K-18-64

aetna®
ERISA 5500 SCHEDULE A UNIT
4300 CENTREWAY PLACE
ARLINGTON, TX 76018

MAY 18, 2018

FAULKNER COUNTY
TOM ANDERSON
801 LOCUST STREET
CONWAY, AR 72034

Re: Annual Reporting Under Employee Retirement Income Security Act of 1974 (ERISA)
For: FAULKNER COUNTY - 0849611
Policy Period : January 01, 2017 through December 31, 2017

We have enclosed information for your policy period listed above to help you complete the Schedule A to ERISA Form 5500 Annual Report. We are providing this information in accordance with U.S. Department of Labor regulations.

Note that compliance with the ERISA requirements for completion of the Annual Report and its filing with the Internal Revenue Service is the sole responsibility of employers, plan administrators and their professional advisors. Aetna Life Insurance Co. cannot and does not assume any responsibility for such compliance, but we are pleased to provide information pertaining to your insurance program as needed to complete the Report.

Information may also be included in the enclosure(s) for your consideration in completing Schedule C of your Form 5500. This information may consist of one or more of the following: Producer Service Fees, Indirect Compensation (as it pertains to meals and entertainment) and/or Direct Billed Fees. Information pertaining to Indirect Compensation and Direct Billed Fees is provided on a calendar year basis, which may not coincide with your plan year.

If you have other benefits plans with Aetna Life Insurance Co., you may receive additional ERISA information to complete your Schedule A and Schedule C for those plans under separate cover.

If you have any additional reporting needs, please contact your Aetna Life Insurance Co. account manager, or call 1-800-818-0691 to speak with the ERISA support team.

Sincerely,

Aetna Life Insurance Co.

Enclosure(s)

849611-TP-05182018

aetna®

INSURANCE INFORMATION
AETNA LIFE INSURANCE COMPANY AND AFFILIATES

The following information is intended for your use in completing Schedule A of Form 5500.

For Fiscal Plan Year beginning 01/01/2017, and ending 12/31/2017.

C. Name of Plan Sponsor: FAULKNER COUNTY

PART I Information Concerning Insurance Contract Coverage, Fees, and Commissions.

1. Coverage: Traditional Prospective

(a) Name of Insurance Carrier: Aetna Life Insurance Co.	(d) Contract Number or Identification:	(e) Approximate number of persons covered at end of policy or contract year.	Policy or contract year	
(b) EIN 06-6033492	0849611	324	(f) From: 01/01/2017	(g) To: 12/31/2017
(c) NAIC Code: See Attached				

2. Insurance fees and commissions paid to agents and brokers:

Contract or identification	(a) Name and address of the agents or brokers to whom commissions or fees were paid.	(b) Amount of commissions paid	(c) & (d) Fees Paid	
			Amount	Purpose
TOTAL				

Reported fees and commissions may be attributed to multiple Aetna companies.

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

- ☐ Health (other than dental or vision)
- ☐ Dental
- ☐ Vision
- ☐ Life Insurance
- ☐ Temporary disability (accident and sickness)
- ☐ Long-term disability
- ☐ Supplemental unemployment
- ☐ Prescription drug
- ☑ Stop loss (large deductible)
- ☐ HMO contract
- ☐ PPO contract
- ☐ Indemnity contract
- ☐ Accidental Death Dismemberment
- ☐ Short Term Disability

8 Experience Rated Contracts: N/A

9. Non experience rated contracts:

(a) Total premiums or subscription charges paid to carrier. $310,436.35

(b) If the carrier, service or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in 2 above, report amount. . . . . .

Specify nature of costs -->

This information was generated as of March 26, 2018.

