Rebates/Network Transaction Fees

3.12.1. Pass-Through of Manufacturer Derived Revenue and Network Transaction Fees

Pharmacy Benefit Manager will submit and diligently pursue on behalf of SEGIP and PEIP the collection of all Rebates related to utilization by Members or Pharmacy Benefit Manager's relationship with the Employee Plans. Pharmacy Benefit Manager will pass through to State, on behalf of SEGIP and PEIP one hundred percent (100%) of all such Rebates received by Pharmacy Benefit Manager or any Affiliate. In addition, to the extent that Pharmacy Benefit Manager collects a per-submission service fee from retail Participating Pharmacies for the use of the Pharmacy Benefit Manager's retail online adjudication system (sometimes called "click fees" and referred to herein as "Network Transaction Fees"), Pharmacy Benefit Manager shall pass through one hundred percent (100%) of such Network Transaction Fees to the State. Pharmacy Benefit Manager, consistent with the HIPAA Privacy Rule, will submit Members' PHI to pharmaceutical manufacturers solely for the purpose of obtaining Rebates on behalf of SEGIP or PEIP. Pharmacy Benefit Manager will report to the State in writing by the thirtieth (30th) day of the first month in each calendar quarter all sources of Manufacturer Derived Revenue received by Pharmacy Benefit Manager during the preceding calendar quarter, whether or not such Manufacturer Derived Revenue constitutes Rebates payable to the State under this Agreement.

3.12.2. Calculation of Rebates

Pharmacy Benefit Manager will calculate the Rebates payable to State under this Agreement. State will receive one hundred percent (100%) of this amount. Depending upon how quickly after the dispensing of a drug they are submitted to Pharmacy Benefit Manager, Claims submitted directly by Members may not be eligible for Rebates.

3.12.3. Payment of Rebates and Network Transaction Fees

Pharmacy Benefit Manager will pay the State, Rebates and, if collected, Network Transaction Fees, on a monthly basis in accordance with the terms set forth in Exhibit A to this Agreement. Pharmacy Benefit Manager will pay the State the actual Rebates collected with respect to the Claims adjudicated during a calendar month, and Network Transaction Fees, if collected, within thirty (30) business days following the end of each calendar month in which such amounts are received by Pharmacy Benefit Manager or its Affiliates, after final audit and validation of accuracy. Such Rebates are generally collected beginning in the fifth (5th) month of the term of the Agreement, and continuing thereafter. If any such Rebates and Network Transaction Fees is paid later than thirty (30) business days after the end of the month received by Pharmacy Benefit Manager, the State will be entitled to receive four percent (4%) annual interest on such Rebates or Network Transaction Fees, accruing from the date such Rebates or Network Transaction Fees were required to be paid to the State under this Agreement, until the date of payment. The State may offset any amounts due and owing by Pharmacy Benefit Manager to the State in connection with such Rebates against compensation payable under Section 5 (Payments to Pharmacy Benefit Manager). As mutually agreed, the Parties may use Rebates or Network Transaction Fee payments to fund Pharmacy Benefit Manager's administrative fees or portions thereof, the terms of which may be described in Exhibit A.

3.13. Quarterly Meetings

Pharmacy Benefit Manager will convene the joint Pharmacy Benefit Manager and MMB steering team meetings to conduct ongoing performance review under this Agreement, to identify actions which will enhance that performance and to discuss other timely and relevant issues. Pharmacy Benefit Manager will confer with State representatives and will prepare and distribute a proposed agenda at least two (2) weeks in advance of each meeting. These steering team meetings between MMB and Pharmacy Benefit Manager will occur no less often than quarterly, unless otherwise mutually agreed upon. Pharmacy Benefit Manager and MMB may jointly agree that, subject to unplanned priorities, certain of the quarterly meetings may be designated to focus on in-depth discussion of specific critical operational areas. Pharmacy Benefit Manager and MMB may arrange other meetings the Parties deem necessary to review in more detail performance relating to networks, patient satisfaction, and financial data. At the mutual agreement of MMB and Pharmacy Benefit Manager, these meetings may include Preferred Pharmacy representatives or other Parties whose participation may be useful or appropriate.

3.14. Health Initiatives and E-prescribing Initiatives

Pharmacy Benefit Manager will assist State with the identification of a technological methodology to implement such health initiatives and to use commercially reasonable efforts to assist in the coordination of efforts related to implementation of such health initiatives the State develops to the extent agreed by State and Pharmacy Benefit Manager with State's preferred vendor, if one is identified by State. These efforts will include, but not be limited to, facilitating where applicable, identifying quality measures, coordinating disease management efforts, setting targets for health care pharmacies, making measures available on-line to the public, and, when appropriate, modifying pharmacy payment systems to emphasize rewarding quality care. The specific health care areas toward which such efforts will be directed are conditions such as diabetes, cardiac, and preventive care.

Pharmacy Benefit Manager will also collaborate with State to define and implement policies to achieve the e-prescribing initiative established by the State.

3.15. Social Media

Pharmacy Benefit Manager will cooperate with State in its efforts to use social media in connection with the administration of the Employee Plans, and will keep State informed about its own uses of such media.

3.16. Vaccine Program Terms and Conditions.

The Vaccine Program will be subject to the Terms and Conditions listed in Exhibit O.

3.17. Confidentiality

Pharmacy Benefit Manager, will maintain in confidence all claims for benefits, benefit payments and other records and reports obtained or generated in connection with performing its services under this Agreement, consistent with all applicable State and Federal laws and regulations including, without limitation, the HIPAA rules, and will not reveal, without the State's prior written consent, any such information except to the individuals to whom the information relates, or to the extent permitted or required by law to entities directly affected that

have demonstrated a need to know, such as health care pharmacies, case and disease managers, employee assistance counselors, disability managers, and health promotion professionals, or as otherwise may be required by law or legal process.

3.18. Identity Theft Prevention and Mitigation

Pharmacy Benefit Manager will maintain appropriate procedures to prevent and mitigate identity theft that will, at a minimum, comply with applicable laws and address the following:

(a) Appropriate procedures to prevent, identify, detect and report the Breach of PHI (as defined in Section 11 (Privacy Protections and Compliance with Minnesota Government Data Practices Act)).

(b) The actions Pharmacy Benefit Manager will take: (i) if Pharmacy Benefit Manager detects possible theft or misuse of a Member's PHI; and (ii) to mitigate the consequences of any Breach of PHI within the control of Pharmacy Benefit Manager.

(c) Timing and process for notifying State of any Breach of Unsecured PHI in accordance with Section 11.7 (Obligation of Pharmacy Benefit Manager – Unauthorized Uses and Disclosures).

(d) Timing and process for notifying Members of suspected instances of identity theft not related to a Breach of Unsecured PHI.

(e) Member assistance to restore the identity and credit of each Member whose identity or credit is adversely affected if the Breach of PHI: (i) was due to the negligence of Pharmacy Benefit Manager or its agents; and (ii) can reasonably be anticipated to be used to perpetuate identity theft against a Member ("Identity Theft Mitigation Services").

Identity Theft Mitigation Services must be reasonably designed to mitigate the consequences of a Breach of a Member's PHI involved and the circumstances surrounding the Breach. Identity Theft Mitigation Services will include twelve (12) months of credit monitoring services if a Member's Social Security Number or financial account information was part of the Breach of Unsecured PHI. The Pharmacy Benefit Manager will pay the cost of Theft Mitigation Services. Pharmacy Benefit Manager will pay all costs to notify Members whose information is reasonably believed to have been impermissibly accessed and all costs to comply with mandated reporting requirements. State will, if reasonably possible, provide Pharmacy Benefit Manager an opportunity review and provide comments to any proposed Member notification under issued pursuant to this Section.

3.19. Reports and Reporting

3.19.1. Standard Reports

Pharmacy Benefit Manager and the State will cooperate to identify reports from Pharmacy Benefit Manager's library of standard reports that meet the State's needs and which can be provided on a mutually agreed upon timeline. Pharmacy Benefit Manager will prepare and deliver to the State, for both SEGIP and PEIP, core reports no later than thirty (30)

days from the close of the month or quarter, as applicable. The State may also choose additional reports from Pharmacy Benefit Manager's library of standard reports. Additionally, the State may choose to implement Pharmacy Benefit Manager's web-based reporting tool for up to three (3) named users at no additional costs to the State; provided that the State agrees to Pharmacy Benefit Manager's standard terms and conditions of the use of such tool at the time of such implementation.

3.19.2. State Claims Information

Pharmacy Benefit Manager will provide the State, upon reasonable request, with an electronic file in Pharmacy Benefit Manager's standard format of all paid Claims for the State's prescription drug program. Such data may also be provided from time to time, at the request of the State, to the State's designated representative for purposes of assisting in the implementation and management of disease management programs or other programs desired by State.

3.19.3. Other Reports

Prepare and furnish to the State such financial and administrative records and reports as the State may reasonably require in order to effectively administer the Employee Plans and to evaluate the services provided by Pharmacy Benefit Manager and the experience of the Employee Plan in providing benefits. Within five (5) days of Pharmacy Benefit Manager receiving the State's request for an ad hoc report, the Parties will negotiate in good faith to agree on a due date for such ad hoc report.

3.19.4. Department of Health

Pharmacy Benefit Manager will collaborate with the State with respect to submission of SEGIP and PEIP Employee Plan data to the Minnesota Department of Health as required by statute for the purpose of providing data to the State legislature regarding the quality of services being provided. The submission of data for the Employee Plans will be consistent with all applicable legal requirements for maintaining the confidentiality of individually identified patient data.

3.19.5. Health Data Warehouse

Pharmacy Benefit Manager will provide the State or its delegates with accurate and reliable raw data under the parameters for the implementation and operation of a data warehouse as prescribed by the State. Data to be provided by Pharmacy Benefit Manager will include detailed Claims and enrollment data sets including information that the State deems necessary to conduct analysis. Pharmacy Benefit Manager will provide Claims data to the State or its delegates for the data warehouse identifying and separating out pharmacy services by vendor. Pharmacy Benefit Manager will provide this information into a data repository and, further, will resolve any detected errors which have been identified in this process. Data warehouse tapes are due within twenty (20) business days of the close of each month.

3.19.6. Third-Party Administrators

Pharmacy Benefit Manager will provide to third-party administrators designated by State pharmacy Claim data for Members in the designated intervals and format to facilitate proper operation of Employee Plans.

3.19.7. Assessment for Late or Inaccurate Reports

The State will begin assessing Pharmacy Benefit Manager One Hundred Dollars ($100) per business day for past due or inaccurate reports. These assessments will begin to accrue beginning on the date the report becomes past due or the date an inaccurate report is identified and continue until the date State receives the correct report. With regard to inaccurate data warehouse reports, this assessment will apply to data warehouse and renewal reports from which the State or its consultants have used the information to make financial decisions. The State may, at its discretion, waive any assessments due to extenuating circumstances. This assessment is in addition to the Performance Guaranties as set forth in Exhibit C.

3.20. Local Presence

Pharmacy Benefit Manager will provide a Minnesota-based representative if Pharmacy Benefit Manager and the State agree that such a representative is necessary to improve the service provided to the Members. The addition of such representative will not, in and of itself, result in a change to the compensation payable to Pharmacy Benefit Manager. Pharmacy Benefit Manager also will establish a relationship with the University of Minnesota Pharmacy program.

3.21. Most Favored Nation Pricing

All of the financial terms and conditions granted by the Pharmacy Benefit Manager to the State are and will remain during the term of this Agreement at least as favorable as the financial terms and conditions granted by the Pharmacy Benefits Manager to any previous similarly sized (measured by annual drug spend) commercial or governmental employer health plan purchaser (“Buyer”) of the pharmacy benefit management services / products described in this Agreement. Should Pharmacy Benefit Manager enter into any subsequent agreement with any other Buyer during the term of this Agreement which has materially similar plan utilization, adopts the same or substantially similar formulary as the State, uses the same retail pharmacy network as the State, and adopts CVS as its sole Specialty drug provider, which provides for financial terms and conditions more favorable than those contained in this Agreement, then this Agreement shall be deemed to be modified to provide the State with those more favorable financial terms and conditions within sixty (60) days of written notification.

Pharmacy Benefit Manager will notify the State promptly of the existence of such more favorable financial terms and conditions and the State will have the right to receive the more favorable financial terms and conditions immediately, as set forth above. If requested in writing by the State, the Pharmacy Benefit Manager will amend this Agreement to contain the more favorable financial terms and conditions.

3.22. Subcontractor Reporting

If the total value of this contract may exceed $500,000, including all extension options, Contractor must track and report, on a quarterly basis, the amount spent with diverse small businesses. When this applies, Contractor will be provided free access to a portal for this purpose, and the requirement will continue as long as the contract is in effect.

SECTION 4 OBLIGATIONS OF THE STATE

The State will perform the following obligations during the term of this Agreement:

4.1. Eligibility and Enrollment

4.1.1. Eligibility Data

The State will provide Pharmacy Benefit Manager (either directly or through an authorized third party administrator) with a weekly eligibility file, in a format mutually agreed upon by the Parties. The State will provide timely eligibility updates (for example, additions, terminations, change of address or personal information, etc.) to ensure accurate determination of the eligibility status of Member. The State acknowledges that: (a) Pharmacy Benefit Manager provides such eligibility data to the Participating Pharmacies and understands that Pharmacy Benefit Manager and Participating Pharmacies will act in reliance upon the accuracy of data received from State; (b) Pharmacy Benefit Manager will continue to rely on the information provided by State until Pharmacy Benefit Manager receives notice that such information has changed; and (c) Pharmacy Benefit Manager will not be liable to the State for any Claims or expense resulting from the provision by the State (or its designees) of inaccurate, erroneous, or untimely information. In lieu of the eligibility file, the State may provide eligibility information by updating the claims adjudication system of Pharmacy Benefit Manager directly (except for the initial eligibility file, which must be provided to Pharmacy Benefit Manager during the initial implementation), provided the State continues to meet Pharmacy Benefit Manager's conditions and specifications for direct eligibility updates.

4.1.2. Retroactive Changes

The State reserves the right to retroactively change a Member's status under an Employee Plan; provided, however, that retroactive terminations will be handled in accordance with all applicable law, including but not limited to Minnesota Statute § 60A.86, HIPAA, PPACA and the Summary of Benefits. Except in the case of intentional misrepresentation or fraud, State will only retroactively terminate a Subscriber that has not paid the required premium or contribution to the Employee Plan for his or her coverage. All other enrollment changes will be prospective. It is the responsibility of the State to ensure that only those retroactive enrollment changes allowed under this paragraph will be sent to the Pharmacy Benefit Manager. Pharmacy Benefit Manager shall not be liable for the payment of Claims for retroactively terminated Members paid during the period prior to the receipt and processing of the retroactive termination in accordance with Section 3.2.5, or the date received individually from the State via the online eligibility update tool provided by Pharmacy Benefit Manager to the State. The Pharmacy Benefit Manager will properly apply any retroactive terminations of Members to any manually submitted Claims from a Member or Participating Pharmacy.

4.2. Summary of Benefits

The State will provide Pharmacy Benefit Manager with a copy of the current Summary of Benefits for the Employee Plans. State will notify Pharmacy Benefit Manager in writing of any changes to the Employee Plans, at least thirty (30) days before any such change is implemented. The most recent Summary of Benefits will govern. The State will have sole authority to determine the terms of the Benefit Plan and the coverage of benefits thereunder.

SECTION 5 PAYMENTS TO PHARMACY BENEFIT MANAGER

5.1. Administrative Fee

The only compensation State will pay to Pharmacy Benefit Manager for services performed pursuant to this Agreement, is a fixed monthly administrative fee for each Member participating in the Employee Plans during the applicable month. The fixed monthly administrative fee per Member is set forth in Exhibit A. State will pay Pharmacy Benefit Manager for administrative charges by Electronic Funds Transfer ("EFT") within two (2) business days from the date of State's receipt of the Pharmacy Benefit Manager invoice.

5.2. Covered Product Payment and Funds Transfer for Covered Product Claims

The State will reimburse the Pharmacy Benefit Manager an amount equal to the actual cost Pharmacy Benefit Manager pays to the dispensing pharmacy for a Covered product on the date dispensed net any dispensing fee or other fee. State will fund the payment of Covered Product Claims submitted to Pharmacy Benefit Manager, whether by Participating Pharmacies or Members; Pharmacy Benefit Manager has no obligation to pay Claims except as and to the extent funded by State. State will fund the payment of Covered Product Claims and all applicable gross receipts, pharmacy, sales, use and similar taxes.

5.2.1. Electronic Funds Transfer

(a) Administrative Fees. Pharmacy Benefit Manager will invoice the State for administrative charges two (2) business days after the last day of each month, for services provided during such month. The invoice amount will be payable within two (2) business days from the date of the State's receipt of the Pharmacy Benefit Manager invoice.

(b) Claims, Including Direct Member Reimbursement. For all Claims processed, Pharmacy Benefit Manager will invoice the State semi-monthly, within two (2) business days after the fifteenth (15^{th}) day and last day of each month. The State agrees to fund Pharmacy Benefit Manager for these Claims by EFT initiated by the State within two (2) business days from the date of the State's receipt of the Pharmacy Benefit Manager invoice. The State further acknowledges and agrees that Pharmacy Benefit Manager, and third parties contracted to Pharmacy Benefit Manager, may retain interest earnings not in excess of market rates pending clearance of electronic transfers and checks in connection with the payment of Covered Product Claims under this Agreement.

5.3. Collections; Interest

To the extent determined by a Court of competent jurisdiction, each Party will be responsible for all reasonable costs and expenses of collection of amounts due from that Party to the other Party, and enforcement of judgments, and will reimburse the other Party for such reasonable costs and expenses, including reasonable attorneys' fees. Any amounts not paid by the due date thereof will bear the interest rate of [redacted] per annum; however, this interest rate will not exceed the maximum rate allowed by applicable laws. The rights and

remedies set forth in this paragraph are in addition to other rights and remedies available to the other Party under law or in equity.

5.4. Performance Guarantees

Final compensation to Pharmacy Benefit Manager may be adjusted based upon assessments incurred for failure to meet Performance Guarantees as described in Exhibit C-2. Pharmacy Benefit Manager will provide a report to the State on all applicable performance guarantees on a quarterly basis; however, assessments for any failure to meet a performance guarantee will be determined on an annual basis, based on the average of the results reported quarterly.

5.5. Reconciliation

Within one hundred-twenty (120) days of the close of a Contract Year, the Pharmacy Benefit Manager will commence the settlement process with the State. The final settlement and reconciliation will be submitted to the State by June 30 immediately following the end of the Contract Year. Elements of the settlement will include, but not be limited to, net paid Claims, administrative and other contractual fees, refunds, performance incentives or penalties, settlements with pharmaceutical supplies or manufacturers, and all applicable sources of revenue; and Pharmacy Benefit Manager shall report any float in association with such reconciliation.

Within thirty (30) days of notice from Pharmacy Benefit Manager, the State will remit to Pharmacy Benefit Manager any financial liability resulting from any reconciliation of liability. Any financial liability of a Pharmacy Benefit Manager to the State as a result of reconciliation will be paid to the State within thirty (30) days after agreement on the reconciliation.

SECTION 6 AUDITS

Pharmacy Benefit Manager will fully cooperate in any State audit of Pharmacy Benefit Manager's books and records relating, in any way, to the Employee Plans. Consistent with Minnesota Statutes § 16C.05 (subd. 5), the Commissioner of Administration, the Commissioner of Minnesota Management and Budget, the Legislative Auditor and the State Auditor, and the consultants thereof, will have access to Pharmacy Benefit Manager's books, records, documents and accounting procedures and practices relevant to this Agreement for a minimum of six (6) years from the last day of the Contract Year to which the record relates for the purpose of auditing Pharmacy Benefit Manager's performance under this Agreement. Specifically, the State will have access to records relating to Rebates received by Pharmacy Benefit Manager, allocation of such Rebates to Employee Plans, etc. Pharmacy Benefit Manager will assign sufficient staff capable of assisting the State in the performance of any audit. Any State audit under this paragraph is subject to the conditions in this Section.

6.1. Annual Audit

Pharmacy Benefit Manager will furnish the State in a timely manner an annual SOC 1 Type 2 Audit Report under the Statement on Standards for Attestation Engagements ("SSAE 18"), or a substantially similar certification audit agreeable to the State, in its sole discretion, issued by the independent auditors of Pharmacy Benefit Manager. Pharmacy Benefit Manager will pay all costs associated with the SSAE 18 or substantially similar certification acceptable to the State.

Pharmacy Benefit Manager, at its sole cost, will furnish to State in a timely manner an annual SOC 2 Audit Report relating to confidentiality, security and privacy under the Statement on Standards for Attestation Engagements ("SSAE 18"), or a substantially similar audit agreeable to State in its sole discretion, issued by the independent auditors of Pharmacy Benefit Manager. The Pharmacy Benefit Manager will provide a bridge letter on a quarterly basis covering the remaining months of the applicable calendar year not covered by the Audit Report.

6.2. Special Audit

The State may audit any documents and records of Pharmacy Benefit Manager it determines to be necessary in order to test or verify the validity of any report, record or claim. Such special audits will be performed at such times as the State reasonably determines are necessary. Such Special Audit may consist of a full claims audit or an annual audit of all aspects of Pharmacy Benefit Manager's administration of the pharmacy benefit under the Employee Plans. If the State determines that a full claims audit is necessary, the cost of such audit will be borne by the State and funded pursuant to Section 6.6 (Costs), except Pharmacy Benefit Manager will be solely responsible for all costs associated with any audit that reveals a regular and systemic pattern of overpayments or under-payments in Claims processing on behalf of any Employee Plan. The Pharmacy Benefit Manager is responsible for overpayment and under-payment discrepancies related to an act or omission of Pharmacy Benefit Manager in violation of this Agreement that is ascertained as a result of any such audit. State may recover any amounts, which have been retained by Pharmacy Benefit Manager in violation of this Agreement, through offset of amounts otherwise payable under this Agreement or, at State's option, a refund issued by Pharmacy Benefit Manager to the State. Except that if Pharmacy Benefit Manager fails to pay any said refund within thirty (30) days of notice of amount due, State may offset any such amount against any amounts due under this Agreement.

6.3. Content of Audit Report

Only aggregate claims records will be reported back to State personnel by the auditors. No records of individual pharmacy records will be disclosed in sufficient detail to infringe or violate the privacy of any Member, or be reported for any purposes other than the audit of Pharmacy Benefit Manager's performance under this Agreement.

6.4. Confidentiality Agreements

State employees, or any designated auditor or agent thereof, assigned by the State to any audit, will sign confidentiality agreements with Pharmacy Benefit Manager as a condition of any disclosures, the contents of which agreement will be agreed upon in advance by the Parties.

6.5. Location and Records

Any audit will be conducted at Pharmacy Benefit Manager's facilities and, unless otherwise agreed to by the Parties, a copy of the auditor's work papers will be stored on Pharmacy Benefit Manager's premises both during and after the audit, subject to the provision of Section 10 (Records).

6.6. Costs

Pharmacy Benefit Manager has agreed to allocate the Audit Credit Amount set forth in Exhibit C of this Agreement for the State, or its third party delegates, to audit Pharmacy Benefit Manager' records of Claims, Manufacturer Derived Revenue, Rebates and dispensing fees. Further, the State will have the right to audit such Claims, Manufacturer Derived Revenue, Rebates and dispensing fees records of Pharmacy Benefit Manager as State determines in its sole discretion are reasonably appropriate in order to test or verify the validity of any report, record, or Claim. Such audit may consist of a Full Claims Audit. If the State determines that a Full Claims Audit is necessary, the cost of such Full Claims Audit will be borne by the State, except that Pharmacy Benefit Manager will be solely responsible for all costs associated with any audit that reveals: (a) a regular and systemic pattern of overpayments or under-payments; or (b) overpayments resulting in material adjustments [redacted] of annual adjusted Claims paid in the year under audit, and resulting from the errors or omissions of Pharmacy Benefit Manager or its agents. Any amounts recovered for overpayments or owed as a result of underpayment discovered during such Audit will inure to the benefit or detriment of the State, as the case may be. Pharmacy Benefit Manager's wholesale purchase contracts are not subject to audit.

SECTION 7 STATE OR PHARMACY BENEFIT MANAGER ERROR

Members may not be deprived of pharmacy benefits under the Employee Plans because of errors by the State or Pharmacy Benefit Manager in performing their respective obligations under this Agreement. Pharmacy Benefit Manager will make adjustments for a period of up to twelve (12) months from the effective date of the error, as directed by the State. This provision will not prohibit adjustments beyond a twelve (12) month period if mutually agreed to by Pharmacy Benefit Manager and the State.

7.1. Liability

Each Party will be responsible for its own acts and behavior and the results thereof. The Minnesota Torts Claims Act, Minnesota Statute § 3.736 and other applicable laws govern the State's liability. However, nothing stated in this Agreement is, or will be deemed to be a waiver of the State's sovereign immunity.

7.2. Indemnification by Pharmacy Benefit Manager

Pharmacy Benefit Manager will indemnify, defend to the extent permitted by the Attorney General; and hold harmless the State, Plan Sponsor, officers, employees, agents, successors and assigns and/or Employee Plans (each an "Indemnitee"), at Pharmacy Benefit Manager's expense, from any and all claims, demands, obligations, liabilities, penalties, costs and damages, including but not limited to, attorneys' fees, to the extent related to or arising out of: (a) a negligent act or omission of Pharmacy Benefit Manager, or its employees, agents, subcontractors or Affiliates, excluding Practitioners or Participating Pharmacies; (b) the performance or non-performance of this Agreement by Pharmacy Benefit Manager or any of its agents, employees, or Affiliates; (c) any unauthorized use, access, or disclosure of PHI or Confidential Personal Information inconsistent with this Agreement or applicable law; or (d) all or part of the Works or Documents infringing upon the intellectual property rights of others.

7.3. Limitation of Liability for Covered Products

(a) THE SERVICES PROVIDED BY PHARMACY BENEFIT MANAGER IN THIS AGREEMENT ARE NOT INTENDED TO SUBSTITUTE FOR OR SUPPLEMENT THE KNOWLEDGE, EXPERTISE, SKILL, AND JUDGMENT OF PHYSICIANS, PHARMACISTS, OR OTHER HEALTH CARE PROFESSIONALS IN PRESCRIBING OR SUGGESTING PHARMACEUTICALS OR OTHER PRODUCTS. THE ABSENCE OF A WARNING FOR A GIVEN DRUG, DRUG DOSAGE, OR DRUG COMBINATION WILL NOT BE CONSTRUED TO INDICATE THAT THE DRUG, DRUG DOSAGE, OR DRUG COMBINATION IS SAFE, APPROPRIATE, OR EFFECTIVE FOR ANY MEMBER.

(b) Pharmacy Benefit Manager will under no circumstances be liable (regardless of the basis for the action) for any damage, side effects or other injury suffered by any Member or other consumer of any pharmaceutical or any other product prescribed, dispensed or distributed by any health care provider, pharmacy, physician, Practitioner or pharmaceutical manufacturer or distributor. Without limiting the foregoing, the State agrees that Pharmacy Benefit Manager will not be liable to the State or any Member for losses, costs, claims, lawsuits, settlements, judgments or expenses, including attorneys' fees, arising as a result of the sale, compounding, dispensing, manufacturing, or use of any prescription drug or product dispensed by a Participating Pharmacy or a Non-Participating Pharmacy whose Claims are processed under this Agreement, or for any violation by such pharmacy of any applicable standard of care or applicable law, including, but not limited to, HIPAA, HITECH or implementing rules and regulations.

SECTION 8 PHARMACY AND THERAPEUTICS COMMITTEE

The State will be entitled to have a representative from the State attend meetings of the Pharmacy and Therapeutics Committee and Pharmacy Benefit Manager will provide MMB minutes of such meetings and/or periodic reports as may be prepared by the Pharmacy and Therapeutics Committee as soon as reasonably possible, upon request, to the extent such minutes or reports specifically relate to services provided under this Agreement. Pharmacy Benefit Manager will redact any Pharmacy and Therapeutics Committee meeting minutes to preserve the confidentiality of the identity of the committee members. Attendees at Pharmacy and Therapeutics Committee Meetings must execute a confidentiality agreement related to such attendance and any minutes or meeting reports from such meetings must be maintained by the State as confidential and restricted from further disclosure, including pursuant to a public records request, to the maximum extent permitted by law.

SECTION 9 ANTITRUST CLAIMS

Pharmacy Benefit Manager assigns to the State any and all claims for overcharges as to goods and/or services provided by third parties (including but not limited to Affiliates of Pharmacy Benefit Manager) in connection with this Agreement, which result from any violation of any federal or state antitrust laws, consumer fraud laws or laws relating to the submission of false or fraudulent claims. Further, if Pharmacy Benefit Manager identifies a class action lawsuit or any other litigation in which the State may have an interest based upon payments the State has made

on behalf of Members, Pharmacy Benefit Manager will promptly provide notice of the lawsuit to MMB and the Attorney General's office (Attn: Christie Eller), to the extent possible, in a time frame which will allow the State to enter into the class action lawsuit if the State desires. If, however, the State timely instructs Pharmacy Benefit Manager to join the class action lawsuit on behalf of the Employee Plan, Pharmacy Benefit Manager will take all actions necessary to secure the Employee Plan's claim in the lawsuit. If the Employee Plan receives a recovery as a result of the filing, Pharmacy Benefit Manager will pay the Plan its pro-rata share of the resulting proceeds.

If the State chooses to enter into the class action lawsuit on its own, Pharmacy Benefit Manager will pass along information to the State that it may acquire in the ordinary course of business and that Pharmacy Benefit Manager will have no duty or obligation, express or implied, to affirmatively seek information on the State's behalf. Upon request, Pharmacy Benefit Manager will forward any notices or claims forms or other pleadings and documents received from a court or settlement Pharmacy Benefit Manager in connection with such lawsuit, and will reasonably assist the State in determining the existence and amount of any potential claim. The cost of such assistance will be borne by the State. Pharmacy Benefit Manager will not be responsible, though, for the preparation or filing of any such claims or the conduct of such litigation on the State's behalf.

SECTION 10 RECORDS

10.1. Records of the State

All data, records, reports and studies relating in any way to the Employee Plans, including, but not limited to financial, claims, demographics and Member-related data and all records and reports created or compiled from such data (collectively, "Records"), are the property of the State. Pharmacy Benefit Manager will treat such Records as non-public records in accordance with Minnesota Statutes § 13.67 and, to the extent applicable, as PHI described in Section 11 (Privacy Protections and Compliance with Minnesota Government Data Practices Act). This includes, but is not limited to financial records, employee records, records relating to claims filed, processed and paid, and records relating to pharmacy reimbursements made pursuant to financial arrangements with a Pharmacy network in the course of administering this Agreement.

Pharmacy Benefit Manager will provide to the State any state-owned Records within forty-five (45) calendar days after the State's request. On termination of this Agreement, the State will have a right to request that all such Records will be returned to the State within sixty (60) days of the date of the request. Pharmacy Benefit Manager will have the right to make copies of such Records as are returned to the State to the extent return is infeasible. In the event the State does not request its Records or any portion thereof, that State will have a complete and unrestricted right to access those Records upon reasonable notice for a period of seven (7) years from the date the Record is generated or such longer period as the State may reasonably request as to specific cases.

Notwithstanding the foregoing, the State acknowledges that the State does not own Pharmacy Benefit Manager's proprietary data, including, but not limited to, Pharmacy Benefit Manager's Pharmacy data, system benefit and eligibility codes, rating and trending formulae and other data, records, reports and studies developed by Pharmacy Benefit Manager for general use in its business, except as otherwise provided in Section 15 (Intellectual Property Rights).

10.2. Required Records

Pharmacy Benefit Manager will maintain and retain accounting records relating to performance under this Agreement. Pharmacy Benefit Manager will maintain such books, records, documents and other evidence pertaining to the administrative costs and expenses of this Agreement in such detail as will properly reflect all revenues, all costs (direct and apportioned), and all other costs and expenses which relate to the performance under this Agreement. Such records will be maintained in accordance with generally accepted accounting principles and in such a form so as to allow the State to audit such records with minimal effort.

10.3. Document Retention

All books, records, documents, and accounting procedures and practices of Pharmacy Benefit Manager pertaining to this Agreement will be maintained and are subject to examination by the State for seven (7) years following the end of the Contract Year during which this Agreement is terminated or State audits of this Agreement have been completed, whichever is later, provided the documents have not been returned to the State. Thereafter Pharmacy Benefit Manager will dispose of such data in accordance with its standard policies and applicable state and federal law. Disposal of PHI will be in accordance with applicable federal and state law.

SECTION 11 PRIVACY PROTECTIONS AND COMPLIANCE WITH MINNESOTA GOVERNMENT DATA PRACTICES ACT

Pharmacy Benefit Manager's employees and agents may have access to private or confidential data maintained by the State to the extent necessary to carry out their responsibilities under this Agreement. Pharmacy Benefit Manager will comply with all the requirements of the Minnesota Government Data Practices Act, HIPAA and this Agreement with respect to all of the data it creates, collects, receives, stores, uses, maintains or disseminates in performing its duties under this Agreement and will designate one individual who will be in charge of the collection, use, and release of this data. Pharmacy Benefit Manager will provide adequate supervision and training to its agents and employees to ensure compliance with the Minnesota Government Data Practices Act, HIPAA and this Section.

No private or confidential data collected, received, stored, disseminated, maintained, or used in the course of performance of this Agreement will be disseminated except as authorized by statute and permitted under this Section, either during the period of this Agreement or thereafter. Pharmacy Benefit Manager will return any and all data furnished by or generated on behalf of the State promptly at the request of the State in whatever form it is maintained by Pharmacy Benefit Manager. Upon the termination or completion of this Agreement, Pharmacy Benefit Manager will not use any of such data or material derived from the data for any purpose and, where so instructed by the State, will destroy or render its material unreadable.

11.1. Data Release

Pharmacy Benefit Manager acknowledges that the State owns all data, reports, Records and studies as described in Section 10 (Records). Upon request by the State, Pharmacy Benefit Manager will release to the State or its designee all or any part of State Data in a format designated by the State and in compliance with all applicable laws and regulations. Pharmacy Benefit Manager will release the State Data as requested no later than fifteen (15) calendar days from the date of the request. With respect to all other requests for release of State Data, Pharmacy Benefit Manager will not to release any State Data without prior written approval by the

State, except in accordance with the terms and conditions of this Section. If the State requests that Pharmacy Benefit Manager release data directly to a third party, the Parties agree that the third party may be required to sign a confidentiality agreement with respect to the date, in a form mutually agreeable to the Parties and consistent with all federal and state laws and regulations.

11.2. Use of Data by Pharmacy Benefit Manager

For the purpose of this Section, "Release" will not include the use by Pharmacy Benefit Manager of any financial, claims, demographic, or Member-related data derived from the Employee Plans provided: (a) such use does not involve delivery of such data to a third party other than those specified in Exhibit E of this Agreement; (b) any third party to whom such data is delivered makes such data available to its employees solely on a need-to-know basis; and (c) any use or disclosure of such data is permitted under Section 11.3 (Use and Disclosure of PHI) and is limited to the purposes related to performance of this Agreement, including, but not limited to, the following:

(a) release of data pursuant to statutory reporting requirements;

(b) quality improvement initiatives;

(c) pharmacy utilization;

(d) health promotion or disease prevention activities, including annual flu surveys;

(e) management research related to patterns of utilization and cost of services;

(f) disease management; and

(g) medical or health services research for purposes related to performance of this Agreement and Pharmacy Benefit Manager's general health promotion purposes.

The Pharmacy Benefit Manager, its agents, and pharmacies will not release or use information related to Members for any commercial purpose without the prior written consent of the State. Commercial purpose includes, but is not limited to, advertising, marketing, and promotion.

The Pharmacy Benefit Manager must not sell any information related to Members arising from the services provided under this Agreement, directly or indirectly, to any third party without either the State's consent or the applicable Member's consent. If Pharmacy Benefit Manager is presented with an opportunity to sell any such information to any third party, Pharmacy Benefit Manager will contact the State, fully disclose the third party's proposed data sales terms, and negotiate a contract with such party related to the release of Member-related information that is agreeable to State, only with the State's consent.

11.3. Use and Disclosure of PHI

This Section 11.3 applies with respect to the use and disclosure of PHI. Capitalized terms used in this Section and not previously defined in the Agreement have the same meaning as those terms in the Standards for Privacy of Individually Identifiable Health Information

(the "Privacy Rule" at 45 CFR Parts 160 and 164) issued pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations, as may be amended from time to time or Subtitle D of the Health Information Technology for Economic and Clinical Act ("HITECH") and its implementing regulations, as amended from time to time.

11.4. Obligations and Activities of Pharmacy Benefit Manager

(a) Pharmacy Benefit Manager will, to the extent practicable, limit the use and disclosure of, and requests for, PHI to the "limited data set" (as defined by HIPAA) or the minimum amount necessary to accomplish the intended purpose of a given use, disclosure, or request consistent with applicable law. It will be the responsibility of Pharmacy Benefit Manager to make this determination.

(b) Pharmacy Benefit Manager will not use or further disclose PHI other than as permitted or required to perform its obligations under this Agreement or as Required by Law. For any use or disclosure Required by Law, other than to the person to whom the PHI relates, Pharmacy Benefit Manager will notify MMB of any such request as soon as practicable prior to release of the requested PHI, but not more than five (5) days after Pharmacy Benefit Manager's receipt of such request.

(c) Pharmacy Benefit Manager will use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. Pharmacy Benefit Manager will also develop and implement policies and procedures and meet the Security Rule documentation requirement as required by HITECH.

(d) Pharmacy Benefit Manager will mitigate, to the extent practicable, any harmful effect that is known to Pharmacy Benefit Manager of a use or disclosure of PHI by Pharmacy Benefit Manager in violation of the requirements of this Agreement.

(e) Pharmacy Benefit Manager will report to MMB, on behalf of the Employee Plan, any use or disclosure of PHI not provided for or permitted by this Agreement of which it becomes aware, including breaches of unsecured PHI as required by 45 CFR § 164.410.

(f) Pharmacy Benefit Manager will ensure that any of its Affiliates, agents, including subcontractors, to whom it provides PHI, that create PHI or from whom it receives PHI, on behalf of the Employee Plan, will agree to the same restrictions and conditions that apply through this Agreement to Pharmacy Benefit Manager with respect to the information.

(g) Pharmacy Benefit Manager will provide access, at the request of MMB acting on behalf of the Employee Plan, and in the time and manner as Required by Law and as mutually agreed upon by MMB and Pharmacy Benefit Manager, to PHI in a Designated Record Set. Such access will be provided to MMB, or as directed by MMB, to the person who is the subject of the PHI (the "Individual") to meet the requirements under 45 CFR § 164.524; provided, however, that this paragraph (g) is applicable only to

the extent Pharmacy Benefit Manager or its agent maintains the Designated Record Set for the Employee Plan.

(h) Pharmacy Benefit Manager will make any amendment(s) to PHI in a Designated Record Set that MMB directs or will on behalf of the Employee Plan pursuant to 45 CFR § 164.526 at the request of MMB or an Individual, and in the time and manner as Required By Law and as mutually agreed upon by MMB and Pharmacy Benefit Manager; provided, however, that this paragraph (h) is applicable only to the extent Pharmacy Benefit Manager or its agent maintains the Designated Record Set for the Employee Plan.

(i) Pharmacy Benefit Manager will make internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Pharmacy Benefit Manager on behalf of the Employee Plan, available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining the Employee Plan's compliance with the Privacy Rule.

(j) Pharmacy Benefit Manager will document such disclosures of PHI and information related to such disclosures as would be required for the Employee Plan to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. Except for repetitive accountable disclosures of Employee Plan's PHI as specified below, the information that Pharmacy Benefit Manager must record for each accountable disclosure (the "Disclosure Information") is: (i) the disclosure date; (ii) the name and (if known) address of the entity to which Pharmacy Benefit Manager made the disclosure; (iii) a brief description of Employee Plan's PHI disclosed; and (iv) a brief statement of the purpose of the disclosure. Pharmacy Benefit Manager further will provide any additional information to the extent required by HITECH or other applicable law and any accompanying regulations.

For repetitive accountable disclosures of Employee Plan's PHI that Pharmacy Benefit Manager makes for a single purpose to the same person or entity, the Disclosure Information that Pharmacy Benefit Manager must record is either the Disclosure Information specified in the paragraph above for each accountable disclosure or: (i) the Disclosure Information specified in the paragraph above for the first of the repetitive accountable disclosures; (ii) the frequency, periodicity, or number of the repetitive accountable disclosures; and (iii) the date of the last of the repetitive accountable disclosures.

(k) Pharmacy Benefit Manager will provide to MMB on behalf of the Employee Plan or to an Individual, in the time and manner as Required By Law and as mutually agreed upon by MMB and Pharmacy Benefit Manager, information collected in accordance with subsection 11.4(j) above, to permit the Employee Plan to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. In addition, where Pharmacy Benefit Manager is contacted directly by an Individual based on information provided to the Individual by the Employee Plan and where so required by HITECH and/or any accompanying

regulations. Pharmacy Benefit Manager will make such Disclosure Information available directly to the Individual.

(l) Pharmacy Benefit Manager will obtain satisfactory assurances, through a written contract or other arrangement, from its agents or subcontractors to whom it provides PHI received from, or created or received by Pharmacy Benefit Manager on behalf of the Employee Plan, requiring the agent or other subcontractor to comply with the applicable requirements of the Privacy Rule and HITECH. When and to the extent required by law, said contract or other arrangement must comply with 45 CFR § 164.504(e)(1)(i) to the same extent as Pharmacy Benefit Manager is required to comply.

11.5. Permitted Uses and Disclosures by Pharmacy Benefit Manager

Except as otherwise limited in this Agreement, and consistent with HIPAA and HITECH, including the minimum necessary standard stated in Section 11.4(a), Pharmacy Benefit Manager may:

(a) Use or disclose PHI to perform functions, activities or services, for, or on behalf of the Employee Plan, in a manner consistent with this Agreement or as otherwise authorized by MMB on behalf of the Employee Plan, provided that such use or disclosure would not violate the Privacy Rule or HITECH if done by the Employee Plan.

(b) Disclose Summary Health Information to MMB or its designee on behalf of the Employee Plan, if MMB requests disclosure of the Summary Health Information for the purpose of: (i) obtaining premium bids from health plans for providing health insurance coverage under the Employee Plan; or (ii) modifying, amending or terminating the Employee Plan. "Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals participating in the Employee Plan, but it excludes all identifiers that must be removed for the information to be de-identified within the meaning of the Privacy Standards, except that it may contain geographic information to the extent that it is aggregated by a five-digit zip code.

(c) Use PHI for the proper management and administration of Pharmacy Benefit Manager or to carry out the legal responsibilities of Pharmacy Benefit Manager.

(d) Disclose PHI for the proper management and administration of Pharmacy Benefit Manager, provided that disclosures are Required By Law, or Pharmacy Benefit Manager obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be 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 Pharmacy Benefit Manager of any instances of which it is aware in which the confidentiality of the information has been breached.

(e) Use PHI to provide Data Aggregation services to the Employee Plan as permitted by 45 CFR § 164.504(e)(2)(i)(B).

(f) Participate in a Record Locator Service as authorized under Minnesota law, as the State may designate from time to time.

11.6. Obligations of the Employee Plan

The Employee Plan through MMB will:

(a) Provide Pharmacy Benefit Manager with a copy of the notice of privacy practices that the Employee Plan produces in accordance with 45 CFR § 164.520, as well as any changes to the notice.

(b) Provide Pharmacy Benefit Manager with any changes in, or revocation of, permission by an individual to use or disclose PHI, if such changes affect Pharmacy Benefit Manager's permitted or required uses and disclosures.

(c) Notify Pharmacy Benefit Manager of any restriction to the use or disclosure of PHI that the Employee Plan has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Pharmacy Benefit Manager's use or disclosure of PHI.

(d) Not request Pharmacy Benefit Manager to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or HITECH if done by the respective Employee Plan, except as set forth in subsection 11.2 (Use of Data by Pharmacy Benefit Manager) above.

(e) Amend and maintain the Employee Plan Document and Summary of Benefits to allow MMB to receive and use PHI for Plan Administration functions. "Plan Administration" functions are defined as activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Employee Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. "Plan Administration" functions do not include any employment-related functions or functions in connection with any other benefit or benefit plans.

11.7. Obligation of Pharmacy Benefit Manager – Unauthorized Uses and Disclosures

The Pharmacy Benefit Manager will:

(a) Cooperate with Employee Plan in investigating any "Breach" of "Unsecured PHI" (as those terms are defined by HITECH and any implementing regulations) of information maintained by Pharmacy Benefit Manager or any agent, including subcontractors of Pharmacy Benefit Manager ("Breach of Unsecured PHI"). Pharmacy Benefit Manager will also cooperate with Employee Plan in meeting the obligations of the Employee

Plan under the breach notification provisions of HITECH or other security breach notification laws.