Date **May 18, 2018 FINAL RELEASE**

Registrar

AETNA LIFE INSURANCE COMPANY AND AFFILIATES hereby certifies that the foregoing statement is complete and accurate

John M Stenson FSA

John Stenson, VP Corp Accounting,
AETNA LIFE INSURANCE COMPANY AND AFFILIATES

849611-TP-05182018

State	NAIC Code	Service Area	EIN
	95003	Aetna Health Inc. (an Arizona Corporation)	06-6033492
	95094	Aetna Health Inc. (a Georgia Corporation)	06-6033492
	95910	Aetna Dental Inc (a Texas Corporation)	06-6033492
	60054	Aetna Life Insurance Company	06-6033492
	11183	Aetna Dental Inc (a New Jersey Corporation)	06-6033492
	N/A	Aetna Dental of California Inc.	06-6033492

Faulkner County

FORM 5500 and SCHEDULE C Data Report

01/01/17-12/31/17

FORM 5500 Data Report

Part I	**Annual Report Identification Information**	
A.	This return/report is for	A single-employer plan
Part II	**Basic Plan Information**	
1a.	Name of Plan	Faulkner County Employee Welfare Health Benefit Plan
1b.	Three-digit plan number (PN)	Client to Populate
1c.	Effective date of plan	1/1/2017
2a.	Plan Sponsor's Name and Address:	Faulkner County 801 Locust Street Conway AR 72034
2b.	Employer Identification Number (EIN)	71-6045509
2c.	Sponsor's telephone number	501-450-4900
2d.	Business code	Client to Populate
5	Total number of participants at the beginning of the plan year	332
6.	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).	
a(1).	Total number of active participants at the beginning of the plan year	331
a(2).	Total number of active participants at the end of the plan year	324
b.	Retired or separated participants receiving benefits	0
c.	Other retired or separated participants entitled to future benefits	0
d.	Subtotal. Add lines 6a, 6b, and 6c	324
8b.	If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions: Client to Populate	

FORM 5500 Schedule C Data Report

Part I Service Provider Information

1. Information on Persons Receiving Only Eligible Indirect Compensation

a Check "Yes" or "No" to indicate whether you are excluding a person from the remainder of this Part because they received only eligible indirect compensation for which the plan received the required disclosures (see instructions for definitions and conditions) ☐ Yes ☑ No

2. Information on Other Service Providers Receiving Direct or Indirect Compensation. Except for those persons for whom you answered "yes" to line 1a above, complete as many entries as needed to list each person receiving, directly or indirectly, $5,000 or more in total compensation (i.e., money or anything else of value) in connection with services rendered to the plan or their position with the plan during the plan year. (See instructions).

(a) Enter name and EIN or address (see instructions)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
CoreSource, Inc. 35-1846036	12, 14, 49	None	129,663	No	No	0	No
Aetna - PPO 06-6033492	12, 49	None	27,473	No	No	0	No
Hawkins, Jessen & Clayborn, LLC 27-1613685	16, 22	None	89,978	No	No	0	No
Conway Regional PHO 71-0749388	12, 49	None	7,826	No	No	0	No
Multiplan, Inc 13-3068979	12, 14, 49	None	6,226	No	No	0	No

Part I. 2. Explanation of Fields (per IRS form)
(b) Service Code(s)
(c) Relationship to employer, employee organization, or person known to be a party-in-interest
(d) Enter direct compensation paid by the plan. If none, enter -0-.
(e) Did service provider receive indirect compensation? (sources other than plan or plan sponsor)
(f) Did indirect compensation include eligible indirect compensation, for which the plan received the required disclosures?
(g) Enter total indirect compensation received by service provider excluding eligible indirect compensation for which you answered "Yes" to element (f). If none, enter -0-.
(h) Did the service provider give you a formula instead of an amount or estimated amount?

EXHIBIT A

INSTALLATION, ADMINISTRATIVE AND ADDITIONAL SERVICE FEES
Term: effective from January 1, 2018 through December 31, 2018

FAULKNER COUNTY

1. The following information is being provided to the undersigned pursuant to Prohibited Transaction Class Exemption 84-24 issued by the U.S. Department of Labor in order to exempt the proposed transactions between the Plan, Plan Sponsor and Plan Supervisor from any applicable prohibited transaction or provisions of ERISA. The following information is being provided to permit Plan Sponsor, as Plan Administrator to determine the compensation received by Plan Supervisor in the form of commissions, service fees and other similar payments is reasonable, that the services provided are necessary for the operation of the Plan and the provision of services by Plan Supervisor is in the best interest of the Plan.