(b) Provide State a copy of Pharmacy Benefit Manager's relevant privacy policies and procedures within ten (10) days of request by State.

(c) Certify, in writing, to State no later than February 1 of each Contract Year, whether Pharmacy Benefit Manager secures PHI related to Members through use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services ("Secretary"). Pharmacy Benefit Manager will notify State in writing within five (5) days of any material change in circumstances affecting the accuracy of its certification.

(d) If Pharmacy Benefit Manager becomes aware that PHI related to any Member under the control of Pharmacy Benefit Manager or any agent of Pharmacy Benefit Manager, including subcontractors, has been accessed, used, or disclosed in a manner not permitted under Subpart E of 45 CFR § 164 or HITECH ("Unauthorized Use or Disclosure"), Pharmacy Benefit Manager will:

(1) Notify State in writing without unreasonable delay, but in no event later than five (5) business days, of the Unauthorized Use or Disclosure of Member PHI. The notice will be sent by email or U.S. Mail to the address designated by State consistent with Section 17.6 and includes, at a minimum, the following information, to the extent it is known to Pharmacy Benefit Manager:

i. The identity of the individual who discovered the Unauthorized Use or Disclosure;

ii. A description of the Unauthorized Use or Disclosure;

iii. The date the Unauthorized Use or Disclosure was discovered by Pharmacy Benefit Manager;

iv. To whom PHI was impermissibly disclosed (but such information should be provided in a way that does not itself lead to Unauthorized Use or Disclosure);

v. The date the Unauthorized Use or Disclosure occurred;

vi. The type of PHI that was the subject of the Unauthorized Use or Disclosure;

vii. When and what steps were taken to mitigate any harmful effect of the Unauthorized Use or Disclosure; if applicable, whether the PHI was recovered and, if so, when;

viii. The Pharmacy Benefit Manager's assessment of whether there is a low probability that the protected information has

been, or may be compromised and the basis for its assessment;

ix. Steps the Pharmacy Benefit Manager has taken or will take to prevent a similar Unauthorized Use or Disclosure in the future; and

x. The Identity Theft Mitigation Services Pharmacy Benefit Manager will provide in accordance with Section 3.17 (Confidentiality).

(2) Pharmacy Benefit Manager will diligently investigate any Unauthorized Use or Disclosure and provide State with additional relevant information as it becomes available to Pharmacy Benefit Manager.

(e) Develop and implement procedures for discovery and prevention of Unauthorized Use or Disclosure.

(f) Notify State of any request by law enforcement to delay notification to affected Members of an Unauthorized Use or Disclosure.

(g) Cooperate with State in preparing and providing notification, or upon written request from State, prepare and provide notification: (i) to affected Members; and (ii) of Breaches of Unsecured PHI to the Secretary of Unauthorized Uses or Disclosures that State determines is appropriate or required.

(h) Pay all reasonable costs actually incurred by the State to investigate and provide notifications that the State believes are legally required to Members and governmental agencies related to an Unauthorized Use or Disclosure of PHI maintained by Pharmacy Benefit Manager, or its agents or subcontractors of PHI compiled, processed, maintained, transmitted or stored by Pharmacy Benefit Manager, its agents, or subcontractors, (provided that pharmacies and health care providers providing services to Member will not be deemed "subcontractors" under this Agreement), including, but not limited to, investigation of the Unauthorized Use or Disclosure, notification to Members and governmental agencies, responding to governmental agency audits, data requests, inquiries, investigations or similar action. For the avoidance of doubt, costs that have been “actually incurred” by the State will include, but are not limited to, documented State employee time utilized for the investigation of the Unauthorized Use or Disclosure, notification to Members and governmental agencies, and/or responding to governmental agency audits, data requests, inquiries, investigations or similar action. Notwithstanding the foregoing, the State will reasonably cooperate with Pharmacy Benefit Manager regarding the sending of required notices in order to take advantage of Pharmacy Benefit Manager’s insurance coverage for such notices.

(i) Provide Identity Theft Mitigation Services in accordance with Section 3.18 (Identity Theft Prevention and Mitigation).

11.8. Effect of Termination of the Agreement

(a) Except as provided in Section 16 (Term and Termination), upon termination of this Agreement, for any reason, Pharmacy Benefit Manager will return or destroy all PHI received from the Employee Plan, or created or received by Pharmacy Benefit Manager on behalf of the Employee Plan. This provision will apply to PHI that is in the possession of subcontractors or agents of Pharmacy Benefit Manager. Pharmacy Benefit Manager will retain no copies of PHI.

(b) If Pharmacy Benefit Manager determines that returning or destroying PHI is infeasible, Pharmacy Benefit Manager will provide to MMB notification of the conditions that make return or destruction infeasible. Pharmacy Benefit Manager will extend the protections of this Section to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Pharmacy Benefit Manager maintains such PHI.

11.9. Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required at the time of the specific use or disclosure in question.

(b) Amendment. The Parties agree to take any action necessary to amend this Agreement from time to time as is necessary for the Employee Plan to comply with the requirements of the Privacy Rule, HIPAA, HITECH or other applicable laws.

(c) Interpretation. Any ambiguity in this Agreement will be resolved in favor of a meaning that permits the Employee Plan to comply with the Privacy Rule.

(d) In the event that either Party has knowledge of material breach of this Section 11 (Privacy Protections and Compliance with Minnesota Government Data Practices Act) by the other Party and cure is not possible, the non-breaching Party may terminate the Agreement. When neither cure nor termination is feasible, the non-breaching Party will report the violation to the Secretary.

(e) In clarification of the Parties' intent with respect to Pharmacy Benefit Manager's obligations under Section 11.4 (Obligations and Activities of Pharmacy Benefit Manager) above, such obligations will not be triggered by:

(1) any unintentional acquisition, access, or use of PHI by a person acting under the authority of Pharmacy Benefit Manager if:

(A) such acquisition, access, or use was made in good faith and within the scope of authority with Pharmacy Benefit Manager; and

(B) it does not result in further Use or Disclosure in a manner not permitted under the Privacy Rule; or

(2) an inadvertent Disclosure by a person who is authorized to access PHI at Pharmacy Benefit Manager to another person authorized to access PHI at the Pharmacy Benefit Manager; and the information received as a result of such Disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule; or

(3) a Disclosure of PHI where Pharmacy Benefit Manager has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information; or

(4) an Unauthorized Use or Disclosure that does not compromise the security or privacy of the PHI; i.e., does not pose a significant risk of financial, reputational, or other harm to the Member; or

(5) an Unauthorized Use or Disclosure of PHI that is rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5 on the HHS Web site; or

(6) a Use or Disclosure of PHI in a Limited Data Set (i.e. PHI that does not include the identifiers listed at 45 CFR § 164.514(e)(2)), and which further excludes date of birth, and zip code.

11.10. Member Participation in Surveys or Other Research.

If a particular survey or research involves Member contact by telephone or mail, Pharmacy Benefit Manager will, after obtaining any approval of the State required pursuant to this Section to release identifiable data, contract potential participating Members with a pre-notification letter explaining the purpose of the survey or research. The pre-notification letter may be waived on a case-by-case basis upon written approval from the State of an acceptable alternate method of notification.

11.11. Release of Demographic and Health-Related Data to a Third Party for Academic or Actuarial Research

In conformance with Minnesota Statute § 72A.502, Subd. 7, Minnesota Statute § 144.335 and Chapter 11, Pharmacy Benefit Manager may release demographic and health-related information for medical or health service research purposes to an actuarial or research organization such as an academic institution without securing the State's prior written approval provided that: (a) any data released under this provision is aggregated with data from other populations and does not include any Individual or group identifiers; (b) such data will not be used for any commercial purposes resulting in direct economic gain by Pharmacy Benefit Manager or

the third party; and (c) the population is large enough such that individual characteristics of a record cannot result in inadvertent identification of an Individual. In all other instances, Pharmacy Benefit Manager will not release any other data, including but not limited to Member data, demographic data, financial, claims or health-related data for any purpose to any third party, without the State's prior written approval. Pharmacy Benefit Manager will require strict adherence to appropriate research protocols by requiring that each such academic or actuarial organization sign a written agreement, which at minimum conforms with the requirements of Minnesota Statute § 72A.502, Subd. 7, Minnesota Statute § 144.335 and Chapter 11, prior to the release of any data.

11.12. Survey or Market Research Conducted by Pharmacy Benefit Manager or its Subcontractors

In all situations in which the State would be charged all or a pro-rated portion of the cost, Pharmacy Benefit Manager will provide the State with a written notice of all surveys and market research activity to be conducted by Pharmacy Benefit Manager or its subcontractors that involves Members, including the timing of the research, the purpose of the research, the unit of analysis, the cost that will be charged back to the State, and how the data will be used in a continuous quality improvement process. The State reserves the right to: (a) deny access to any of the State's data for the purposes of conducting survey or market research; and/or (b) not pay for any portion of survey or market research conducted by Pharmacy Benefit Manager or its subcontractors where the State determines that it is not in its best interest to do so. Pharmacy Benefit Manager will share the results of survey data and/or market research activity with the State in a timely fashion where the State has paid for any portion of the survey. In all situations where the State will not bear any of the cost, Pharmacy Benefit Manager or its subcontractors may conduct such survey or market research without obtaining prior approval from the State provided that: (a) any data released under this Section is aggregated with data from other populations and does not include any Individual or group identifiers; (b) such data will not be used for commercial purposes resulting in direct economic gain by Pharmacy Benefit Manager or the subcontractor; and (c) the population is large enough such that individual characteristics of a record cannot result in inadvertent identification of an Individual.

11.13. HIPAA Security Rule

(a) Definitions: The following terms are defined as set forth below. Any terms used but not otherwise defined in this Section have the same meaning as in 45 CFR §§ 160.103 and 164.304.

(1) "Security Rule" will mean the Security Standards for the Protection of Electronic Health Information at 45 CFR §§ 160 and 164, Subparts A and C.

(2) "Electronic PHI" will have the meaning found in the Security Rule, 45 CFR § 160.103.

(b) Obligations and Activities of Pharmacy Benefit Manager regarding Electronic PHI:

(1) Pharmacy Benefit Manager will comply with the applicable requirements of the Security Rule.

(2) Pharmacy Benefit Manager will ensure that any agent, including a subcontractor, that creates, receives, maintains, or transmits Electronic PHI on behalf of Pharmacy Benefit Manager, will implement reasonable and appropriate safeguards to protect it. Pharmacy Benefit Manager will comply with the Security Rule by entering into a contract or other arrangement with such agent or subcontractor that complies with HIPAA and HITECH including breaches of unsecured PHI as required by 45 CFR § 164.410.

(3) Pharmacy Benefit Manager will report to MMB, on behalf of the Employee Plan, any Security Incident of which it becomes aware, in accordance with Section 11.7 (Obligation of Pharmacy Benefit Manager – Unauthorized Uses and Disclosures).

(4) The Security Rule defines a "Security Incident" as an attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system, involving Electronic PHI that is created, received, maintained or transmitted by or on behalf of a Party. Since the Security Rule includes attempted unauthorized access, use, etc., the Employee Plan needs to have notice of attempts to bypass electronic security mechanisms. The Parties recognize and agree that the significant number of meaningless attempts to, without authorization, access use, disclose, modify or destroy Electronic PHI will make a real-time reporting requirement unreasonably difficult for Pharmacy Benefit Manager. Therefore, the Parties agree to the following reporting procedures for Security Incidents that result in actual unauthorized access, use, disclosure, modification or destruction of information or interference with system operations ("Successful Security Incidents") and for Security Incidents that do not so result ("Unsuccessful Security Incidents").

For Unsuccessful Security Incidents, the Parties agree that this subparagraph (b) constitutes notice of such Unsuccessful Security Incidents. By way of example, the Parties consider the following to be illustrative of Unsuccessful Security Incidents when they do not result in actual unauthorized access, use, disclosure, modification or destruction of Electronic PHI or interference with an information system:

- Pings on Pharmacy Benefit Manager's firewall;
- Port scans;
- Attempts to log on to a system or enter a database with an invalid password or username;
- Denial-of-service attacks that do not result in a server being taken off-line; and

- Malware (worms, viruses, etc.).

For Successful Security Incidents, Pharmacy Benefit Manager will give notice to MMB on behalf of the Employee Plan not more than five (5) business days after Pharmacy Benefit Manager learns of the Successful Security Incident.

(c) Term. The requirements of this Section apply to the contract or other arrangement between Pharmacy Benefit Manager and its agent or subcontractor required by 45 CFR § 164.308(b)(4) in the same manner as such requirements apply to contracts or other arrangements between Employee Plan and Pharmacy Benefit Manager.

(d) Miscellaneous.

(1) A reference in this Section to a section in the Security Rule means the section as in effect or as amended.

(2) The Parties will take any action necessary to amend this Agreement or this Section of the Agreement from time to time as is necessary for the Employee Plan to comply with the requirements of the Security Rule and the Health Insurance Portability and Accountability Act, Public Law 104-191.

(3) Any ambiguity in this Section will be resolved in favor of a meaning that permits the Employee Plans to comply with the Security Rule.

(e) Third Party Beneficiaries. Nothing in this Section will be construed to create any third party beneficiary rights in any person including any participant or beneficiary under the Employee Plan.

SECTION 12 REPRESENTATIONS, WARRANTIES, AND COVENANTS

Pharmacy Benefit Manager represents, warrants, and covenants to State and the Employee Benefits Plans that as of the Effective Date and during the term of this Agreement that:

12.1. Qualified to do Business in Minnesota

Pharmacy Benefit Manager is and will be qualified to do business in the State and is not prohibited by its articles of incorporation, bylaws, or the law of the state under which it is incorporated from performing the services required under this Agreement.

12.2. Permits and Licenses

Pharmacy Benefit Manager has obtained any and all necessary permits or licenses to do business in the State. Pharmacy Benefit Manager's Minnesota Tax Identification Number is 4917121 and its Federal Employer Identification Number is 75-2882129.

12.3. No Benefit to State Official or Employee

No elected or appointed official or employee of the State of Minnesota has benefited or will benefit financially or materially from the Agreement (e.g., has been paid a gratuity or other inducement by Pharmacy Benefit Manager), except that this Section 12.3 will not be construed in such a manner as to prevent or limit the participation of any such official or employee from participating in the Employee Plans as a Member.

12.4. Equal Opportunity Employment and Affirmative Action Plan

Pharmacy Benefit Manager will not discriminate against any employee or applicant for employment for work under this Agreement because of race, color, religion, sex, age, or national origin, and will insure that applicants who are employed and employees are treated during employment, without regard to race, color, religion, sex, age, or national origin. This provision will include, but not be limited, to the following: employment; upgrading; demotion or transfer; recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Pharmacy Benefit Manager now complies and will comply with Minnesota Statute § 363A.36 and Minnesota Rules §§ 5000.3400 to 5000.3600. Pharmacy Benefit Manager has and will maintain an affirmative action plan approved by the Minnesota Commissioner of Human Rights, to the extent such approval is required by applicable law.

12.5. Immigration Reform and Control Act Compliance

Pharmacy Benefit Manager now complies and will continue to comply with the Immigration Reform and Control Act, Minnesota Statute § 16C.075. During the term of this Agreement, Pharmacy Benefit Manager will employ the United States Department of Homeland Security E-Verify procedures to verify the employment eligibility of all new employees of Pharmacy Benefit Manager hired during the term of this Agreement to perform duties within the United States. Pharmacy Benefit Manager will obtain this certification from all subcontractors who will participate in the performance of this contract and maintain subcontractor certifications for inspection by the State if such inspection is requested.

12.6. Affidavit of Noncollusion

Pharmacy Benefit Manager has and will provide State with a complete and accurate Affidavit of Noncollusion in the form attached as Exhibit I.

12.7. [RESERVED]

12.8. Data Security and Encryption

The hardware on which Member data is compiled, stored, processed, or transmitted is and will remain secure and the data will be encrypted consistent with all applicable laws and industry standards.

12.9. Location of Data

All Member data will be compiled, processed, transmitted and stored within the geographical boundaries of the contiguous United States.

12.10. Intellectual Property Non-Infringement

The Works and Documents provided to State under this Agreement do not and will not infringe upon any intellectual property rights of other persons or entities.

12.11. Compensation

Pharmacy Benefit Manager will not receive any direct or indirect compensation for the services performed pursuant to this Agreement or its relationship with State or Employee Plans other than the fees and Claim reimbursements paid by the State pursuant to Section 5 (Payments to Pharmacy Benefit Manager) of this Agreement and Manufacturer Derived Revenue.

12.12. Women's Economic Security Act

Pharmacy Benefit Manager will comply with the Women's Economic Security Act.

12.13. Disaster Recovery Plan

Pharmacy Benefit Manager will maintain a disaster recovery plan for the purpose of protecting data infrastructure including telephones, desktop computers, networks and mainframe components. Such disaster recovery plan will include an identified hotsite for recovery and back-up and also identify the staff, systems and services needed to conduct critical services, and where and how those services will be delivered until full restoration is achieved. The plan will also provide a detailed process involving communication via media sources to update members, customers, providers and others as to the status of recovery, and direction on urgent care needs.

12.14. Commercial Use of Covered Individual Data Prohibited

Pharmacy Benefit Manager, including its Affiliates, agents and subcontractors, will not release or use information related to Members for any commercial purpose except those related to performance of this Agreement. Commercial purpose includes, but is not limited to, data aggregation, advertising, marketing, and promotion. Pharmacy Benefit Manager will not incorporate Participant opt-out consent provisions for marketing, promotion or other commercial uses in Participant communications permitted or required under this Agreement.

12.15. Insurance Coverage

Pharmacy Benefit Manager will maintain during the term of this Agreement, including any extensions thereof, the insurance coverage described in Section 14 (Insurance).

12.16. Notification of Events Affecting Accuracy of Any Representation, Warranty, or Covenant

Pharmacy Benefit Manager will notify State in writing promptly, but not later than five (5) business days, after discovering that any of the representations or warranties in this Agreement was inaccurate when made, or, as a result of changes in circumstances has become inaccurate.

SECTION 13 TAXES

Pharmacy Benefit Manager will pay any state or federal taxes or fees which may be levied upon the services provided by Pharmacy Benefit Manager under this Agreement, including any taxes assessed upon Pharmacy Benefit Manager's net income; provided, however, that the State or Members will pay any sales, excise or other similar taxes payable at the time of sale of Covered Products to a Member. Said tax payments will be made in accordance with state or federal law.

SECTION 14 INSURANCE

Pharmacy Benefit Manager will obtain and maintain during the term of this Agreement all insurance or program of self-insurance required under this Section and approved by the Minnesota Department of Administration, with insurance companies (if applicable) having an "AM BEST" rating of A-(minus); Financial Size Category (FSC) VII or better, and authorized to do business in the State of Minnesota. Pharmacy Benefit Manager will not commence work under the Agreement until it has all such coverage in place. All policies and certificates (if applicable) Pharmacy Benefit Manager will provide will remain in force and effect except on thirty (30) days prior written notice to the State's Materials Management Division before cancellation, expiration, or change in any way that would affect the coverage afforded the insured as respects this Agreement. Pharmacy Benefit Manager will provide State with satisfactory evidence of the following policies:

14.1. Workers' Compensation Insurance

Except as provided below, Pharmacy Benefit Manager must provide Workers' Compensation insurance for all its employees and, in case any work is subcontracted, Pharmacy Benefit Manager will require the subcontractor to provide Workers' Compensation insurance in accordance with the statutory requirements of the State of Minnesota, including Coverage B, Employer's Liability. Insurance minimum amounts are as follows:

(a) $100,000 – Bodily Injury by Disease per employee

(b) $500,000 – Bodily Injury by Disease aggregate

(c) $100,000 – Bodily Injury by Accident

If Minnesota Statute § 196.041 exempts Pharmacy Benefit Manager from Workers' Compensation insurance or if Pharmacy Benefit Manager has no employees in the State of Minnesota, Pharmacy Benefit Manager must provide a written statement, signed by an authorized representative, indicating the qualifying exemption that excludes Pharmacy Benefit Manager from the Minnesota Workers' Compensation.

If, during the course of the contract, Pharmacy Benefit Manager becomes eligible for Workers' Compensation, Pharmacy Benefit Manager must comply with the Workers' Compensation Insurance requirements in this Section and provide the State of Minnesota with a certificate of insurance.

Further, Pharmacy Benefit Manager certifies that it is in compliance with Minnesota Statute § 176.181, Subdivision 2, pertaining to workers' compensation insurance coverage. Pharmacy Benefit Manager's employees and agents will not be considered State employees. Any claims that may arise under the Minnesota Workers' Compensation Act on behalf of these

employees or agents and any claims made by any third party as a consequence of any act or omission on the part of these employees or agents are in no way the State's obligation or responsibility.

14.2. Commercial General Liability

Insurance or a program of self-insurance and excess insurance that protects Pharmacy Benefit Manager from claims for damages for bodily injury, including sickness or disease, death, and for care and loss of services as well as from claims for property damage, including loss of use which may arise from operations under the contract whether the operations are by Pharmacy Benefit Manager or by anyone directly or indirectly employed by Pharmacy Benefit Manager under this Agreement. Pharmacy Benefit Manager shall require subcontractors to carry equivalent levels of insurance to those stated below, including the limitations on deductibles, and Pharmacy Benefit Manager's obligations hereunder shall in no manner or respect be reduced by a failure of a subcontractor to carry such insurance. Insurance minimum amounts are as follows:

(a) $1,000,000 – per occurrence

(b) $2,000,000 – annual aggregate

(c) $2,000,000 – annual aggregate – Products/Completed Operations

The following coverages will be included:

(a) Premises and Operations Bodily Injury and Property Damage

(b) Personal and Advertising Injury

(c) Blanket Contractual Liability

(d) Products and Completed Operations Liability

(e) State of Minnesota named as an Additional Insured

14.3. Commercial Automobile Liability

Insurance protecting Pharmacy Benefit Manager from claims for damages for bodily injury as well as from claims for property damage resulting from the ownership, operation, maintenance or use of all owned, hired, and non-owned autos which may arise from operations under this contract, and in case any work is subcontracted Pharmacy Benefit Manager will require the subcontractor to provide Commercial Automobile Liability Insurance minimum amounts are as follows:

$2,000,000 – per occurrence Combined Single limit for Bodily Injury and Property Damage.

In addition, owned, hired, and non-owned automobile coverages must be included. The State of Minnesota must be named as an additional insured.

14.4. Professional/Technical, Errors and Omissions, and/or Miscellaneous Liability Insurance

A policy providing coverage for all claims Pharmacy Benefit Manager may become legally obligated to pay resulting from any actual or alleged negligent act, error, or omission related to Pharmacy Benefit Manager's professional services required under this Agreement. Pharmacy Benefit Manager is required to carry the following amounts:

(a) $2,000,000 – per claim or event

(b) $2,000,000 – annual aggregate

Any deductible will be the sole responsibility of Pharmacy Benefit Manager and may not exceed One Hundred Thousand Dollars ($100,000) without the prior written approval of the State. If Pharmacy Benefit Manager desires authority from the State to have a deductible in a higher amount, Pharmacy Benefit Manager will so request in writing, specifying the amount of the desired deductible and providing financial documentation by submitting the most current audited financial statements or other approved documentation so that the State can ascertain the ability of Pharmacy Benefit Manager to cover the deductible from its own resources.

The retroactive or prior acts date of such coverage will not be after the Effective Date of this Agreement.

This policy will provide coverage for all claims Pharmacy Benefit Manager may become legally obligated to pay resulting from any actual or alleged negligent act, error, or omission related to Pharmacy Benefit Manager's obligations under this Agreement and include an extended reporting period provision of a minimum of three (3) years following completion of the work.

Evidence of insurance has been provided to the State as of the date of this Agreement and such evidence of insurance or self-insurance has been determined to be acceptable to the State.

14.5. Cyber Liability Insurance

Pharmacy Benefit Manager will procure and maintain during the term of this Agreement cyber liability coverage with policy limits of not less than Five Million Dollars ($5,000,000) to afford the State, Employee Plans and Members protection in the event of unauthorized access to or use of confidential information under the control of Pharmacy Benefit Manager, its subcontractor or assigns. Pharmacy Benefit Manager will notify the State immediately of receipt of notice of non-renewal, cancellation of coverage, or a material change in the terms of any insurance coverage initiated by Pharmacy Benefit Manager or its insurer.

Evidence of insurance has been provided to the State as of the date of this Agreement and such evidence of insurance or self-insurance has been determined to be acceptable to the State.

SECTION 15 INTELLECTUAL PROPERTY RIGHTS

15.1. Trade Secrets

The State recognizes that Pharmacy Benefit Manager claims that portions of this Agreement may constitute trade secrets under Minnesota law. The State will classify portions of this Agreement based on the State's direction regarding the classification of the portions of the Agreement that are nonpublic as nonpublic information is defined pursuant to Minnesota Statute § 13.37, Subd. 2, provided that the Pharmacy Benefit Manager prepares and provides to the State a redacted version of the Agreement by January 1 of the Contract Year which may be released to any persons requesting access to this Agreement under the Minnesota Government Data Practices Act based on the requirements and purposes of this law. Pharmacy Benefit Manager and the State will consult with each other regarding any issues arising with respect to requested disclosures. In the event of a request for disclosure of this Agreement under the Minnesota Government Data Practices Act the Pharmacy Benefit Manager and State will provide the redacted version of this Agreement for such release. State will not bear any cost or have any obligation to defend claims by Pharmacy Benefit Manager that redacted information is non-public data.

15.2. State Ownership Rights

The Parties agree that if intellectual property of any kind will be developed by Pharmacy Benefit Manager specifically for the State under this Agreement, then the Parties will execute a Work Order (as defined below) further describing such intellectual property and the fees to be paid by the State for such intellectual property. The State owns all rights, title, and interest in all of such intellectual property rights, including copyrights, patents, trade secrets, trademarks, and service marks embodied in any Work requested, created specifically for the State, and paid for by the State pursuant to a Work Order (as defined below). For avoidance of doubt, "Work" does not include open enrollment materials, standard reports, standard electronic files or extractions therefrom, product designs, report formats, marketing materials, business processes or methods or any other information created by Pharmacy Benefit Manager as part of its overall general business operations and purposes ("Pharmacy Benefit Manager's Pre-Existing Intellectual Property"). "Work Order" means a writing that expressly references this Agreement, and specifically describes the Deliverables to be provided to the State by Pharmacy Benefit Manager. "Deliverables" are any physical or electronic media (including storage media) to be provided to the State by Pharmacy Benefit Manager pursuant to a Work Order. "Works" means all Deliverables that embody or comprise inventions, improvements, discoveries (whether or not patentable), databases, computer programs, reports, notes, studies, photographs, negatives, designs, drawings, specifications, materials, tapes, disks, and Documents, as defined herein, that are conceived, reduced to practice, created or originated by Pharmacy Benefit Manager, its employees, agents, and sub-contractors, either individually or jointly with others in the performance of a Work Order. "Documents" are Deliverables that are the originals of any databases, computer programs, reports, notes, studies, photographs, negatives, designs, drawings, specifications, materials, tapes, disks, or other materials, whether in tangible or electronic forms, prepared by Pharmacy Benefit Manager, its employees, agents, or sub-contractors, in the performance of a Work Order. All right, title, and interest in all copyrightable material which Pharmacy Benefit Manager conceives of or originates, either individually or jointly with others, and which are created specifically and exclusively for the State and delivered to the State under a Work Order, will constitute Work and be the property of the State and are by this Agreement assigned to the State along with ownership of any and all copyrights in the copyrightable material. Pharmacy Benefit Manager will, upon the request of the State execute all

papers and perform all other acts necessary to assist the State to obtain and register copyrights on such materials. Where applicable, works of authorship created by Pharmacy Benefit Manager for the State in performance of a Work Order will be considered "works made for hire" as defined in the U.S. Copyright Act. Except as expressly otherwise provided herein, Pharmacy Benefit Manager retains all rights, title, and interest in and reserves the right to use and control the use of its intellectual property rights in its assets including, but not limited to, its software, reporting packages, user documentation, operations, procedures, and trademarks and service marks. ("Pharmacy Benefit Manager's Pre-Existing Intellectual Property"). Pharmacy Benefit Manager grants to the State, a non-exclusive royalty-free license to use Pharmacy Benefit Manager's Pre-Existing Intellectual Property. The State will not use any such items except as expressly allowed under this Agreement and also will not refer to Pharmacy Benefit Manager or its trade name or marks in any publication without the prior written approval of Pharmacy Benefit Manager, except for the State's governmental purposes.

15.2.1. Ownership Service Marks

Pharmacy Benefit Manager recognizes that the service marks "Minnesota Advantage Health Plan℠," "Advantage Health Plan℠," "SEGIP℠," and "PEIP℠" are good and valid service marks and are owned by the State. Pharmacy Benefit Manager agrees that it has no rights in said service marks except as set forth in this Agreement. Pharmacy Benefit Manager will not contest the ownership or validity of any rights of the State in said service marks. Pharmacy Benefit Manager further agrees that its use of said service marks inures to the benefit of the State; and the State is the exclusive owner of all goodwill now or hereafter associated with said service marks.

15.3. Obligations

Notwithstanding any other provisions of this Agreement, Pharmacy Benefit Manager will indemnify; defend, to the extent permitted law; and hold harmless the State, at Pharmacy Benefit Manager's expense, from any action or claim brought against the State to the extent that it is based on a claim that all or part of the Works infringe upon the intellectual property rights of others. The State will promptly: (a) notify Pharmacy Benefit Manager upon learning of any such action or claim; and (b) tender defense of such claim to Pharmacy Benefit Manager, to the extent allowable by law. If such a claim or action results in the State being unable to use Works, or in Pharmacy Benefit Manager's or the State's opinion is likely to result in the State being unable to use Works: (a) the State will immediately cease using such Works; and (b) Pharmacy Benefit Manager will, at the Pharmacy Benefit Manager's option: (i) procure for the State the right or license to use the intellectual property rights at issue; (ii) replace or modify the allegedly infringing Works as necessary and appropriate to obviate the infringement claim; or (iii) refund to the State the amounts paid for any Works specifically related to the development of such Works. This remedy of the State will be the exclusive remedy for such infringement.

SECTION 16 TERM AND TERMINATION

16.1. Term

The Initial Term of this Agreement will be from January 1, 2021, to December 31, 2021.

(a) Renewal and Nonrenewal. The State may, at its option, elect to renew the Agreement for one (1) additional subsequent renewal term of one (1) year

upon expiration of its Initial term on December 31, 2021, upon written notice of renewal to Pharmacy Benefit Manager which is received no later than ninety (90) days prior to expiration of the then-current term (each, a "Renewal Term"). Pharmacy Benefit Manager may, at its option, elect not to renew the Agreement upon expiration of its term on December 31, 2021, upon written notice of non-renewal to the State which is received no later than June 1, 2021. The terms of the Agreement during the renewal term will be the same as this Agreement except that the Parties will negotiate the following provisions by the later of the deadlines indicated below or ten (10) working days following the settlement of all collective bargaining agreements between the State and bargaining units representing State employees, and will affix to this Agreement as Exhibit K, except as otherwise noted, the terms agreed to with respect to each provision for the subsequent Contract Year:

Provision	Negotiated Deadline
Monthly Administration Fee	June 30
Pay for Performance programs and terms	June 30

The provisions listed above will be adjusted as agreed upon by the Parties by the dates set forth above. The Parties will execute an Acknowledgement of Agreement to Renewal Provision (see Exhibit K) as soon as reasonably practicable following agreement by the Parties to any provision set forth above. If agreement cannot be reached between the Parties as to any provision listed above by the dates set forth above, either Party may request that the disputed provision be submitted to mediation pursuant to Section 17.2 (Mediation). If the Parties remain unable to reach agreement as to any provision listed above or if Pharmacy Benefit Manager fails to provide a proposal with respect to any financial term and the deadlines for non-renewal have passed, the terms of the Agreement for the subsequent Contract Year will be as follows:

(1) with respect to those provisions upon which the Parties have reached agreement, such provisions will have the terms agreed to by the Parties pursuant to this Section;

(2) with respect to those provisions upon which the Parties have been unable to agree, such provisions will have the same terms as were in force for the prior Contract Year; and

(3) with respect to those financial provisions for which Pharmacy Benefit Manager has failed to propose a value for the renewal period, such provisions will have the same terms as were in force for the prior Contract Year.

16.2. Notice of Material Breach and Right to Terminate Agreement

In the event of a Material Breach of the terms of this Agreement, the non-breaching Party will provide written notice to the breaching Party within thirty (30) days of discovery of the breach. If the breach is not corrected to the non-breaching Party's satisfaction within a reasonable

period of time, but no longer than thirty (30) days from the receipt of the notice specified in the foregoing sentence (unless the non-breaching Party agrees in writing to a longer period), the non-breaching Party may terminate this Agreement upon written notice to the breaching Party.

16.3. Remedies for Material Breach by Pharmacy Benefit Manager

(a) When an act or omission of Pharmacy Benefit Manager results in a Material Breach the State, at its option, and in addition to any other remedy available under this Agreement or applicable law, may require Pharmacy Benefit Manager's corporate auditors to audit the area of Pharmacy Benefit Managers, or it's subcontractor's, operation in which the Material Breach occurred for the purpose of confirming that corrective action has been taken. The entire cost of such audit will be paid by Pharmacy Benefit Manager.

(b) In the event that the audit determines that corrective action has not been taken to eliminate the cause of the Material Breach, the State, at its option, and in addition to any other remedy available under this Agreement or applicable law, may assess Pharmacy Benefit Manager One Thousand Dollars ($1,000) per day for a minimum of ten (10) days. Such assessment will be measured from the date the auditor determines the corrective action has not been taken and will continue until the auditor confirms that corrective action has been taken.

(c) If the Employee Plans terminate this Agreement due to a Material Breach, the Employee Plans may off-set any costs related to the Material Breach against any compensation payable to the Pharmacy Benefit Manager under Section 5 (Payments to Pharmacy Benefit Manager) of this Agreement.

(d) The Employee Plans, in addition to any other remedies available under this Agreement or applicable law, have the right to report issues to the applicable enforcement agency. To the extent it is able, if any such report is occurring; the State will provide Pharmacy Benefit Manager with prior notice of such report.

16.4. Other Terminations; Partial Years

Pursuant to applicable State law, the State reserves the right to terminate the Agreement immediately if it determines in its sole discretion that the further performance of services by Pharmacy Benefit Manager under this Agreement is not necessary or will not serve the interests of the State or the Employee Plans. If this Agreement is terminated for any reason on a date other than a December 31, except termination due to a Material Breach by Pharmacy Benefit Manager, all goals, targets, forfeitures, etc., will be prorated and settlement, etc., to the extent possible, will be computed at that time as if the termination date were a December 31.

16.5. Failure of Legislature to Approve Plan

If, by either action or the failure to act by the Minnesota Legislature, the Minnesota Legislative Coordinating Commission or any of the Legislature's duly appointed bodies with power to act under Minnesota law, the Employee Plans is not adopted in full (with respect to any persons

covered under the Employee Plans or to be covered under the Employee Plan), Pharmacy Benefit Manager will administer the Employee Plan and otherwise fulfill its obligations under this Agreement in accordance with any and all reasonable revisions to the Employee Plan as communicated to Pharmacy Benefit Manager in writing by the State. Furthermore, the Parties will meet and negotiate any amendments to the provisions of this Agreement which may be necessary as a result of the failure of the Employee Plans to be adopted in its entirety, including but not limited to financial provisions.

16.6. Conflicts of Interest

Notwithstanding anything in this Agreement to the contrary, the State may terminate this Agreement without notice if the State determines that gratuities, in any form, were offered or given by Pharmacy Benefit Manager or any of its employees, agents, or representatives to any officer or employee of the State for the purpose of securing this Agreement, or securing favorable treatment with respect to the award of, or the making of any determinations with respect to performance under this Agreement.

SECTION 17 MISCELLANEOUS PROVISIONS

17.1. Reservation of Rights

Nothing in this Agreement will modify, limit or restrict the authority of the Commissioner of Minnesota Management and Budget to remove a health plan from or add a health plan to the SEGIP or PEIP.

17.2. Mediation

Any disputes or disagreements arising in connection with the negotiation of terms to be applicable during a subsequent Contract Year pursuant to the renewal provisions set forth in Sections 16.1 (Term) may be subject, upon the written agreement of both Parties, to the mediation provisions of this Section. If a Party elects to submit such dispute or disagreement to mediation, the mediation will be conducted by an independent third party, duly qualified as a neutral and listed on the Minnesota State Court ADR Roster, and agreeable to both Parties. Costs of the mediator will be shared equally by the Parties. Such mediation will be held at a location mutually agreeable to the Parties and the mediator.

17.3. Compliance with Laws, Agreements and Policies

In performing the services required by this Agreement, Pharmacy Benefit Manager will comply strictly with all applicable federal and state statutes as well as all applicable regulations, collective bargaining agreements and administrative policies adopted by the State or MMB. The State also will comply strictly with all applicable federal and state statutes as well as all applicable regulations.

17.4. Independent Contractor

Pharmacy Benefit Manager makes this Agreement and will function as an independent contractor. Pharmacy Benefit Manager will not state or imply the contrary to anyone. The employees and agents of Pharmacy Benefit Manager and any pharmacies providing services to Members through the network established by Pharmacy Benefit Manager will not be treated as the agents or employees of the State for any purpose.

17.5. Significant Events

Pharmacy Benefit Manager will notify the State as soon as possible of significant events which may affect the level of service of either Pharmacy Benefit Manager or its key pharmacies or subcontractors.

For events where Pharmacy Benefit Manager has prior knowledge (e.g., items (a) to (c) below), notice must be given no later than five (5) working days before the event. For events where Pharmacy Benefit Manager has no prior knowledge (e.g., items (d) to (i) below), notice must be given no later than five (5) working days after the event. Such events include, but are not limited to:

(a) Disposal of major assets equal to [redacted] or more of the net worth of either Pharmacy Benefit Manager or a key subcontractor;

(b) Termination, non-renewal, or modification of any major contract or subcontract with Pharmacies that provides services to [redacted] or more of Members;

(c) Termination, non-renewal, or modification of any major contract or subcontract whereby Pharmacy Benefit Manager services if such termination or non-renewal would prevent Pharmacy Benefit Manager from performing its obligation pursuant to this Agreement;

(d) Insolvency, or other financial problems that would affect Pharmacy Benefit Manager's ability to meet its obligations;

(e) Receipt of a notice of intent to impose receivership, conservatorship, rehabilitation status, or special regulatory monitoring by an outside agency;

(f) Withdrawal of state or federal licensing that is necessary to perform its obligation under this Agreement;

(g) Strikes, slowdowns, or any other substantial impairment of Pharmacy Benefit Manager's facilities; or

(h) Any other occurrence which may affect the ability of Pharmacy Benefit Manager to perform its contractual obligations to the State.

17.6. Notices

All notices required or permitted to be given by this Agreement will be in writing and will be deemed given when either personally delivered, sent by first class mail, delivered by

courier or transmitted by facsimile and confirmed in writing, to the other Party at the respective addresses stated below:

If to State of Minnesota:

Minnesota Management and Budget Department
200 Centennial Building
658 Cedar Avenue
St. Paul, MN 55155
Attention: Linda Schmidt

Notices related to an unauthorized use or disclosure of Member data may be delivered by secure electronic mail but must be delivered to:

Minnesota Management and Budget Department
200 Centennial Building
658 Cedar Avenue
St. Paul, MN 55155
Attention: Lorna Smith
lorna.smith@state.mn.us

If to Pharmacy Benefit Manager:

CVS Health
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:

CVS Health
9501 E. Shea Blvd.
Scottsdale, AZ 85260
Attn: Senior Vice President, Health Care Services
Fax No: (480) 391-4704

Pharmacy Benefit Manager or the State may change its address for receiving notices upon ten (10) days advance notice to the other Party.

17.7. Severability

If any provision of this Agreement will be held to be invalid, illegal or unenforceable, the validity, legality or enforceability of the remaining provisions will not in any way be affected or impaired thereby.

17.8. Governing Law

Except as the Parties may be subject to federal law (such as the Public Health Service Act, the Health Insurance Portability and Accountability Act of 1996, the Consolidated Omnibus Budget Reconciliation Act of 1985, and the Mental Health Parity Act of 1996), any questions, claims, disputes or litigation concerning or arising from this Agreement will be governed by the laws of the State of Minnesota, without regard to its conflicts of law rules, and will be commenced and venued in a court of competent jurisdiction in Ramsey County, Minnesota.

17.9. Prior Agreements

This Agreement will in no way affect or modify ongoing obligations resulting from any agreement between the Parties, including but not limited to, relating to the administration of Member Claims incurred prior to the Effective Date of this Agreement and financial reimbursement for administration of such Claims incurred prior to the Effective Date of this Agreement.

17.10. Entire Agreement; Modification

This Agreement states the entire final agreement and understanding between Pharmacy Benefit Manager and the State with respect to the subject matter hereof and understandings between them with respect to the same subject matter. Pharmacy Benefit Manager and the State agree that neither is relying on any representations, warranties or understandings not explicitly stated in this Agreement, and that no oral statement has been made to either Party that in any way tends to waive any of the terms or conditions of this Agreement. No part of this Agreement may be waived, modified or supplemented in any way except by a written instrument signed by duly authorized representatives of Pharmacy Benefit Manager and the State.

17.11. Assignment, Delegation and Outsourcing

Pharmacy Benefit Manager cannot assign, delegate or outsource any significant obligation under this Agreement to another organization, company or entity without the prior written consent of the State which consent State may grant or withhold at its sole discretion. Notwithstanding anything to the contrary in this Section 17.11, Pharmacy Benefit Manager may, in its sole discretion and without obtaining consent from the State: (a) assign this Agreement and/or any of its rights or obligations under this Agreement to any direct or indirect Affiliates of Pharmacy Benefit Manager; and/or (b) subcontract all or part of its obligations under this Agreement to any direct or indirect Affiliates of Pharmacy Benefit Manager. The term “Affiliates” for purposes of this Section will mean any entity that directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with Pharmacy Benefit Manager. The Affiliates and other subcontractors to which Pharmacy Benefit Manager has assigned or subcontracted its rights or obligations under this Agreement are listed in Exhibit E. Pharmacy Benefit Manager will remain responsible and liable for any obligations assigned, subcontracted or outsourced. Pharmacy Benefit Manager will give written notice to the State of any such assignment or subcontracting within fifteen (15) days. Notwithstanding anything in this paragraph to the contrary, if business or legal circumstances do not allow for prior notice to and consent from the State (e.g. it is not commercially prudent or is otherwise prohibited), Pharmacy Benefit Manager may, in its discretion, change the subcontractors listed in Exhibit E without the prior consent of the State. In such a circumstance Pharmacy Benefit Manager will provide the State with notice of such change in subcontractor as soon as reasonably possible.

17.12. No Third Party Beneficiaries

There will be no third party beneficiaries to this Agreement, and no individual (including an Individual as defined in the Privacy Rule) or entity who is not a Party to this Agreement will have any rights in connection with a breach or violation of this Agreement.

17.13. Waiver

Neither the failure nor any delay on the part of either Party to this Agreement to exercise any right, power or privilege under this Agreement will operate as a waiver thereof, nor will any single or partial exercise of any such right, power or privilege preclude any other or further exercise thereof, or the exercise of any other right, power, or privilege. In the event any party to this Agreement should waive any breach of any provision of this Agreement, it will not be deemed or construed as a waiver of any other breach of the same or different provision.

17.14. Force Majeure

Neither Party will be deemed to have breached this Agreement or be held liable for any failure or delay in the performance of all or any portion of its obligations under this Agreement if prevented from doing so by a cause or causes beyond its control. Without limiting the generality of the foregoing, such causes include acts of God or a public enemy, fires, floods, storms, earthquakes, riots, strikes, boycotts, lock-outs, acts of terrorism, acts of war or war-operations, restraints of government, power or communications line failure or other circumstances beyond such Party's control, or by reason of the judgment, ruling or order of any court or agency of competent jurisdiction, or change of law or regulation (or change in the interpretation thereof) subsequent to the execution of this Agreement. The Party claiming force majeure must provide the other Party with reasonable written notice. However, as soon as cause preventing performance ceases, the party affected thereby will fulfill its obligations as set forth under this Agreement. This Section will not be considered to be a waiver of any continuing obligations under this Agreement, including, without limitation, the obligation to make payments.

17.15. Governing Documents

This Agreement will include and incorporate all Appendices and Exhibits. The provisions within the body of this Agreement will govern to the extent that any provision of a document incorporated or "click-wrap agreements" conflict with the provisions contained within the body of this Agreement.

17.16. Survival

The respective rights and obligations set forth in Section 3.18 "Identity Theft Prevention and Mitigation"; Section 6 "Audits"; Section 7 "State or Pharmacy Benefit Manager Error"; Section 10 "Records"; Section 11 "Privacy Protections and Compliance with Minnesota Government Data Practices Act"; Section 15 "Intellectual Property Rights"; and Section 17.16 "Survival" will survive the termination of this Agreement.