2. The commission, installation, service fees, compensation arrangements and other similar payments to be provided under the Agreement are as set forth below. It is understood, however, that PPO Access Fees and other vendor fees, if applicable, are subject to the terms and conditions of the underlying agreement and may be subject to change at times other than the renewal date of this Agreement.

3. Pursuant to the Agreement for Plan Supervisor, Plan Sponsor shall remit to Plan Supervisor the following administrative fees and other costs:

Description of Service for the Faulkner County Employee Welfare Health Benefit Plan.	
• Medical Administration Fee	$14.78 per employee per month

4. In addition to the basic administrative services listed above, Plan Sponsor has agreed that the following services are to be performed by Plan Supervisor pursuant to the terms and conditions set forth in the applicable Addendum, or other description of services:

☑ **Claim Appeal Determination Addendum**	No Charge	
☑ **COBRA Administration Services Addendum**		
Description of Fee		
• COBRA Administration Fee	$1.32 per employee per month	
☑ **Health Care Management Services Addendum**		
Description of Fee		
• Review (CoreSource) (Includes Inpatient U/R, Large Case Mgt., Special Delivery)	$3.17 per employee per month	
YourCare (Health Fitness Corp.):		
• Advantage	$3.65 per employee per month	
☑ **CoreSource EdgeServices Addendum**	**Total Fee**	**Fee to Vendor**
Description of Fee – % of savings		
• Out of Network Claim Review (MultiPlan)		
o Complementary Network Discounts	30%	7.50%
o Negotiated Discounts/Data iSight	30%	7.50%
• Advanced Fraud, Waste and Abuse		
o Fraud Services (CoventBridge)	Hourly Rate (based on review/service)	
o Waste & Abuse Services (Change Healthcare)	30%	22%
• Subrogation (Conduent Payment Integrity Solutions fka Xerox)	30%	20%
• Medical Bill Review (HHC Group)		
o Line Item Bill Review	30%	20%
o Medical Record Review	30%	25%
o Claims Negotiation (if not eligible for Medical Bill Review)	30%	15%

Note: Any of the above vendors may be used to provide services.

☑ **Preferred Provider Arrangement (Plan Supervisor Contracts)–per employee per month**

Description of Fee	Total Fee	Fee to Vendor
• Conway PHO Alliance	$2.00	$2.00

Network Providers are solely responsible for the provision of medical care to Participants and exclusively maintain the physician/hospital-patient relationship with Participants. Plan Supervisor is neither directly nor indirectly a provider of medical services, and Plan Supervisor does not certify or guarantee the care or quality of care rendered by any network provider.

☑ **Aetna Signature Administrators Network Arrangement– per employee per month**

Description of Fee	Total Fee	Fee to Vendor
Network Access Fee	$8.23	$7.23
Aetna IOE Transplant Program	Included in Network Access Fee	

Plan Sponsor has indicated that it wishes Plan Supervisor to provide Plan Sponsor with access to the Aetna Signature Administrators® program ("ASA"). In order to access ASA services, Plan Sponsor understands and agrees that it shall be required to execute and abide by the terms of the Managed Care Services Agreement ("ASA Agreement"). Plan Sponsor's failure to comply with the terms of this Agreement and the ASA Agreement may result in termination of Plan Sponsor's access to ASA, in accordance with the terms of those contracts.

☑ **Include Sutter Health and its affiliates' facilities and providers (Sutter) in Aetna Signature Network. Plan Sponsor agrees to the following requirements:**
Sutter physicians determine whether services are medically necessary, non-experimental or non-investigational; therefore, no medical necessity, investigational or experimental exclusions or criteria shall be applied by Plan Supervisor to Sutter claims. The Plan Document shall be consistent with these requirements (Amended Plan Document). Plan Sponsor agrees to arbitrate any disputes with Sutter and Aetna. Plan Sponsor agrees to all other Sutter requirements as set forth in the Sutter and Aetna agreement as amended, which is available pursuant to an executed Aetna non-disclosure/confidentiality agreement. Plan Sponsor agrees to obtain written approval of its Amended Plan Document from its stop loss insurance carrier, and agrees that failure to obtain such written approval may result in the denial of stop loss insurance coverage for Sutter claims.