17.17. Debarment

17.17.1. Debarment by State, its Departments, Commissions, Agencies, or Political Subdivisions

Pharmacy Benefit Manager certifies that neither it nor its principals is presently debarred or suspended by the State, or any of its departments, commissions, agencies, or political subdivisions. Pharmacy Benefit Manager's certification is a material representation upon which the Agreement award was based. Pharmacy Benefit Manager will provide immediate written notice to the State's Authorized Representative if at any time it learns that this certification was erroneous when submitted or becomes erroneous by reason of changed circumstances.

17.17.2. Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion

Federal money will be used or may potentially be used to pay for all or part of the work under this Agreement, therefore Pharmacy Benefit Manager certifies that it is in compliance with federal requirements on debarment, suspension, ineligibility and voluntary exclusions specified in the solicitation document implementing Executive Order 12549. Pharmacy Benefit Manager's certification is a material representation upon which this Agreement award was based.

[Remainder of Page Intentionally Left Blank]

IN WITNESS WHEREOF, the duly authorized representatives of Pharmacy Benefit Manager and the State have executed this Agreement as of the Effective Date.

PHARMACY BENEFIT MANAGER:

CaremarkPCS Health, L.L.C.

DocuSigned by:
By: Diane Gale
BA6B2FF3EBB04E0...

Title: VIce President and Group Head

Date: 12/27/2020

By: _____

Title: _____

Date: _____

[individual signing certifies that funds have been Encumbered as required by Minn. Stat. § 16A15.]

DocuSigned by:
By: Stephine Holloway
DD50B6883134150...
Date: 12/29/2020

STATE:

COMMISSIONER OF ADMINISTRATION

DocuSigned by:
By: Haylie Heil
4AB4CCB119DA413...
(authorized signature)

Title: Contracts Specialist

Date: 12/29/2020

MINNESOTA MANAGEMENT & BUDGET

DocuSigned by:
By: Lorna Smith
0141D8E767134E1...
(authorized signature)

Title: Director, Employee Insurance

Date: 12/28/2020

DocuSigned by:
By: Kristin Batson
DF71411FB45345E...
(authorized signature)

Title: Acting Deputy Commssioner

Date: 12/28/2020

LIST OF EXHIBITS

Exhibit A

ADMINISTRATIVE SERVICES FEE SCHEDULE

The State will pay Pharmacy Benefit Manager the following administrative fee per Member per month (the "PMPM"), in accordance with Section 5.1 of the Agreement:

PASS-THROUGH PROPOSAL (BROAD NETWORK)

Administration Fee	All Years
Guaranteed Maximum Administration Fee	
Per Member Per Month (PMPM)	[redacted]

This PMPM is based on the assumption that the State continues to utilize the Pharmacy Benefit Manager for all Plan services described in this Agreement. If the State does not continue to use Pharmacy Benefit Manager for all such services, the parties will negotiate in good faith to adjust the PMPM to reflect the economic impact of the modification in the Pharmacy Benefit Manager services.

The administrative fee will include the following services, which are all set forth more fully in the Agreement:

BASIC SERVICES
Retail Network • Use of the CVS Health National Network • CVS Health MAC • Pharmacist Toll-Free Number
Mail Service Pharmacy • Use of the CVS Health Mail Service Pharmacy • Proper Prescription Container • Profile/Order Form and Return Envelope • Member Counseling Label (Drug specific) • Automatic Prescription Refill/Renewal • Stuffer • Refill Sticker • Prescription Receipt • Prescription Bottle Label • Snap Caps (if requested)
Customer Care Center • Member Toll-Free Number • Bilingual Customer Care Representatives • 24-hour Emergency Access to Registered Pharmacists • Hearing Impaired and Handicapped Services • Caremark.com Online Pharmacy Service • Refill-by-Phone (Nuance Interactive Voice Response)

Account Management

- Annual Analyses to Measure Impact of Clinical Interventions
- Onsite Visits to Discuss Program Performance
- Customized Reporting Packages Based on Program Design

Communication Materials

- Initial Implementation Benefit Communication Materials
  - 2 Identification Cards
  - Standard Introductory Letter
  - Profile/Order Form
- Dear Doctor Letters
- Refill-by-Phone Brochures
- Newsletters
- Payroll Stuffers
- Generic Drug Fliers
- Fulfillment of Communication Materials (bulk-shipped via ground service)
- Paper Claim Forms in Sufficient Quantities
- Other Forms Necessary for Proper Plan Operation

Reporting

- Standard Management Reports
- Clinical Intervention Reports (Included with the purchase of optional programs)
- Health Management Reports (Included with the purchase of optional programs)
- Performance Guarantee Report Card
- Prescription Savings Guide – We are pleased to offer your members one digital report annually, at no additional charge.
  NOTE: Prescription Savings Guides are provided to members with a minimum yearly savings opportunity of $50.00.

Other Services

- Administration of Eligibility Submitted via Magnetic Tape or Electronically
- Electronic Claims Adjudication through our Integrated Claims Adjudication System
- Senior Referral Services
- Online Services (On-site eligibility maintenance and prior-authorization overrides).

*Some generic solutions require the client to waive copays.

Core Clinical Services and Programs (as elected by the State):

	Core Clinical Services and Programs		Cost
(a)	**Formulary Management (as described in Section 3.8 of the Agreement)**		[redacted]
(b)	**Safety Programs**		
	i.	POS Safety Review	
	ii.	Retrospective Safety Review with Pharmacy Claims	

	iii.	Safety and Monitoring Solution	[redacted]
	iv.	Physicians Profiling Report	
	v.	POS Utilization Management - Dose Optimization - Quantity Limit - Step Therapy	
(c)	**Savings Programs**		
	i.	Comprehensive Generics Solutions a. DAW Solution 1 and or 2 b. Value Drug Savings Tool c. DAW Penalty	
	ii.	POS Preferred Product Messaging	
	iii.	Generic Step Therapy (Prior Auth fee will apply)	
(d)	**Pharmacy Advisor**		
	i.	Pharmacy Advisor Support: Adherence	
	ii.	Pharmacy Advisor Support: Ready Fill at Mail®	
	iii.	Pharmacy Advisor Support: Closing Gaps in Medication	

Other Optional Core Services	Cost
Non-HDHP Accumulator Integration With the Medical Carriers	[redacted]
HDHP Accumulator Integration With the Medical Carriers	
ePrescribing Fee	
Production & Distribution of Monthly Claims & Eligibility File Feed to Medical Vendors	
Production & Distribution of Monthly Claims & Eligibility File Feed to Deloitte's Data Warehouse	
Online Reporting Portal Access	

Online Eligibility Access	[redacted]
Coordination of Benefits	
Specialty: Dose & Waste Management	
CareTeam Choice	

Exhibit B

OPTIONAL PROGRAMS

Optional Clinical Programs and Services. As consideration for the clinical services and programs selected by the State as described in the Plan Design Document and this Agreement, State shall pay to Pharmacy Benefit Manager the fees set forth below:

1. Enhanced Clinical Programs and Services (optional programs, to be elected in writing by the State if selected):

Enhanced Clinical Programs and Services			Fee	Guaranteed Return on Investment
(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:	[redacted] PMPM **OR [Pricing to be elected before program implementation]** [redacted] per Claim	N/A
		1. Physician consultation	[redacted]/hour	N/A
		2. Referral to appropriate government agencies to conduct criminal investigations	[redacted]/hr investigator	N/A
	ii.	Prior Authorization In instances where a state regulation requires denial oversight by a physician the charges for Prior Authorization requests are as follows: 1. Internal Pharmacy Benefit Manager Physician: [redacted]	[redacted] per prior authorization	N/A
	iii.	Appeals	[redacted] per review of benefit coverage [redacted] per review of medical necessity	N/A
	iv.	External Review – Coordination of records with State's contracted IROs	[redacted] during the first two-year Term, provided the volume of requests remains materially consistent with historical volumes.	N/A
	v.	Specialty Guideline Management (Specialty)	[redacted] provided the State maintains an exclusive Specialty benefit with Pharmacy Benefit Manager.	N/A

Enhanced Clinical Programs and Services			Fee	Guaranteed Return on Investment
	vi.	Medication Therapy Management	[redacted] Per comprehensive medication review (CMR)	N/A
	vii.	Drug Savings Review	[redacted] PMPM OR [Pricing to be elected before program implementation] [redacted] per Claim	[redacted] ROI over 1 year
		Pharmacy Benefit Manager 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 [redacted] of the expense to the State for these services over the Clinical Program Year. In the event Pharmacy Benefit Manager fails to meet the targeted savings, the State 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 the State 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)		Formulary Exceptions/Non-clinical requests (includes formulary exceptions, DAW, mandatory mail, plan exclusions, and formulary edits for specific classes)	[redacted] per request	N/A
(c)		Pharmacy Advisor		
	i.	Pharmacy Advisor Counseling Condition specific messaging plus: • Face-to-face interventions and messaging at CVS/pharmacy • Inbound pharmacist phone support for Members who utilize mail and other Participating Pharmacies (for CVS/pharmacy early option) • Outbound and inbound pharmacist phone support for Members who utilize mail and other Participating Pharmacies (for All Channels option)	CVS/pharmacy only: [redacted] PMPM **OR [Delivery channel to be elected before program implementation]** All Channels: [redacted] PMPM	1[redacted] annual ROI [redacted] annual ROI
		The State may terminate the Pharmacy Advisor program by providing Pharmacy Benefit Manager at least 60-days prior written notice. The pricing described above for Pharmacy Advisor is based on the following conditions: (i) In the event the State desires to include additional lines of business, implement a portion of the Members, or reduces the Members participating in the Pharmacy Advisor program, Pharmacy Benefit Manager may revise pricing for the program; (ii) The State agrees to implement all of the current conditions in Pharmacy Advisor Counseling: Asthma/COPD, Breast Cancer, Depression, Diabetes, Cardiovascular conditions, and Osteoporosis; and (iii) The above pricing reflects the current program and future program expansions may require an additional fee.		

Enhanced Clinical Programs and Services		Fee	Guaranteed Return on Investment
	Pharmacy Benefit Manager guarantees that the aggregate gross savings realized from the Pharmacy Advisor Counseling Program services over the Clinical Program Term shall be [redacted] (for CVS/pharmacy only option) OR [redacted] (for All Channels option) of the aggregate fees paid by the State for the Clinical Program Term. 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. This Pharmacy Advisor Counseling ROI is contingent upon State providing Pharmacy Benefit Manager with (a) the required prior year Member, Eligibility and Prescription data elements prior to calculation of the ROI if Pharmacy Benefit Manager was not the State's PBM in the calendar year prior to the State's implementation of the Pharmacy Advisor Counseling Program; and (b) sufficient and accurate eligibility information, which includes Member current telephone numbers. The ROI savings calculation shall be determined as follows: 1. Medication Possession Ratio: If a Member'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 Member 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) Pharmacy Benefit Manager will include the associated savings in its ROI guarantee. State 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 Pharmacy Benefit Manager 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. Pharmacy Benefit Manager reserves the right to revise the ROI in the event of changes to Plan design or Member population that materially impacts the effectiveness of the Pharmacy Advisor Counseling Program. State 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 Condition Alerts, during any period that the State receives an ROI savings guarantee under the Pharmacy Advisor Counseling Program. In the event Pharmacy Benefit Manager fails to meet the ROI guarantee, Pharmacy Benefit Manager shall, within one-hundred fifty (150) days after the close of the Clinical Plan Term, credit the State for its portion of any ROI short-fall following the end of the applicable Clinical Program Term. Pharmacy Benefit Manager's maximum obligation under the ROI shall be the amount of fees paid by the State during the Clinical Program Term.		
ii.	Condition Alerts	[redacted] PMPM	[redacted] annual ROI*
	The State may terminate the Pharmacy Advisor Condition Alerts Program by providing Pharmacy Benefit Manager at least 60-days prior written notice. The State may terminate the Pharmacy Advisor Condition Alerts Program by providing Pharmacy Benefit Manager at least 60-days prior written notice. *Pharmacy Benefit Manager guarantees that the aggregate savings realized from the Condition Alerts Program over the Clinical Program Term shall be [redacted] of the aggregate fees paid by the State for the Clinical Program Term. For the purpose of this guarantee, the term "Clinical Program Term" means the thirty-six (36) month period following implementation of the Condition Alerts Program. The ROI is contingent upon the State providing Pharmacy Benefit Manager with (a) the required historical and ongoing Member, eligibility, prescription data elements and medical data elements if Pharmacy Benefit Manager is not the PBM prior to calculation of the ROI; or (b) required historical and ongoing medical claims data, if Pharmacy Benefit Manager is the PBM in the calendar year prior to the State implementing the program.		
	The ROI savings calculation shall be determined as follows:		

Enhanced Clinical Programs and Services	Fee	Guaranteed Return on Investment
	1. For each successful Care Consideration (i.e. closed gap, such as the first fill of recommended drug) the State shall generate savings based on the Health Economic Model ("HEM"). The HEM calculates the avoided cost of clinical adverse events due to successful Care Considerations. 2. The parties acknowledge and agree the HEM model is adjusted annually by Pharmacy Benefit Manager to incorporate the latest industry research. These annual adjustments shall not be considered a material change to the Condition Alerts Program.	
	State 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 Pharmacy Benefit Manager to improve medication adherence and close gaps in care associated with certain chronic conditions that typically have high levels of medical costs. State further acknowledges that savings will be calculated using a predetermined, literature based fixed dollar amount per condition. This predetermined amount will be an estimate of the healthcare costs avoided by the Plan because of the Member's adherence to evidence-based guidelines based on published literature. Pharmacy Benefit Manager reserves the right to revise the ROI in the event of changes to Plan design or Member population that materially impacts the effectiveness of the Condition Alerts Program. In the event Pharmacy Benefit Manager fails to meet the ROI guarantee, Pharmacy Benefit Manager shall, within two hundred seventy (270) days after the close of the Clinical Program Term, credit the State for its portion of any ROI short-fall following the end of the applicable Clinical Program Term. Pharmacy Benefit Manager's maximum obligation under the ROI shall be the amount of fees paid by the State during the Clinical Program Term.	

NOTE: Any program enhancements that are developed by Pharmacy Benefit Manager during the Term may be available to the State for an additional fee. Pharmacy Benefit Manager reserves the right to adjust any ROI listed in this Section 1 if the total number of Members changes by [redacted] or more or if the State implements certain Plan design or other program changes as designated by Pharmacy Benefit Manager.

2. Additional Services:

Optional Services	Cost
Paper Submitted Claim (per processed Claim)	[redacted]/Claim
Manual Eligibility Submission	[redacted]/Manual Entry
State-Specific Custom Programming and/or Custom Report Generation (In the event RxNavigator cannot produce a custom report and requires special programming)	[redacted]/hour
RxNavigator® licenses	[redacted] user/IDs at no cost [redacted] per additional user/ID
Communications: Upon implementation, Pharmacy Benefit Manager pays for the initial printing and processing of personalized member benefit communication materials that include two teslin material ID cards. Pharmacy Benefit Manager is also responsible for the postage required to mail materials during the initial implementation (bulk shipment to a single location or directly to individual Members). **Post-Implementation** Typically, production fees and postage apply to all materials	No additional charge. Standard fees are [redacted] (including postage) for one benefit communication material with two ID cards. ID

Optional Services	Cost
issued to members after the plan's effective date.	card-only requests (two ID cards) will be charged back to the State at [redacted] each (including postage). Pharmacy Benefit Manager will assess some fees if revisions to the benefit communication materials occur as a result of plan design changes or standard updates. Pharmacy Benefit Manager will discuss any charges with the State in advance.
Post-Implementation Shipping Options Outside of implementation materials, Pharmacy Benefit Manager can ship your ongoing member communication materials in bulk to a single location for member distribution or mail directly to members. Any customized communication materials not included with the Benefit communication materials (e.g., pre-enrollment or marketing materials) are at the State's expense. Upon request, combined medical/prescription ID cards are at an additional cost. Pharmacy Benefit Manager will discuss any additional charges with the State prior to production.	When mailing directly to Members, Pharmacy Benefit Manager uses USPS First Class mail. Member mailings will be charged back to the State, typically at [redacted] for each black-and-white letter and [redacted] for each color letter, including postage. Mailings that require inserts may be charged at a higher rate
File Extracts Subject to execution of appropriate confidentiality agreements, Pharmacy Benefit Manager will provide our standard electronic claims data file, the Claims Experience Tape, at up to six locations at no charge, as set forth in Exhibit A. Standard files for additional locations are available at an additional charge per month per location. For file extracts required to support client audits, the State or its third-party designee reasonably acceptable to Pharmacy Benefit Manager may conduct an annual claims audit for the prior Contract Year to ensure accuracy by Pharmacy Benefit Manager in claims processing, financial compliance, performance guarantees, business operations, and other contractual obligations. The costs for specific files are as follows:	Should the State require a customized electronic claims data file, a charge of [redacted] per hour of development required will be assessed. The claim files needed to support the audit will be billed to the State at the rate of [redacted] month for the requested audit period. Older period files are billed at a rate of [redacted] per year. Claims file: [redacted] each Open refill file: [redacted] each Preauthorization: [redacted] each
Actuarial Services	Pharmacy Benefit Manager will provide actuarial services for an additional cost, based on the scope of analysis required.

Charges for services not identified in this Exhibit B shall be quoted upon request.

Exhibit C-1

PERFORMANCE GUARANTEES – FINANCIAL

1. MAIL, RETAIL, REBATES AND SPECIALTY.

PASS-THROUGH PROPOSAL (BROAD NETWORK)

Discounts	2021	2022 (option)
Guaranteed Minimum Discounts (Retail 30)†		
Brand	AWP – [redacted]	AWP – [redacted]
Overall Generic Discount* (Retail 30 and Retail 90 combined)	AWP – [redacted]	AWP – [redacted]
Guaranteed Minimum Discounts (Retail 90)		
Brand	AWP – [redacted]	AWP – [redacted]
Overall Generic Discount* (Retail 30 and Retail 90 combined)	AWP – [redacted]	AWP – [redacted]
Guaranteed Minimum Discounts (Mail) & (CVS90 at Retail)		
Brand	AWP – [redacted]	AWP – [redacted]
Overall Generic Discount*	AWP – [redacted]	AWP – [redacted]
Guaranteed Minimum Discounts (Specialty)		
"Exclusive" Overall Discount Guarantee (AWP - %)	AWP – [redacted]	AWP – [redacted]

* Per the State's response to bidder question #57, Pharmacy Benefit Manager is providing an aggregate MAC and Non-MAC overall generic discount.

** Please refer to the Specialty Fee Schedule (Attachment 1 to Exhibit C-1) for additional pricing terms and conditions.

† Specialty at retail will be priced at AWP – [redacted] or MAC, if applicable, plus [redacted] per Claim.

Dispensing Fees*	All	Dispensing
Guaranteed Maximum Dispensing Fee (Retail 30)*		
Brand	[redacted]	**Brand**
Generic	[redacted]	**Generic**
Guaranteed Maximum Dispensing Fee (Retail 90)		
Brand	[redacted]	**Brand**
Generic	[redacted]	**Generic**
Guaranteed Maximum Dispensing Fee (Mail) & (CVS90 at Retail)		
Brand	[redacted]	**Brand**
Generic	[redacted]	**Generic**
Guaranteed Maximum Dispensing Fee (Specialty)		
Brand	[redacted]	**Brand**
Generic	[redacted]	**Generic**

* Per Claim, measured in the aggregate.

Rebates[1]	2021	2022 (option)
Paid Basis	Per brand claim	
Guaranteed Minimum Rebate (Retail 30)		
	2-Tier Qualifying: [redacted]	2-Tier Qualifying: [redacted]
	3-Tier Non-qualifying: [redacted]	3-Tier Non-qualifying: [redacted]
	3-Tier Qualifying: [redacted]	3-Tier Qualifying: [redacted]
Guaranteed Minimum Rebate (Retail 90)		
	2-Tier Qualifying: [redacted]	2-Tier Qualifying: [redacted]
	3-Tier Non-qualifying: [redacted]	3-Tier Non-qualifying: [redacted]
	3-Tier Qualifying: [redacted]	3-Tier Qualifying: [redacted]

Rebates[1]	2021	2022 (option)
Guaranteed Minimum Rebate (Mail) & (CVS90 at Retail)		
Rebate Guarantee	2-Tier Qualifying: [redacted] 3-Tier Non-qualifying: [redacted] 3-Tier Qualifying: [redacted]	2-Tier Qualifying: [redacted] 3-Tier Non-qualifying: [redacted] 3-Tier Qualifying: [redacted]
Guaranteed Minimum Rebate (Specialty)		
Rebate Guarantee	[redacted]	[redacted]

[1] See Section 2 of this Exhibit C-1 for Rebate Conditions. **As of January 1, 2021, all State plan designs qualify for 3-Tier Qualifying Rebate guarantees.**

a. **Retail and Mail Conditions.** The pricing for retail and mail set forth above is contingent upon the following conditions:

(i) Pharmacy Benefit Manager will exclude the following from mail and retail discount and dispensing fee guarantees:
- Specialty/biotech drug Claims
- 340B Claims;
- Compound drug Claims;
- Paper or Member submitted Claims;
- Coordination of Benefits (COB) or secondary payor Claims;
- Vaccine and vaccine administration Claims;
- Usual and Customary Claims

(ii) Retail network and mail guarantees for Brand Drugs and Generic Drugs are measured and reconciled by component. Any dollar savings generated in excess of one retail component may not be used to offset a short fall for any other retail component. CVS90 at Retail Network Claims filled at CVS/pharmacy locations are reconciled with the Mail component. The reconciliation calculations shall be as follows:

Aggregate Discount Reconciliation Categories:
- Retail 30 Brands
- Retail 90 Brands
- Retail Generics
- Mail/CVS90 at Retail Network Brands

- Mail/CVS90 at Retail Network Generics
- Specialty Overall Discount

For each of these categories, Pharmacy Benefit Manager shall calculate the performance measure using the following formula:

1 - ([The sum of adjudicated ingredient cost for the year]/[The sum of AWP for the year])

If the performance measure fails to meet or exceed the guaranteed minimum AWP discount, Pharmacy Benefit Manager shall pay the State a performance shortfall payment to be calculated using the following formula:

([Actual minimum discount guarantee] – [performance measure])*[The sum of AWP for the year]

With respect to the Retail Generics reconciliation, Pharmacy Benefit Manager shall calculate a performance measure and, if applicable, a performance shortfall payment amount independently for each of Retail 30 Generics and Retail 90 Generics, and the results of these calculations shall be added together/netted against each other to determine the final performance shortfall payment amount, if any.

The Retail 30 maximum dispensing fee guarantee shall be calculated as follows:

Pharmacy Benefit Manager shall calculate the performance measure will be calculated using the following formula:

[The sum of adjudicated dispensing fees for the year]/[The total number of final paid Claims adjudicated during the year]

If the performance measure fails to meet or exceed the guaranteed maximum dispensing fee guarantee, Pharmacy Benefit Manager shall pay the State a performance shortfall payment to be calculated using the following formula:

([Performance measure] – [Average dispensing fee guarantee])*[The total number of final paid Claims adjudicated during the year]

(iii) Zero balance due Claims (Claims where the Plan member paid the full cost of the Claim and the State paid zero) shall be included in the reconciliation at the actual adjudicated cost of the Claim and shall not be counted as AWP–100% as a consequence of the State not being billed for such Claims.

(iv) Generic discount guarantees, as described in the pricing charts above, for each of the Retail 30 and Retail 90 networks are measured and reconciled together.

(v) The amount billed to the State will be equal to the amount paid to the Participating Pharmacies. The State acknowledges that Participating Pharmacy rates and fees are variable and in a transparent arrangement Claims will process at the Participating Pharmacy paid rate.

(vi) The State shall pay the lower of the Participating Pharmacy's U&C price or the discounted price plus the dispensing fee.

(vii) Pharmacy Benefit Manager's generic pricing program is monitored based on the State's utilization, and pricing is adjusted to meet Pharmacy Benefit Manager's State commitments. MAC pricing is established by Pharmacy Benefit Manager for a multi-source drug (i.e., a drug with more than two sources) included on the MAC drug list applicable to State, which list may be amended from time to time by Pharmacy Benefit Manager in maintaining its generic pricing program. A copy of the MAC drug list shall be provided to State prior to execution of this Agreement and thereafter upon State's request.

(viii) The Participating Pharmacy may collect from the Member the lowest of the discounted price, the applicable Cost Share, or the Participating Pharmacy's Usual and Customary price.

(ix) Pharmacy Benefit Manager specialty pharmacies will be the exclusive provider of specialty pharmacy services. Claims for Specialty Drugs will not be processed through the retail network, except for those Specialty Drugs that Pharmacy Benefit Manager's specialty pharmacies are unable to dispense. All initial and refill Specialty Drug prescriptions are limited to dispensing from Pharmacy Benefit Manager specialty pharmacies and retail CVS/pharmacy locations.

(x) Specialty pricing includes 340B Claims. Rates for 340B Claims may vary, and the amount paid by CVS/caremark to covered entities for 340B Claims may not equal the amount billed to Client, and CVS/caremark shall retain any difference.

(xi) For compound drugs, Pharmacy Benefit Manager 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. Pharmacy Benefit Manager 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.

(xii) Pharmacy Benefit Manager 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 determining the classification of drugs (e.g., prescription vs. over the counter, brand vs. generic, single-source vs. multi-source) for purposes of this Agreement. "Brand Drug" will be defined as a FDA approved drug that is manufactured and distributed by an innovator drug company, or its licensee, or, as applicable, a DESI drug, and coded in Medi-Span with "M", "O", "N" (except where claims submitted with the value of "O" and with a DAW Code of "5"– which will be coded as a Generic Drug). In limited circumstances, Pharmacy Benefit Manager may override the Medispan indicator after review of additional information supplied by Medi-Span to classify a drug as Generic. When this occurs, the change is applied as a standard across Pharmacy Benefit Manager's book of business.

b. Shipping fees and/or postage will not be increased if Pharmacy Benefit Manager's third party carrier increases its charges to Pharmacy Benefit Manager for shipping fees and/or postage costs**.**

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

GDR GUARANTEES	
MAIL	January 1, 2021 – December 31, 2021: [redacted]
RETAIL	January 1, 2021 – December 31, 2021: 8[redacted]

The State acknowledges and agrees the Generic Dispensing Rate ("GDR") guarantees are dollar for dollar with a maximum amount at risk of [redacted] for mail for retail, combined, reconciled by component. The GDR guarantee calculation assumes the following: (i) the data received is a full data set and accurately reflects the State's utilization, (ii) AWP source for the data supplied is consistent with the go-forward measurement database (i.e., Medi-Span), or will be adjusted for any differences in the previous AWP source used by the State, (iii) Plan design and membership will remain constant. The State further acknowledges and agrees certain changes to the Plan design or demographics may materially affect Pharmacy Benefit Manager's ability to meet the GDR guarantees (for example, situations where generically available medications are excluded from the benefit such as OTC equivalent strengths). In the event of any changes 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. If a Brand Drug does not lose patent protection when expected, or a Generic Drug does not launch when anticipated, 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. In the event the GDR guarantee is not met, the amount due to the State for the guarantee shall be calculated based on the following formula: (Average Amount Paid per Multi-Source Brand Drug - Average Amount Paid per Generic Drug) multiplied by (GDR guarantee - GDR measured) multiplied by total Claims. Specialty Drugs, compound drug Claims, paper Claims, COB Claims and vaccines are not included in the GDR guarantee calculation**.**

d. Retail Network.

The Pharmacy Benefit Manager's Retail 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. Pharmacy Benefit Manager Retail 90 Network pricing is applicable for non-specialty Claims equal to or greater than the State's qualified retail plan design limits, and filled by a participating Pharmacy Benefit Manager Retail 90 Network pharmacy. Claims up to the State's qualified retail days' supply plan design limits can be filled at any Participating Pharmacy. Claims greater than the State's retail plan design limits shall only be filled by a Pharmacy Benefit Manager Retail 90 Network pharmacy or CVS90 at Retail Network pharmacy.

2. STATE CREDITS

This Section 2 of Exhibit A sets forth various rebates and credits to be paid or credited by Pharmacy Benefit Manager to the State (collectively "State Credits") as identified in Section 1 of this Exhibit C-1. It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, these State 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, the State acknowledges and agrees that, as a condition to its right to receive State Credits from Pharmacy Benefit Manager, all State Credits received shall be used exclusively for providing benefits to Members of the Plan and defraying the reasonable expense of administering the Plan.

a. Drug Rebates.

STATE ALLOCATION	PHARMACY BENEFIT MANAGER RETENTION
100%	**0%**

Within thirty (30) days of the beginning of each calendar month, Pharmacy Benefit Manager will remit to State the minimum Guaranteed Rebate Amount collected during the prior calendar month.

No minimum guaranteed Rebate shall be credited for any Generic Drug, whether such Claim is filled with a Generic Drugs or by a Brand Drug dispensed in lieu of a Generic Drug at the Generic Drug reimbursement rate, however, if any Rebate is actually earned and collected, such Rebate shall be passed through to the State.

Two-tier qualifying plan design consists of an open plan design, with the first tier made up of generic drugs and the second tier made up of brand drugs, with no minimum cost-share differential but including formulary interventions recommended by Pharmacy Benefit Manager.

Three-tier nonqualifying plan design consists of a plan design with the first tier made up of generic drugs, the second tier made up of preferred brand drugs, and the third tier made up of nonpreferred brand drugs, with a copayment or coinsurance differential between preferred and nonpreferred brand drugs.

Three-tier qualifying plan design consists of a plan design with the first tier made up of generic drugs, the second tier made up of preferred brand drugs, and the third tier made up of nonpreferred brand drugs, with at least a $15 copayment differential between preferred and nonpreferred brand prescriptions, at least a $15 differential in the minimum copayment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and nonpreferred brand. For example, if preferred brand coinsurance was 20%, nonpreferred brand would need to be 30% to qualify. **As of January 1, 2021, all State plan designs qualify for three-tier qualifying Rebate minimum guarantees.**

Pharmacy Benefit Manager guarantees that the State's share of Rebates shall be as identified in this Section 1 of this Exhibit C-1 (the "Guaranteed Rebate Amount"). All Claims may be aggregated for purposes of this guarantee. In the event that Rebates paid to the State are less than the Guaranteed Rebate Amount, Pharmacy Benefit Manager shall pay to the State the amount of any deficiency. Final reconciliation between Rebates paid and Rebates guaranteed pursuant to this Section shall be performed within one hundred twenty (120) days after the close of the Contract Year. Pharmacy Benefit Manager will remit to State any difference owed within thirty (30) days of reconciliation. For subsequent years, any Rebate guarantee shall be determined by annual negotiation by the parties of a mutually acceptable Guaranteed Rebate Amount based on projected market estimates.

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

(i) The State authorizes Pharmacy Benefit Manager to contract with pharmaceutical companies for Rebates as a group purchasing organization for the Plan. Pharmacy Benefit Manager or its affiliates may receive fees from pharmaceutical companies' administrative fees [redacted] of the Wholesale Acquisition Cost ("WAC") of the brand products dispensed across Pharmacy Benefit Manager's book of business. These administrative fees shall be passed thought to State in their entirety as a component of the Rebates paid.

(ii) Rebate guarantees will be effective January 1, 2021 and will remain in effect until December 31, 2021. Rebate guarantees are contingent upon the Pharmacy Benefit Manager'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, not being materially adversely impacted by legislative, regulatory, or judicial action. The State acknowledges that whether and to what extent pharmaceutical companies are willing to provide Rebates to the State may depend upon a variety of factors, including the State meeting criteria for Rebates and the extent of participation in Pharmacy Benefit Manager's formulary management programs as set forth herein, as well as Pharmacy Benefit Manager receiving sufficient information regarding each Claim for submission to pharmaceutical companies for Rebates.

(iii) Rebates guarantees assume alignment with Pharmacy Benefit Manager Formulary with formulary exclusions, alignment with Pharmacy Benefit Manager Advanced Control Specialty Formulary and are conditioned on: (i) the State's adoption of our specialty utilization management edits, including prior authorization and quantity edits; and (ii) the State implements and maintains a generics first plan design for specialty, allowing up to 90 days supply at mail, and plan performance materially the same as the baseline data provided by, or relied upon by Pharmacy Benefit Manager, including information regarding Member enrollment and utilization of pharmacy services. Rebate guarantees assume utilization mix and volume remain consistent with the data provided in the procurement through which this Agreement was derived, through the Term of the Agreement. Rebate guarantees are based upon fully-funded Plan designs. Rebate guarantees are paid quarterly for each component and reconciled annually in the aggregate. Rebate minimum guarantees exclude:

- 340B Claims,
- Lipid disorders-PCSK9 Claims, and
- New-to-market biosimilar Claims,

however, any Rebates actually collected for such Claims shall be passed through 100% to the State. Specialty Rebates apply to Specialty Brand Drug Claims, regardless of distribution channel, and are based upon utilization management programs for the Hepatitis C class that align with the product label.

b. Additional Credits.

Audit	2021
Total Dollar ($) Amount	[redacted]
Basis: Per Member or Per Employee	Per Member per year

General Administrative Credit	2021
Total Dollar ($) Amount	[redacted]
Basis: Per Member or Per Employee	Per Member per year

(i) General Audit Credit. Pharmacy Benefit Manager shall provide the State with an audit credit of up to [redacted] per Member annually. This Credit provided to the State can be applied to offset costs incurred by the State in the administration of an audit pursuant to the terms of the Agreement. This audit credit will be credited to the State's monthly invoices. Identification of the expenses attributable to this audit credit shall be mutually agreed upon. The State shall provide Pharmacy Benefit Manager with documentation of expenses actually incurred in the form of an invoice, account statement, or other detailed documentation. Expenses applied to this credit will not exceed fair market value of such expenses. If the State terminates this agreement prior to expiration of its initial term for any reason other than breach by Pharmacy Benefit Manager, or if Pharmacy Benefit Manager terminates the agreement as a result of the State's breach, the State shall repay Pharmacy Benefit Manager all audit credits provided to the State by Pharmacy Benefit Manager. Any unused Credit remaining at the end of the first year of the Term of the Agreement may be rolled into the second year of the Term of the Agreement. Any unused Credit remaining at the end of the second year of the Term of the Agreement shall be forfeited.

(ii) General Administrative Credit. Pharmacy Benefit Manager agrees to provide the State an additional annual credit in the amount up to [redacted] per Member which will be available during the term of the Agreement. The number of Members shall be based on the information provided by the State during this process. This credit may be used to offset certain expenses incurred by the State in the administration of the State's prescription benefit plan or the services provided by Pharmacy Benefit Manager during the Term. The credit, for example, may be applied to offset legitimate implementation expenses, communication expenses, member ID cards, postage, special programming charges, or clinical programs offered by Pharmacy Benefit Manager. The State will be requested to provide reasonable documentation of expenses incurred to be applied to this credit. Alternatively, the State may elect to have this credit applied to its monthly invoices on a prorated basis. If the State terminates this agreement prior to expiration of its initial term for any reason other than breach by Pharmacy Benefit Manager, or if Pharmacy Benefit Manager terminates the agreement as a result of the State's breach, the State shall repay Pharmacy Benefit Manager all general credits provided to the State by Pharmacy Benefit Manager.

Attachment 1 to Exhibit C-1
SPECIALTY FEE SCHEDULE

		Exclusive		
Drug Therapy	**Drug Name**	**Year 1 AWP Discount**	**Year 2 AWP Discount**	**Notes**
Acromegaly	OCTREOTIDE	[redacted]		
Acromegaly	SANDOSTATIN			
Acromegaly	SOMATULINE			
Acromegaly	SOMAVERT			
Alcohol Dependency	VIVITROL			
Allergen Immunotherapy	ORALAIR			
Allergic Asthma	CINQAIR			
Allergic Asthma	NUCALA			
Allergic Asthma	XOLAIR			
Alpha-1 Antitrypsin Deficiency	ARALAST NP			
Alpha-1 Antitrypsin Deficiency	GLASSIA			
Alpha-1 Antitrypsin Deficiency	ZEMAIRA			
Anemia	ARANESP			
Anemia	EPOGEN			
Anemia	PROCRIT			
Botulinum Toxins	BOTOX			
Botulinum Toxins	DYSPORT			
Botulinum Toxins	MYOBLOC			
Botulinum Toxins	XEOMIN			
Cardiac Disorders	DOFETILIDE			
Cardiac Disorders	TIKOSYN			
Coagulation Disorders	CEPROTIN			
Contraceptives	IMPLANON			
Contraceptives	MIRENA			
Contraceptives	NEXPLANON			
Contraceptives	SKYLA			
Cryopyrin Associated Periodic Syndromes	ARCALYST			
Cryopyrin Associated Periodic Syndromes	ILARIS			
Cystic Fibrosis	BETHKIS			
Cystic Fibrosis	KALYDECO			
Cystic Fibrosis	KITABIS PAK			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
Cystic Fibrosis	ORKAMBI			
Cystic Fibrosis	PULMOZYME			
Cystic Fibrosis	TOBI			
Cystic Fibrosis	TOBI PODHALER			
Cystic Fibrosis	TOBRAMYCIN			
Dupuytren's Contracture	XIAFLEX			
Electrolyte Disorders	SAMSCA			
Gastrointestinal	GATTEX			
Gastrointestinal	SOLESTA			
Gout	KRYSTEXXA			
Growth Hormone	GENOTROPIN			
Growth Hormone	HUMATROPE			
Growth Hormone	INCRELEX			
Growth Hormone	NORDITROPIN			
Growth Hormone	NUTROPIN			
Growth Hormone	OMNITROPE			
Growth Hormone	SAIZEN			
Growth Hormone	SEROSTIM			
Growth Hormone	TEV-TROPIN			
Growth Hormone	ZOMACTON			
Growth Hormone	ZORBTIVE			
Hematopoietics	MOZOBIL			
Hematopoietics	NEUMEGA			
Hemophilia	ADVATE			
Hemophilia	ADYNOVATE			
Hemophilia	ALPHANATE			
Hemophilia	ALPHANINE SD			
Hemophilia	ALPROLIX			
Hemophilia	BEBULIN			
Hemophilia	BENEFIX			
Hemophilia	CORIFACT			
Hemophilia	ELOCTATE			
Hemophilia	FEIBA			
Hemophilia	HELIXATE			
Hemophilia	HEMOFIL M			
Hemophilia	HUMATE-P			
Hemophilia	IDELVION			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
Hemophilia	IXINITY			
Hemophilia	KOATE			
Hemophilia	KOGENATE			
Hemophilia	KOVALTRY			
Hemophilia	MONOCLATE			
Hemophilia	MONONINE			
Hemophilia	NOVOEIGHT			
Hemophilia	NOVOSEVEN RT			
Hemophilia	NUWIQ			
Hemophilia	OBIZUR			
Hemophilia	PROFILNINE SD			
Hemophilia	RECOMBINATE			
Hemophilia	REFACTO			
Hemophilia	RIASTAP			
Hemophilia	RIXUBIS			
Hemophilia	STIMATE			
Hemophilia	TRETTEN			
Hemophilia	WILATE			
Hemophilia	XYNTHA			
Hepatitis B	ADEFOVIR DIPIVOXIL			
Hepatitis B	BARACLUDE			
Hepatitis B	ENTECAVIR			
Hepatitis B	EPIVIR HBV			
Hepatitis B	HEPSERA			
Hepatitis B	LAMIVUDINE_HEPB			
Hepatitis B	TYZEKA			
Hepatitis C	COPEGUS			
Hepatitis C	DAKLINZA			
Hepatitis C	HARVONI			
Hepatitis C	INCIVEK			
Hepatitis C	INFERGEN			
Hepatitis C	OLYSIO			
Hepatitis C	PEGASYS			
Hepatitis C	PEG-INTRON			
Hepatitis C	REBETOL			
Hepatitis C	RIBAPAK			
Hepatitis C	RIBASPHERE			
Hepatitis C	RIBAVIRIN			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
Hepatitis C	SOVALDI			
Hepatitis C	TECHNIVIE			
Hepatitis C	VICTRELIS			
Hepatitis C	VIEKIRA PAK			
Hepatitis C	ZEPATIER			
Hereditary Angioedema	BERINERT			
Hereditary Angioedema	CINRYZE			
Hereditary Angioedema	FIRAZYR			
Hereditary Angioedema	KALBITOR			
Hereditary Angioedema	RUCONEST			
HIV	ABACAVIR			
HIV	ABACAVIR SULFATE-LAMIVUDINE			
HIV	APTIVUS			
HIV	ATRIPLA			
HIV	COMBIVIR			
HIV	COMPLERA			
HIV	CRIXIVAN			
HIV	DESCOVY			
HIV	DIDANOSINE			
HIV	EDURANT			
HIV	EGRIFTA			
HIV	EMTRIVA			
HIV	EPIVIR			
HIV	EPZICOM			
HIV	EVOTAZ			
HIV	FUZEON			
HIV	GENVOYA			
HIV	INTELENCE			
HIV	INVIRASE			
HIV	ISENTRESS			
HIV	KALETRA			
HIV	LAMIVUDINE/ZIDOVUDINE			
HIV	LAMIVUDINE_HIV			
HIV	LEXIVA			
HIV	NEVIRAPINE			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
HIV	NORVIR			
HIV	ODEFSEY			
HIV	PREZCOBIX			
HIV	PREZISTA			
HIV	RESCRIPTOR			
HIV	RETROVIR			
HIV	REYATAZ			
HIV	SELZENTRY			
HIV	STAVUDINE			
HIV	STRIBILD			
HIV	SUSTIVA			
HIV	TIVICAY			
HIV	TRIUMEQ			
HIV	TRIZIVIR			
HIV	TRUVADA			
HIV	TYBOST			
HIV	VIDEX			
HIV	VIRACEPT			
HIV	VIRAMUNE			
HIV	VIRAMUNE XR			
HIV	VIREAD			
HIV	VITEKTA			
HIV	ZERIT			
HIV	ZIAGEN			
HIV	ZIDOVUDINE			
Hormonal Therapies	AVEED			
Hormonal Therapies	ELIGARD			
Hormonal Therapies	FIRMAGON			
Hormonal Therapies	LEUPROLIDE ACETATE			
Hormonal Therapies	LUPANETA PACK			
Hormonal Therapies	LUPRON DEPOT			
Hormonal Therapies	NATPARA			
Hormonal Therapies	SUPPRELIN			
Hormonal Therapies	TRELSTAR			
Hormonal Therapies	VANTAS			
Hormonal Therapies	ZOLADEX			
I.V.I.G.	BIVIGAM			
I.V.I.G.	CARIMUNE			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
I.V.I.G.	CYTOGAM			
I.V.I.G.	FLEBOGAMMA			
I.V.I.G.	GAMASTAN S/D			
I.V.I.G.	GAMMAGARD			
I.V.I.G.	GAMMAGARD LIQUID			
I.V.I.G.	GAMMAKED			
I.V.I.G.	GAMMAPLEX			
I.V.I.G.	GAMUNEX			
I.V.I.G.	HEPAGAM B			
I.V.I.G.	HIZENTRA			
I.V.I.G.	HYPERHEP B			
I.V.I.G.	HYPERRHO S/D			
I.V.I.G.	HYQVIA			
I.V.I.G.	MICRHOGAM			
I.V.I.G.	NABI-HB			
I.V.I.G.	OCTAGAM			
I.V.I.G.	PRIVIGEN			
I.V.I.G.	RHOGAM			
I.V.I.G.	RHOPHYLAC			
I.V.I.G.	VARIZIG			
I.V.I.G.	WINRHO			
Idiopathic Thrombocytopenic Purpura	NPLATE			
Idiopathic Thrombocytopenic Purpura	PROMACTA			
Infectious Disease	ACTIMMUNE			
Infectious Disease	ALFERON N			
Infertility	BRAVELLE			
Infertility	CETROTIDE			
Infertility	CHORIONIC GONADOTROPIN			
Infertility	FOLLISTIM AQ			
Infertility	GANIRELIX ACETATE			
Infertility	GONAL-F			
Infertility	MENOPUR			
Infertility	NOVAREL			
Infertility	OVIDREL			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
Infertility	PREGNYL			
Infertility	REPRONEX			
Inflammatory Bowel Disease	CIMZIA			
Inflammatory Bowel Disease	ENTYVIO			
Iron Overload	DEFEROXAMINE			
Iron Overload	DESFERAL			
Iron Overload	EXJADE			
Iron Overload	JADENU			
Lipid Disorder	KYNAMRO			
Lipid Disorders - PCSK9 Inhibitors	PRALUENT			
Lipid Disorders - PCSK9 Inhibitors	REPATHA			
Lysosomal Storage Diseases	ALDURAZYME			
Lysosomal Storage Diseases	CERDELGA			
Lysosomal Storage Diseases	CEREDASE			
Lysosomal Storage Diseases	CEREZYME			
Lysosomal Storage Diseases	CYSTAGON			
Lysosomal Storage Diseases	ELAPRASE			
Lysosomal Storage Diseases	FABRAZYME			
Lysosomal Storage Diseases	LUMIZYME			
Lysosomal Storage Diseases	MYOZYME			
Lysosomal Storage Diseases	NAGLAZYME			
Lysosomal Storage Diseases	VIMIZIM			
Lysosomal Storage Diseases	VPRIV			
Migraine	ZECUITY			
Movement Disorders	APOKYN			
Movement Disorders	NORTHERA			
Movement Disorders	NUPLAZID			
Movement Disorders	TETRABENAZINE			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
Movement Disorders	XENAZINE	[redacted]		
Multiple Sclerosis	AMPYRA			
Multiple Sclerosis	AUBAGIO			
Multiple Sclerosis	AVONEX			
Multiple Sclerosis	BETASERON			
Multiple Sclerosis	COPAXONE 20			
Multiple Sclerosis	COPAXONE 40			
Multiple Sclerosis	EXTAVIA			
Multiple Sclerosis	GILENYA			
Multiple Sclerosis	GLATOPA			
Multiple Sclerosis	LEMTRADA			
Multiple Sclerosis	MITOXANTRONE			
Multiple Sclerosis	PLEGRIDY			
Multiple Sclerosis	REBIF			
Multiple Sclerosis	TECFIDERA			
Multiple Sclerosis	TYSABRI			
Neutropenia	GRANIX			
Neutropenia	LEUKINE			
Neutropenia	NEULASTA			
Neutropenia	NEUPOGEN			
Neutropenia	ZARXIO			
Oncology - Injectable	ADCETRIS			
Oncology - Injectable	ARZERRA			
Oncology - Injectable	AVASTIN			
Oncology - Injectable	AZACITIDINE			
Oncology - Injectable	BELEODAQ			
Oncology - Injectable	BENDEKA			
Oncology - Injectable	DACOGEN			
Oncology - Injectable	DARZALEX			
Oncology - Injectable	DECITABINE			
Oncology - Injectable	ELSPAR			
Oncology - Injectable	EMPLICITI			
Oncology - Injectable	ERBITUX			
Oncology - Injectable	FOLOTYN			
Oncology - Injectable	FUSILEV			
Oncology - Injectable	GAZYVA			
Oncology - Injectable	HALAVEN			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
Oncology - Injectable	HERCEPTIN	[redacted]		
Oncology - Injectable	INTRON A			
Oncology - Injectable	ISTODAX			
Oncology - Injectable	IXEMPRA			
Oncology - Injectable	JEVTANA			
Oncology - Injectable	KADCYLA			
Oncology - Injectable	KEYTRUDA			
Oncology - Injectable	KYPROLIS			
Oncology - Injectable	LEVOLEUCOVORIN CALCIUM			
Oncology - Injectable	ONCASPAR			
Oncology - Injectable	OPDIVO			
Oncology - Injectable	PERJETA			
Oncology - Injectable	PROLEUKIN			
Oncology - Injectable	RITUXAN			
Oncology - Injectable	SYLATRON			
Oncology - Injectable	TECENTRIQ			
Oncology - Injectable	TEMODAR (INJECTABLE)			
Oncology - Injectable	THYROGEN			
Oncology - Injectable	TORISEL			
Oncology - Injectable	TREANDA			
Oncology - Injectable	VALSTAR			
Oncology - Injectable	VECTIBIX			
Oncology - Injectable	VELCADE			
Oncology - Injectable	VIDAZA			
Oncology - Injectable	XGEVA			
Oncology - Injectable	YERVOY			
Oncology - Injectable	ZALTRAP			
Oncology - Injectable	ZOLEDRONIC ACID_ONC			
Oncology - Injectable	ZOMETA			
Oncology - Oral	AFINITOR			
Oncology - Oral	ALECENSA			
Oncology - Oral	BEXAROTENE CAP			
Oncology - Oral	BOSULIF			
Oncology - Oral	CABOMETYX			
Oncology - Oral	CAPECITABINE			
Oncology - Oral	COTELLIC			
Oncology - Oral	ERIVEDGE			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
Oncology - Oral	FARYDAK	[redacted]		
Oncology - Oral	GLEEVEC			
Oncology - Oral	HYCAMTIN			
Oncology - Oral	IBRANCE			
Oncology - Oral	IMATINIB MESYLATE			
Oncology - Oral	INLYTA			
Oncology - Oral	JAKAFI			
Oncology - Oral	LONSURF			
Oncology - Oral	MEKINIST			
Oncology - Oral	MUGARD			
Oncology - Oral	NEXAVAR			
Oncology - Oral	NINLARO			
Oncology - Oral	ODOMZO			
Oncology - Oral	POMALYST			
Oncology - Oral	PURIXAN			
Oncology - Oral	REVLIMID			
Oncology - Oral	SPRYCEL			
Oncology - Oral	STIVARGA			
Oncology - Oral	SUTENT			
Oncology - Oral	TAFINLAR			
Oncology - Oral	TARCEVA			
Oncology - Oral	TARGRETIN			
Oncology - Oral	TASIGNA			
Oncology - Oral	TEMODAR (ORAL)			
Oncology - Oral	TEMOZOLOMIDE			
Oncology - Oral	THALOMID			
Oncology - Oral	TYKERB			
Oncology - Oral	VOTRIENT			
Oncology - Oral	XALKORI			
Oncology - Oral	XELODA			
Oncology - Oral	XTANDI			
Oncology - Oral	YONDELIS			
Oncology - Oral	ZELBORAF			
Oncology - Oral	ZOLINZA			
Oncology - Oral	ZYKADIA			
Oncology - Oral	ZYTIGA			
Osteoarthritis	EUFLEXXA			
Osteoarthritis	GEL-ONE			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
Osteoarthritis	GENVISC 850			
Osteoarthritis	HYALGAN			
Osteoarthritis	HYMOVIS			
Osteoarthritis	MONOVISC			
Osteoarthritis	ORTHOVISC			
Osteoarthritis	SUPARTZ			
Osteoarthritis	SYNVISC			
Osteoporosis	FORTEO			
Osteoporosis	PROLIA			
Osteoporosis	RECLAST			
Osteoporosis	ZOLEDRONIC ACID_OST			
Paroxysmal Nocturnal Hemoglobinuria	SOLIRIS			
Phenylketonuria	KUVAN			
Pre-Term Birth	MAKENA			
Psoriasis	AMEVIVE			
Psoriasis	COSENTYX			
Psoriasis	OTEZLA			
Psoriasis	STELARA			
Psoriasis	TALTZ			
Pulmonary Arterial Hypertension	ADCIRCA			
Pulmonary Arterial Hypertension	ADEMPAS			
Pulmonary Arterial Hypertension	EPOPROSTENOL			
Pulmonary Arterial Hypertension	LETAIRIS			
Pulmonary Arterial Hypertension	OPSUMIT			
Pulmonary Arterial Hypertension	ORENITRAM			
Pulmonary Arterial Hypertension	REMODULIN			
Pulmonary Arterial Hypertension	REVATIO			
Pulmonary Arterial Hypertension	SILDENAFIL CITRATE			
Pulmonary Arterial Hypertension	TRACLEER			
Pulmonary Arterial Hypertension	TYVASO			
Pulmonary Arterial Hypertension	UPTRAVI			