Network Providers are solely responsible for the provision of medical care to Participants and exclusively maintain the physician/hospital-patient relationship with Participants. Plan Supervisor is neither directly nor indirectly a provider of medical services, and Plan Supervisor does not certify or guarantee the care or quality of care rendered by any network provider.

☑ **CoreSource On-Line Payment Manager** **No Additional Charge**

CoreSource On-Line Payment Manager enables Participants to pay their own out-of-pocket obligations directly to providers. Plan Sponsor agrees that the CoreSource On-Line Payment Manager services are part of the Plan.

As of 1/1/18, SimpleRewards will no longer be earned for future payments made through the Online Payment Manager. SimpleRewards earned prior to 1/1/18 may be used until 12/31/19 subject to the rules of the program.

☑ **Relay Services** **No additional charge**

Plan Sponsor agrees to the release of eligibility data to Relay Network, LLC to provide telephonic messaging, including text messaging, to Participants who opt into the service. Such messaging shall include, but not be limited to, services and benefits available under the Plan, reminders on preventive care, surveys, and educational information.

☑ **Other Services and Expense Reimbursements**

Description of Fee	
• Broker Fee (Medical)	$9.00 per employee per month
• Annual Plan Document Legislative Review Fee	$1,000.00 annually

• Government Compliance Fee	Included in Medical Administration Fee
• CoreReport Fee**	Included in Medical Administration Fee

***If Plan Sponsor is given access to Verscend Health, Inc. ("Verscend") reporting it may use such Verscend reporting only for Plan Supervisor's/Plan Sponsor's own internal use to manage the cost of its Plan and not for the use or benefit of any other third party. Plan Sponsor shall maintain the confidentiality of the Verscend reporting and not reverse engineer, modify or change such Verscend reporting. Plan Sponsor shall limit access to the Verscend reporting to those employees that have a reasonable need for such access and will inform the employees who are allowed such access of the restrictions contained in this Agreement.*

• Physician Reviews (medical/dental)	Actual Cost
• American Dental Examiners	Actual Cost
• Medical Records Fees	Actual Cost
• Printing Costs	Actual Cost
• Postage Costs	Actual Cost
• Identification Cards	Actual Cost
• Other Miscellaneous Expenses	Actual Cost
• Funding Delinquency Notice	$ 5.00 per letter

The Plan Supervisor may assign or subcontract a portion of its duties to others, including an affiliate, Trustmark Insurance Company.

5. Commissions/premiums on insurance policies are payable as set forth below.

		Commissions Payable To:	
	Premium	**Plan Supervisor**	**Broker**
Specific Stop Loss Employee	$61.46	***See Below**	***See Below**
Specific Stop Loss Family	$168.68	***See Below**	***See Below**
Aggregate Stop Loss	$9.84	***See Below**	***See Below**
Other Insured Coverages	N/A or list		

*Specific and aggregate costs shown have been loaded to include 15% stop loss fees paid to the broker. Actual contracts will reflect "net" fees paid to the carrier. Monthly invoices will reflect costs shown above with fees included.

Plan Supervisor receives 3% of the stop loss premium as compensation from Aetna during Plan Sponsor's first stop loss policy year, and 2% for a renewal year.

ACKNOWLEDGMENT AND APPROVAL

The undersigned Plan Sponsor hereby certifies that he/she (1) is authorized to sign on behalf of the Plan Administrator and the Plan, (2) acknowledges receipt of the foregoing explanation of services and fees and has read and understands it, and (3) approves the purchase of such insurance (if applicable) and the payment to Plan Supervisor of such sales commissions, service fees and other compensation arrangements as listed. The addenda attached hereto are hereby incorporated into the Agreement.

PLAN SPONSOR & PLAN ADMINISTRATOR

Jim Baker

Signature

Jim Baker

Print Name

Title: Faulkner County Judge

Date: 6-5-18

CORESOURCE, INC.