		Exclusive		
Drug Therapy	Drug Name	Year 1 AWP Discount	Year 2 AWP Discount	Notes
Pulmonary Arterial Hypertension	VELETRI			
Pulmonary Arterial Hypertension	VENTAVIS			
Pulmonary Disorders	ESBRIET			
Pulmonary Disorders	OFEV			
Renal Disease	SENSIPAR			
Retinal Disorders	EYLEA			
Retinal Disorders	ILUVIEN			
Retinal Disorders	LUCENTIS			
Retinal Disorders	MACUGEN			
Retinal Disorders	OZURDEX			
Retinal Disorders	RETISERT			
Retinal Disorders	VISUDYNE			
Rheumatoid Arthritis	ACTEMRA			
Rheumatoid Arthritis	ENBREL			
Rheumatoid Arthritis	HUMIRA			
Rheumatoid Arthritis	ORENCIA			
Rheumatoid Arthritis	OTREXUP			
Rheumatoid Arthritis	RASUVO			
Rheumatoid Arthritis	REMICADE			
Rheumatoid Arthritis	SIMPONI			
Rheumatoid Arthritis	XELJANZ			
RSV	SYNAGIS			
Seizure Disorders	HP ACTHAR GEL			
Seizure Disorders	SABRIL			
Systemic Lupus Erythematosus	BENLYSTA			
Transplant	ASTAGRAF XL			
Transplant	CELLCEPT			
Transplant	CYCLOSPORINE			
Transplant	ENVARSUS XR			
Transplant	GENGRAF			
Transplant	MYCOPHENOLATE MOFETIL			
Transplant	MYCOPHENOLIC ACID			
Transplant	MYFORTIC			
Transplant	NEORAL			
Transplant	NULOJIX			

		Exclusive		
Drug Therapy	**Drug Name**	**Year 1 AWP Discount**	**Year 2 AWP Discount**	**Notes**
Transplant	PROGRAF	[redacted]		
Transplant	RAPAMUNE			
Transplant	SANDIMMUNE			
Transplant	SIROLIMUS			
Transplant	TACROLIMUS			
Transplant	ZORTRESS			
Urea Cycle Disorders	BUPHENYL			
Urea Cycle Disorders	RAVICTI			
Urea Cycle Disorders	SODIUM PHENYLBUTYRATE			
	Default Rate:			
	Overall Effective Discount (OED):			
	Dispensing Fee:			

NOTES:

The Overall Effective Discount ("OED") offer is conditioned on (i) Pharmacy Benefit Manager being the exclusive provider of specialty services; and (ii) the State implements and maintains a generics first plan design for specialty. All initial and refill specialty prescriptions are limited to dispensing from Pharmacy Benefit Manager specialty pharmacies and retail CVS/pharmacy locations. Pharmacy Benefit Manager may amend the individual drug discounts from time to time to manage the OED commitment. The OED is measured and reconciled annually across all Specialty Drugs dispensed from a Pharmacy Benefit Manager specialty owned or affiliated pharmacy. The following are excluded from the OED guarantee and will be priced as stated below:

- New to market Specialty Drugs will be priced at AWP -[redacted] or MAC, if applicable.
- New to market limited distribution drugs will be priced at AWP -[redacted].
- New to market biosimilars will priced at AWP -[redacted].

The OED offer also takes into account provision by Pharmacy Benefit Manager of the care management program, which includes additional nurse-based rare condition management services (the "Care Management Services") for Members with the following rare conditions: Crohn's Disease, Cystic Fibrosis, Gauchers Disease, Hemophilia, Lupus, Multiple Sclerosis, Rheumatoid Arthritis, and Ulcerative Colitis. Care Management Services are provided as part of Pharmacy Benefit Manager's specialty pharmacy medication therapy management services. As part of the Care Management Services, Pharmacy Benefit Manager will utilize Specialty Pharmacy Claims to identify Members likely to have the relevant rare conditions, and a care management nurse will work with such Members to provide health assessments to help them manage their health - including identification of signs and symptoms, support for co-morbidities, and coordination of care. The State acknowledges it has received a general description of the care management services and agrees to allow, and cooperate with, Pharmacy Benefit Manager to undertake such services. The State hereby agrees that it will cooperate with

Pharmacy Benefit Manager's implementation of the Care Management Services, including without limitation: (i) Member outreach; (ii) facilitating communication with medical and other healthcare providers as well as any health plans administering the State's Members; and (iii) permitting the use of the State's name in communications with Members as part of the Care Management Services.

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

PER DIEMS, NURSING & EQUIPMENT:

* Remodulin, Veletri & Epoprostenol Sodium for Injection: [redacted] per day
**Ventavis: The State 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, the State shall reimburse Pharmacy Benefit Manager [redacted] for each I-Neb.
*** Unless otherwise stated above: [redacted] per dose

Nursing Charges: [redacted] per visit up to 2 hours, [redacted] for each hour thereafter. Alternatively, Pharmacy Benefit Manager can refer any medically necessary nursing services to the State'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 Pharmacy Benefit Manager under the Agreement, Pharmacy Benefit Manager 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, Pharmacy Benefit Manager shall bill the State 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, Pharmacy Benefit Manager reserves the right to adjust pricing upon notice to the State.

Attachment 2 to Exhibit C-1

CVS90 AT RETAIL NETWORK

The following terms and conditions apply to Pharmacy Benefit Manager's CVS90 at Retail Network Program (the "Program"), which will enable the State's Members to obtain certain over 83-day supply maintenance medication prescriptions either at a local CVS/pharmacy or from one of Pharmacy Benefit Manager's mail service pharmacies and to participation by the State's Plan(s) in the Program.

PROGRAM TERMS AND CONDITIONS:

1. There are no additional fees or expenses to the State associated with the implementation of the Program.

2. The Program may be a change to the State's existing plan design. The State is responsible for complying with all laws and regulations applicable to its Plan, for making any appropriate notifications to its Members concerning the Program and for making any appropriate changes to its Plan design documents to reflect its participation in the Program.

3. Pharmacy Benefit Manager will implement and administer the Program as part of the Services provided under the Agreement. All terms and conditions set forth in the Agreement will apply to the Program, although the Program will be governed by the terms and conditions in this exhibit to the extent of any conflict between this exhibit and the remainder of the Agreement.

4. The Program applies only to "Maintenance Prescriptions." A Maintenance Prescription is a prescription for more than an 83-day supply of certain medications that are covered by the State's Plan(s), excluding specialty medications.

5. A Maintenance Prescription will be dispensed by a CVS/pharmacy retail location, but the State will receive the same pricing discounts and dispensing fees, if any, that would apply if the prescription had been filled at one of Pharmacy Benefit Manager's mail service pharmacies. The Member will pay, and Pharmacy Benefit Manager will direct the dispensing CVS/pharmacy to collect, the same "Cost Share" the Member would have paid if the prescription was filled at one of Pharmacy Benefit Manager's mail service pharmacies. Maintenance Prescriptions will not be subject to the usual and customary price or other retail network pricing charged by the CVS/pharmacy.

6. Maintenance Prescriptions will be treated the same as prescriptions filled at Pharmacy Benefit Manager's mail service pharmacies for purposes of any mail pricing guarantees and generic dispensing rate guarantees set forth in Exhibit C-1 of the Agreement. Maintenance 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. By having Pharmacy Benefit Manager implement the Program for the State's Plan(s), the State represents to Pharmacy Benefit Manager that it is (1) not subject to any laws or regulations that would limit or otherwise impact the State's ability to offer the Program to its Members, or (2) if the State is subject to any such laws or regulations, it has obtained all required regulatory or legal approvals necessary for its participation in the Program or has

otherwise determined that it may offer the Program in compliance with such laws and regulations. Pharmacy Benefit Manager cannot be responsible for any legal requirements applicable to the State's Plan or to the State's participation in the Program. To the extent permitted by law, the State shall indemnify and hold harmless Pharmacy Benefit Manager for any costs, losses, damages, reasonable attorneys' fees and expenses resulting from any regulatory action, lawsuit or other legal proceeding relating to whether the State's Plan or the State's participation in the Program is in compliance with applicable laws and regulations. The State shall provide Pharmacy Benefit Manager with prompt written notice if it becomes aware of any such actual or threatened regulatory action, lawsuit or other legal proceeding relating to the Program and to cooperate with Pharmacy Benefit Manager and allow Pharmacy Benefit Manager to participate in and/or assume the defense of any such proceeding.

8. Adoption of the Program requires that the State implement a Plan design that: (i) requires the Cost Share for a Maintenance 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; and (ii) allows Pharmacy Benefit Manager to communicate with Members regarding the benefits of moving to a ninety (90) day supply consistent with the Plan design.

9. Due to a change in applicable law or regulation and upon written notice to the State, Pharmacy Benefit Manager may modify the Program or suspend the State's participation in the Program.

SCHEDULE 1 to ATTACHMENT 2 TO EXHIBIT C-1

SPECIMEN CVS90 AT RETAIL

PARTICIPATING PHARMACY TERMS AND CONDITIONS

Note: All of these conditions would be in addition to or would supersede certain conditions in the existing retail provider agreement and provider manual.

- CVS90 at Retail – Filling of certain 90 day maintenance scripts by retail for AWP – [redacted].
- Equivalent pricing for mail and retail for generics.
- Customer service requirements

    1. Pharmacy system functionality in both English and Spanish (i.e., warning labels print in Spanish for Spanish-speaking customers).

    2. Telephonic translation service providing translation for approximately 150 languages.

    3. Must extend an average of 24 invitations to participate in a customer service survey to customers randomly each day in each store. The customers must be asked the following:

        - **(QUALIFIER)** Within the past 30 Days, have you had a prescription filled at this pharmacy? Press 1 for yes or 2 for no.
        - **(IF "1")** During your most recent visit to the store, how courteous and professional was the pharmacy staff? Please use a 5-point scale where 1 means not at all courteous and professional and 5 means very courteous and professional.

    The average results of this survey must be that 75% of responses are a 4 or above. The results must be reported monthly with proper documentation.

- Provision of all drugs covered under CVS90 at Retail.
- Provider computer system shall be fully compatible with those used by Pharmacy Benefit Manager.
- Must interface with Pharmacy Benefit Manager relating to CVS90 at Retail processes as follows: (i) establish electronic interface with Pharmacy Benefit Manager systems to accept 90 day prescription requests; (ii) establish electronic interface that integrates Provider's inventory management system with Pharmacy Benefit Manager systems to accept corresponding updates to Provider's inventory for each prescription request sent to Provider and subsequently adjust inventory supply accordingly within 3 days of update; (iii) Provider must have an automated process to contact the prescriber within 24 hours of receipt of 90 day prescription request and must use commercially reasonable efforts to obtain the 90 day prescription from the prescriber within 3 days of receipt of 90 day prescription request; (iv) if unable to obtain 90 day prescription from the prescriber within such 3 day time period, must contact the participant to adjust expectation regarding pick up date, if pick up date merely delayed, or request that participant

contact the prescriber directly, if prescriber refused to write the prescription; (v) develop and establish additional interfaces as necessary as the CVS90 at Retail program develops, including but not limited to, Pharmacy Benefit Manager customer service access to Provider systems to view status of participant's prescription fulfillment and the provision of additional clinical services.

- Provider will maintain policies and procedures to verify the pedigree and chain of custody for all prescriptions dispensed by Provider.

- Provider shall not, under any circumstances, return to stock and dispense drugs that have been previously dispensed.

- Provider shall not have initiated or be involved in any legal demand, dispute or other legal proceeding adverse to Pharmacy Benefit Manager or any of its affiliates unless Provider has a good-faith basis that Pharmacy Benefit Manager or any of its affiliates have violated the Law or the Agreement.

- Provider and its affiliates shall be a participating pharmacy in Pharmacy Benefit Manager's retail network and shall be in compliance with any other provider agreement or other contract between Provider (or any of Provider's affiliates) and Pharmacy Benefit Manager (or any of Pharmacy Benefit Manager's affiliates), if any.

- Provider must agree to provide pharmacy services for all plan sponsors who use a Pharmacy Benefit Manager national network.

- Provider must participate in marketing and communications programs as directed by Pharmacy Benefit Manager.

- Audit rights to verify compliance with all Terms and Conditions.

Exhibit C-2

PERFORMANCE GUARANTEES – NON-FINANCIAL

Pharmacy Benefit Manager will provide the following performance guarantees, placing up to [redacted] of the administrative fees at risk, with assessments as described for non-compliance.

The total amount at risk may be allocated among the performance guarantees at the State's discretion provided 1) no individual guarantee allocation can have no more than 20% of the amount at risk; 2) the total percent allocated must equal 100%; and 3) Pharmacy Benefit Manager receives written notice of the State's allocations at least thirty (30) days prior to the effective date or contract anniversary. In the event Pharmacy Benefit Manager does not receive written notice of the State's allocation, the total amount at risk will be allocated equally among the performance guarantees, unless otherwise stated in the performance guarantees.

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Business Function	Service Offering	Minimum Performance Criteria	Verification Method	Performance Guarantee	Percentage Allocation
Account Management	**Requests**	**Renewal and information requests will be provided to the State in a timely and accurate manner and within [redacted] of written request.**	MMB to verify response results	Pharmacy Benefit Manager shall provide information requests to the State in a timely and accurate manner and within [redacted] of written request. The annual renewal will be provided to the State in the spring of the year prior to the renewal's effective date, within [redacted] of written request. The annual renewal will be finalized with the State by June 30 of the year prior to the renewal's effective date in a format mutually agreed upon with the State of Minnesota.	10%
	Open enrollment support	**PBM will support MMB open enrollment process by attending open enrollment meetings.**	MMB to verify	Pharmacy Benefit Manager shall attend up [redacted] scheduled open enrollment meetings, provided they are scheduled such that two Pharmacy Benefit Manager staff can support all such meetings (i.e., no more than two concurrently and spaced geographically to permit adequate travel time between meeting when two or more are scheduled in one day). The Pharmacy Benefit Manager shall pay half the guaranteed dollars placed at risk for this guarantee if one enrollment meeting is missed and the full amount if two or more meetings are missed.	7.5%
	Satisfaction	**Client program staff satisfaction with the overall performance, responsiveness and knowledge of the Account Manager (or Account Management**	MMB to verify reported results	A satisfaction survey shall be conducted annually among the State's management team. Overall satisfaction ratings of at least [redacted] on a 5-point scale (5 is best rating) shall be guaranteed. For the purposes of this guarantee, satisfaction [redacted] 5-point scale; Excellent, Very Good, Good, Fair, Poor. Pharmacy Benefit Manager shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys. This is measured and reported on a calendar year and State specific basis.	10.0%

Business Function	Service Offering	Minimum Performance Criteria	Verification Method	Performance Guarantee	Percentage Allocation
		Team).			
	Problem resolution	**Within two [redacted] days of problem being identified, a work plan for resolution is to be provided, specifying the resources to be utilized, and action updates until problems is resolved to the State's expectations and satisfaction.**	MMB to verify response time	Within [redacted] business days, or as otherwise mutually agreed upon, of a significant issue being identified, a work plan for resolution shall be provided to State, specifying the resources to be utilized, and action updates shall be provided until the issue is resolved to the State's expectations and satisfaction. For purposes of this guarantee, a "significant issue" shall be defined as (1) an issue that negatively impacts or impairs the proposer adjudication of Member Claims in accordance with the plan design, or (2) that materially negatively impacts the State's ability to manage its benefits program. This is measured and reported on a calendar quarter and State specific basis.	10%
Member services/call center	**Call Center Abandonment Rate**	**Not to exceed [redacted]**	Report Only Metric	Inbound calls to Pharmacy Benefit Manager's toll-free customer service lines shall be answered with an abandonment rate of [redacted] or less. Measurement includes calls routed to an IVR and excludes calls abandoned by the Member within the first [redacted] seconds. This guarantee is measured and reported on a calendar quarter and State specific basis.	
	Answer Speed	**Calls answered in 30 seconds - 9[redacted] or greater**	Report Only Metric	100% of calls will be answered within an average of thirty ([redacted] or less. Measurement includes calls routed to an IVR. This guarantee is measured and reported on a calendar quarter and State specific basis.	
	Member Inquiries	**Acknowledge written member inquiries - [redacted] or greater in 5**	Report Only Metric	Pharmacy Benefit Manager guarantees [redacted] of written inquiries received by Pharmacy Benefit Manager's Customer Care department from all Members will be responded to within [redacted] Days following the	

Business Function	Service Offering	Minimum Performance Criteria	Verification Method	Performance Guarantee	Percentage Allocation
		days; [redacted] in 10 days		Business Day on which such inquiry was received. This is measured on a State specific basis. Pharmacy Benefit Manager guarantees [redacted] of e-mail inquiries received by Pharmacy Benefit Manager's Customer Care department from all Members will be responded to within [redacted] following the Business Day on which such inquiry was received (excluding Sunday). This is measured and reported on a calendar quarter and State specific basis.	
	Identification Cards	**Distribution – Initial cards will be received by employee prior to new plan year. ID cards must be produced and mailed within [redacted] days of receiving a processable eligibility file.**	1) PBM to report implementation timeline dates for MMB to verify. 2) PBM to report mail date to MMB, MMB to verify date window, and verify receipt of ID cards reasonable to mail date. 3) Report Only Metric	2) CVS Health guarantees that based on receipt of a clean, accurate and complete electronic eligibility file no later than the [redacted] of the month that is prior to the effective date of the Agreement or mutually agreed upon re-issue date, that [redacted] of enrollees to CVS Health will be mailed ID cards and/or Welcome Booklets [redacted] days prior to the effective date or re-issue date. This will be measured and reported on a calendar year and State specific basis. 3)Pharmacy Benefit Manager guarantees that [redacted] of new members will be mailed ID cards and/or Welcome Booklets within [redacted] Days of	1) NA 2) 10% 3) Report only

Business Function	Service Offering	Minimum Performance Criteria	Verification Method	Performance Guarantee	Percentage Allocation
				receipt of a clean, accurate and complete electronic file for ongoing eligibility updates. Implementation and re-issues are not considered part of this portion of the guarantee. This is measured and reported on a calendar year and State specific basis.	
	Member/ Patient Satisfaction Survey	**Survey conducted and results reported annually**	Report Only Metric	Satisfaction surveys shall be conducted during the Plan year among the State's base of prescription drug benefit Members. Survey respondents shall be selected at random from Members who have recent experiences with one or more of the following Pharmacy Benefit Manager services: 1) Retail Pharmacy benefits; 2) Mail Service Pharmacy benefits; 3) Customer Care. Overall satisfaction ratings of at least [redacted] shall be guaranteed. If the State does not have sufficient Members with mail or retail Claims at any time during the measurement period, or if the State has not provided Pharmacy Benefit Manager with sufficient Member contact information to support a statistically valid sample, Pharmacy Benefit Manager will conduct the survey without risk of penalty. For the purposes of this guarantee, satisfaction shall be defined as [redacted] on the following 5-point scale; Completely Satisfied, Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied. Pharmacy Benefit Manager shall be responsible for survey design, data collection, analysis and all costs associated with conducting the surveys. This is measured and reported on a calendar year and State specific basis.	
Eligibility	**Update Frequency**	**Ability to receive and process files daily/ weekly (updates and / or**	PBM to report errors to MMB.	Eligibility Error Report. For all clean State eligibility files (i.e., State eligibility files meeting mutually agreed upon file specifications/format), Pharmacy Benefit Manager guarantees to produce and distribute, to the State via	Error Report 10%

Business Function	Service Offering	Minimum Performance Criteria	Verification Method	Performance Guarantee	Percentage Allocation
		full file)	MMB to verify Delivery Date	secure FTP electronic file, a set of error reports for State eligibility file updates within an average of [redacted] from the Pharmacy Benefit Manager adjudication platform file load completion. This performance guarantee is calculated by dividing the sum of the error report duration times (from the Pharmacy Benefit Manager adjudication platform file load completion to error report transmission to the State) by the total number of clean files received from the State. This calculation is State specific and 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 quarter and State specific basis. Eligibility Updates. Clean State eligibility files (i.e., a State eligibility files meeting mutually agreed upon specifications/format and not exceeding agreed upon thresholds) will be loaded into the Pharmacy Benefit Manager adjudication platform within an average of [redacted] from the receipt of a State eligibility file by Pharmacy Benefit Manager (excluding any scheduled adjudication system/software upgrade downtime hours). This performance guarantee is calculated by dividing the sum of clean State file load times by the total number of clean files received from the State. 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 quarter and State specific basis.	Eligibility Updates: 10%
			PBM to notify MMB of file load, MMB to verify date		
Reporting	**Billing Reports**	**Produced within [redacted] of**	MMB to	Pharmacy Benefit Manager guarantees that standard billing reports will be produced within [redacted] of the	2.5%

Business Function	Service Offering	Minimum Performance Criteria	Verification Method	Performance Guarantee	Percentage Allocation
		the close of the billing cycle	verify date billing reports were produced	close of the billing cycle. This is measured and reported on a calendar quarter and State specific basis.	
	Membership Reports	**Reports to be provided quarterly**	MMB to verify date reports are available	Pharmacy Benefit Manager guarantees that standard quarterly membership reports shall be available within [redacted] after the end of each contract quarter. This is measured and reported on a on a calendar quarter and State specific basis.	2.5%
	Monthly Claims Reports	**Reports to be provided quarterly**	MMB to verify date reports are available	Pharmacy Benefit Manager guarantees standard quarterly claims reports shall be available within [redacted] after the end of each contract quarter. This is measured on a calendar quarter and State specific basis.	2.5%
	Rebates	**Full access should be provided to all rebate contracts with pharmaceutical manufacturers within 10 business days of the request.** **PBM will provide full disclosures of rebates received by PBM as a result of State of**	MMB to verify date PBM provides access to rebate contracts MMB to verify date full disclosure of	Pharmacy Benefit Manager shall provide the State with access to rebate contracts with pharmaceutical manufacturers within [redacted] of the request for purposes of conducting rebate audits. (The State acknowledges that request for audit access to such agreements shall not be considered to be given until an appropriate Non-Disclosure Agreement is in place between the Pharmacy Benefit Manager and the State's designated auditor, and such auditor provides Pharmacy Benefit Manager with the list of manufacturer rebate contracts the auditor desires to review.) Pharmacy Benefit Manager shall otherwise reasonably cooperate with rebate audits. Pharmacy Benefit Manager shall provide the State within [redacted] of the request full disclosure of Rebates received by Pharmacy Benefit Manager as a result of Member utilization, including line item detail by National Drug Code number, line item detail by State	2.5% 2.5%

Business Function	Service Offering	Minimum Performance Criteria	Verification Method	Performance Guarantee	Percentage Allocation
		Minnesota utilization, including line item detail by National Drug Code number, line item detail by State of Minnesota group number and line item detail by pharmaceutical manufacturer.	rebates were received	group number and line item detail by pharmaceutical manufacturer, for purposes of conducting rebate audits. Pharmacy Benefit Manager shall otherwise reasonably cooperate with rebate audits	
Claims Administration	**Claims System Availability**	[redacted] **online availability**	PBM to use 2021 report to verify	Scheduled maintenance will not be performed during routine pharmacy business hours. This is measured and reported on a calendar year and Pharmacy Benefit Manager book of business basis.	10.0%
	Claim Adjudication Accuracy	[redacted] **rate of accuracy**	Report Only Metric	Electronic Claims processing accuracy for both retail and mail service pharmacies will be at least [redacted] in any calendar year for which State 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). Pharmacy Benefit Manager shall credit the State 25% of the total amount at risk for this guarantee for each full percentage point below target accuracy rate, up to a maximum	

Business Function	Service Offering	Minimum Performance Criteria	Verification Method	Performance Guarantee	Percentage Allocation
				annual penalty of 100% of the total amount at risk for this guarantee. This is measured and reported on a calendar year and State specific basis.	
Mail Order	**Dispensing Accuracy**	**[redacted] rate of accuracy**	Report Only Metric	Pharmacy Benefit Manager's accuracy in dispensing prescriptions from its mail service pharmacy (correct drug, correct strength, correct dosage form and correct Member) shall be at least [redacted]. This is reported quarterly, measured on a calendar year and State specific basis.	
	Turnaround Time	**Prescriptions will either be dispensed or returned with explanation within [redacted] of receipt** **[redacted] of all clean prescriptions will be dispensed and shipped within 72 hours/3 business days**	Report Only Metric	Within an average of [redacted] of receipt, Pharmacy Benefit Manager shall dispense 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 Pharmacy Benefit Manager's systems standard practices) multiplied by the number of days these prescriptions took to meter divided by the total number of metered prescriptions. This is reported quarterly, measured on a calendar year and State specific basis. Within [redacted] of receipt, Pharmacy Benefit Manager shall dispense at least [redacted] of all clean (not requiring intervention or clarification) mail service pharmacy prescriptions. This is reported quarterly, measured on a calendar year and State specific basis.	
Rebates	**Payment Reconciliation**	**Rebate payment reconciliation will occur within 120 days following year-end.**	MMB to verify date reconciliation was completed	Pharmacy Benefit Manager shall complete the reconciliation between Rebates distributed monthly throughout the year to the Rebates guaranteed under this Agreement within 120 days following year-end.	5.0%

Business Function	Service Offering	Minimum Performance Criteria	Verification Method	Performance Guarantee	Percentage Allocation
	Distribution of Monies	**Vendor will distribute any monies owed due to the annual Rebate reconciliation within 30 days of reconciliation.**	MMB to verify date payment made	Pharmacy Benefit Manager shall make payment of any amount owed due to the annual Rebate reconciliation within 150 days following year-end.	5.0%

CONDITIONS:

For purposes of the performance standards herein, the term “Business Day” will mean Pharmacy Benefit Manager’s normal business hours on any day other than a Saturday or Sunday or a day on which Pharmacy Benefit Manager is closed for general business purposes.

The performance guarantees will be adjusted equitably by the parties to the extent that Pharmacy Benefit Manager has suffered a force majeure event during the applicable measurement period.

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

Pharmacy Benefit Manager will not be liable to State for any failure to satisfy a performance guarantee during any time that no agreement existed between Pharmacy Benefit Manager and State, 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 written agreement actually was executed by the Parties. If any period covered by the Agreement is less than the period covered by the performance guarantee, and Pharmacy Benefit Manager has not met such performance guarantee for such period, the penalty associated with such failure will be prorated to reflect the actual period during which the Agreement was in effect.

Pharmacy Benefit Manager shall provide the performance guarantee report card no later than ninety (90) days after the end of the applicable calendar quarter. Should the report card fall due on a non-business day, the report card will be provided on the first business day following the due date. Any applicable amounts owed to the State will be credited on the month end invoice following the month of the year-end reporting date.

In the event Pharmacy Benefit Manager fails to meet the guarantees, the penalties described above will be the sole and exclusive damages attributable to such failure, provided that, payment of such amounts shall not relieve Pharmacy Benefit Manager from correcting and/or reconciling any underlying error or improperly adjudicated Claims, nor shall it relieve Pharmacy Benefit Manager for a material breach of its obligations under this Agreement.

Exhibit D

SUMMARY OF BENEFITS

A COPY OF THE SUMMARY OF BENEFITS FOR MINNESOTA ADVANTAGE HEALTH PLAN[SM] can be found at:

https://mn.gov/mmb-stat/segip/doc/SoB_current_AHP.pdf

Exhibit E

AFFILIATES AND SUBCONTRACTORS

We directly furnish the core PBM services through our PBM subsidiaries or affiliates and do not have a strategic alliance or subcontract arrangement for such core PBM services. For support or ancillary services, we use the vendors noted below.

Vendor	Locations	Services Provided
Alorica	• St. Paul, Minnesota • Humble, Texas • Mobile, Alabama • Tucson, Arizona • Virginia Beach, Virgina • Muntinlupa City, Philippines (offshore for Pharmacy Help Desk calls only- not member calls)	Pharmacy Help Desk and call center support, including refill and order status requests
Continuum	• Charlotte, North Carolina • Henderson, North Carolina • Houston, Texas • Madison, Mississippi • Frostburg, Maryland • Cary, North Carolina • Orlando, Florida • Wack Wack Mandaluyong City, Philippines (Retail Pharmacy Help Desk calls only)	Customer Care member and Pharmacy Held Desk calls.
FGS	• Braintree, Massachusetts	Print production; commercial printing; standard mailings
Fiserv	• St. Louis, Missouri • Houston, Texas • Indianapolis, Indiana	Print production; primary vendor for communication booklet/ID card production
Language Line	• Glendale, California	Language translation services
Medical Review Institute of America	• Salt Lake City, Utah	Level II appeals and IRO for external review
MES Peer Review	• Norwood, Massachusetts	IRO for external review

Vendor	Locations	Services Provided
National Audit, A SCIOinspire Company	• Jacksonville, Florida	CVS retail pharmacy audits for CVS Pharmacy and Longs
Network Medical Review Co.	• Rockford, Illinois	IRO for external review
Quad Graphics	• Sussex , Wisconsin	Print production; commercial printing; fulfillment; standard mailinos
RR Donnelley	• Multiple locations across the U.S.	Print production; commercial printing; standard mailings
TTEC Healthcare Solutions	• Jonesboro, Arkansas	Customer Care member calls
Universal Wilde	• Westwood, Massachusetts	Print production; commercial printing; fulfillment; standard mailings; communication booklet/ID card maintenance production

Please contact your CVS Health representative before calling any of the above vendors. As a courtesy, they have asked that we inform them in advance that someone will be contacting them for reference purposes.

Exhibit F

MEDICATION THERAPY MANAGEMENT PROGRAM

Overview

Contractor will implement and manage the components of a Medication Therapy Management (MTM) Program as mandated by the H.F. No. 1362, 4th Engrossment -86th Legislative Session (2009 – 2010) [H1362-4], Section 7 [62Q.676], which states:

A pharmacy benefit manager that provides prescription drug services must make available medication therapy management services for enrollees taking four or more prescriptions to treat or prevent two or more chronic medical conditions. For purposes of this section, "medication therapy management" means the provision of the following pharmaceutical care services by, or under the supervision of, a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(2) communicating essential information to the patient's other primary providers; and

(3) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications.

Nothing in this section will be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

Scope of Work

This section describes the high-level scope of the components to be implemented and made available to Minnesota Advantage Health Plan enrollees who are eligible and choose to enroll in the Medication Therapy Management program.

Eligibility and Payment

Eligibility:

The following processes will need to be implemented and supported.

- A process to verify eligibility to ensure that members meet the criteria for the program.
- A process/program to send the qualified members to the PBM MTM Call Center.
- A process for members to opt-in to the MTM Program

Payment:

The annual fee for the program is $95 per member who has opted-in to the MTM program.

PBM MTM Call Center will invoice MMB for the annual fee of the members who do participate in the program.

PBM Call Center *Process*

PBM Call Center will integrate a number of their well-established methods of MTM delivery in this solution. The program will include personalized comprehensive medication reviews for each participating member.

- **Comprehensive Medication Reviews (CMR) Annually**

Using PBM Call Center's proprietary software, a CMR will be offered for each participating member that focuses on enhancing medication safety, reducing drug cost, and improving treatment compliance with standard consensus guidelines. Identified members will receive a letter notifying them of the service followed by a series of phone calls to engage with a pharmacist. Once engaged, the pharmacist will conduct a telephonic interview aimed at:

- Performing a medication reconciliation
- Evaluating the member's adherence to their prescribed regimen
- Performing an assessment of the medical conditions present
- Discussing any member and pharmacist-identified concerns along with the appropriate action plan required to resolve
    - Examples of concerns include, but are not limited to:
        - Appropriate indication (needs additional drug therapy, unnecessary drug therapy)
        - Effectiveness (appropriate drug, dose too low)
        - Safety (adverse reaction, dose too high)
        - Compliance (affordability, instructions not understood, cannot swallow).

Following the interview, the pharmacist will document their findings and contact the necessary prescriber(s) to coordinate care and assist in facilitation of resolution.

Participating members will receive the results of the CMR that includes a personalized medication list and medication action plan, by mail.

- **Provider Notification and communication**

When specific recommendations are identified, PBM MTM Call Center will contact the member's provider with any specific recommendations for consideration. Approved changes will be communicated to the member to ensure alignment on the appropriate medication regimen.

Exhibit G

[RESERVED]

Exhibit H

[RESERVED]

Exhibit I

[RESERVED]

Exhibit J

[RESERVED]

Exhibit K

ACKNOWLEDGEMENT OF AGREEMENT TO RENEWAL PROVISIONS

Pursuant to the provisions of Section 16.1, the State and Pharmacy Benefit Manager acknowledge that agreement has been reached with respect to the following renewal provisions.

PROVISION	NEGOTIATION DEADLINE*	COMPLETED
Exhibit A Monthly Administration Fee	June 30, 2021	
Exhibit C Performance Guaranties	December 1, 2021	
Exhibit F Medication Therapy Management Program Fee	June 30, 2021	
Exhibit B and C any other provision not set forth above that affects the rating process	June 30, 2021	

***** The Negotiation Deadlines are the later of the dates set forth above or ten (10) working days following the settlement of all collective bargaining agreements between the State and bargaining units representing State employees.

Exhibit L

[RESERVED]

Exhibit M

[RESERVED]

Exhibit N

[RESERVED]

Exhibit O

VACCINE PROGRAM TERMS AND CONDITIONS

This Vaccine Program Terms and Conditions Exhibit ("Exhibit") describes Pharmacy Benefit Manager's Vaccine Program (the "Program"), pursuant to which Pharmacy Benefit Manager shall arrange for the provision of certain vaccination services through participating retail pharmacies to those individuals selected by State, 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 State 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, State 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 State'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 State 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 State by Pharmacy Benefit Manager, 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 State's request Pharmacy Benefit Manager shall provide State with a current list of Participating Vaccine Pharmacies. State 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, State elections regarding the Program shall be made through the State's Client Requirements Document ("CRD"), prepared by Caremark and presented to State for review, as amended from time to time with State'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 Pharmacy Benefit Manager continues to offer the Program and State continues to elect to participate in the Program, even in the event that State elects not to participate in, or Pharmacy Benefit Manager elects not to offer, any specific Program component during any portion of the Term of the Agreement. State may, upon at least thirty (30) days' prior written notice to Pharmacy Benefit Manager, 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.** Pharmacy Benefit Manager offers two Participating Vaccine Pharmacy networks under the Influenza Program, the Broader Vaccine Network, and the CVS Only Vaccination Network. State has the option to participate in either network option, but no State 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 State has directed Pharmacy Benefit Manager, in writing, to not implement the Influenza Program, or elected in writing to participate in the CVS Only Vaccination Network, State shall be enrolled in the Broader Vaccine Network. If State elects to participate in the CVS Only Vaccination Network at any time, State's participation in the Broader Vaccine Network shall cease as of the effective date of such election. If State has directed Pharmacy Benefit Manager, in writing, to not implement the Influenza Program, this Section 2 of this Exhibit shall not be applicable and State shall not be enrolled in the Influenza Program.

2.3. **Vaccine Fee Composition.** State 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 State participates in the Influenza Program Pharmacy Benefit Manager shall provide State 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 State not less than thirty (30) days prior to the start of the respective Flu Season and State 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 Pharmacy Benefit Manager. If State does not elect to change its Influenza Program elections, the charges in Pharmacy Benefit Manager's notification to State shall apply to any influenza vaccinations administered to Plan Members under the Influenza Program during the respective Flu Season.

2.5. **Invoicing.** Pharmacy Benefit Manager shall invoice State 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 CRD, as approved by the State 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 CRD shall remain in effect for so long as Pharmacy Benefit Manager offers the Non-Seasonal Program, until modified or terminated by the State 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 State 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 $[redacted] for Zostavax or [redacted] for any other available vaccine. In the event of a change in the administration fees set forth in the preceding sentence, Pharmacy Benefit Manager shall provide State written notification of such change at least thirty (30) days prior to the effective date of the change and State 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 Pharmacy Benefit Manager. If State does not elect to change its Non-Seasonal Program elections, the charges in Pharmacy Benefit Manager's notification to State 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 Pharmacy Benefit Manager's notification. Caremark Retail-90, CVS-90 and CVS Mail at Retail pricing terms, if any, do not apply to non-seasonal vaccines.

3.3. **Invoicing.** Pharmacy Benefit Manager shall invoice State 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 State, 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 State 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 State.

4.1. **Enrollment Form.** Upon request, Pharmacy Benefit Manager shall provide State 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.** Pharmacy Benefit Manager shall provide State with a portable document file (pdf) electronic file ("Electronic File"), from which the vouchers may be printed. State 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.** Pharmacy Benefit Manager 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.** Pharmacy Benefit Manager shall invoice State 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, Pharmacy Benefit Manager shall invoice State monthly and invoices shall be paid within thirty (30) days of receipt.

5. **Additional Terms.**

5.1. Vaccinations administered under the Program shall be administered by licensed pharmacists or pharmacist interns in accordance with all laws and regulations applicable to the respective Participating Vaccine pharmacy. Participating Vaccine Pharmacies may decline to provide vaccinations to minors based on state law or clinical considerations. The provision of all Program services is subject at all times to vaccine availability. In the event of an epidemic, pandemic or similar public health incident(s), Participating Vaccine Pharmacies may be unable to purchase and/or supply vaccine, and product held by Participating Vaccine Pharmacies may be subject to superseding requirements imposed by a governmental authority, including, without limitation, potential seizure. Pharmacy Benefit Manager shall have no liability due to any resulting inability to provide Program services.

5.2. Vaccinations provided pursuant to the Program may be excluded from the calculation of any and all financial and performance guarantees in the Agreement. Except with respect to collection of Cost Share as agreed to by State and Pharmacy Benefit Manager, Pharmacy Benefit Manager undertakes no responsibility to bill any payor other than State for the services described in this Exhibit or any Program Enrollment Form and specifically disclaims any obligation to engage in any coordination of benefits with respect to such services, except

where required by applicable law.

5.3. This Exhibit shall supersede all previous vaccine pricing agreed to by the parties, if any. Capitalized terms used but not otherwise defined in this Exhibit shall have the meaning set forth in the Agreement.