Kimberly A Fiori

Signature

Kimberly A. Fiori

Print Name

Title: Regional President

Date: June 21, 2018

AMENDMENT NO. 2
FOR
FAULKNER COUNTY
EMPLOYEE WELFARE HEALTH BENEFIT PLAN

I. Effective January 1, 2018, the section "**SCHEDULE OF BENEFITS**" shall be amended as follows:

Under the heading "**MEDICAL BENEFITS,**" the subsection "**Copays per Admission or Occurrence**" shall be deleted in its entirety and the following substituted therefore:

	Preferred Provider	***Nonpreferred Provider***
Copays Per Admission Or Occurrence: (Refer to *Medical Expense Benefit, Copay*)		
Emergency Room Visits	$300 *copay* per visit	$300 *copay* per visit
Urgent Care Center Visits	$50 *copay* per visit	N/A

II. Effective January 1, 2018, the section "**SCHEDULE OF BENEFITS**" shall be amended as follows:

Under the heading "**MEDICAL BENEFITS,**" in the subsection "**BENEFIT DESCRIPTION,**" the benefits for "**Emergency Room Services**" and "**Therapy Services**" shall be deleted in their entirety and the following substituted therefore:

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount***, if applicable, otherwise % of ***negotiated rate***)
Emergency Room Services	*100% after $300 *copay*	*100% after $300 *copay*
Therapy Services		
Physical, Speech, Occupational Limitation: 20 visit ***Essential Health Benefits maximum benefit*** per calendar year for each therapy	*100% after $20 *copay*	65%
Dialysis Therapy or Treatment	90%	Not Covered
All Other Covered Therapy	90%	65%

* **Deductible Waived**

III. Effective January 1, 2018, the section "**SCHEDULE OF BENEFITS**" shall be amended as follows:

Under the heading "**PRESCRIPTION DRUG PROGRAM**," the subsection "**Pharmacy Option**" shall be deleted in its entirety and the following substituted therefore:

Pharmacy Option	
Prescription Drug Card	100% after ***copay***
Copay	Generic: $10 ***copay***
	Single Source Brand Name: $30 ***copay***
	Multiple Source Brand Name: $60 ***copay***
	Specialty Drugs: $250 ***copay***
Limitation: Specialty Drugs 30 day supply All Other Retail Drugs 31 day supply	

IV. Effective January 1, 2018, the section "**PREFERRED PROVIDER OR NON-PREFERRED PROVIDER**" shall be amended as follows:

In the subsection "**Exceptions**," the following item #13 and #14 shall be added to the first paragraph and made part of the ***Plan***:

13. Transportation by a ***nonpreferred provider*** ambulance for a condition that meets the definition of ***emergency***.

14. Lactation counseling providers.

V. Effective January 1, 2018, the section "**MEDICAL EXPENSE BENEFIT**" shall be amended as follows:

In the subsection "**Routine Preventive Care/Wellness Benefits**," in the list in the first paragraph, items #2 and #6 shall be deleted in their entirety and the following substituted therefore:

2. Colonoscopies, including pre-procedure consultation, bowel preparation kits and pathology exam, for adults age fifty (50) and over. Refer to *Colorectal Cancer Examinations* below for complete details.

6. Screening for tobacco use and office visits for tobacco cessation. Tobacco cessation products and medications shall be covered under the *Prescription Drug Program* only. ***Covered expenses*** include two (2) tobacco cessation attempts per calendar year.

VI. Effective January 1, 2018, the section "**MEDICAL EXPENSE BENEFIT**" shall be amended as follows:

In the subsection "**Women's Preventive Services**," the following item #9 shall be added to the list in the first paragraph and made part of the ***Plan***:

9. Genetic counseling for women identified to be at higher risk of having a potentially harmful gene mutation, and, if indicated, BRCA testing for harmful BRCA mutations.

VII. Effective January 1, 2018, the section "**MEDICAL EXPENSE BENEFIT**" shall be amended as follows:

In the subsection "**Mastectomy (Women's Health and Cancer Rights Act of 1998),**" item #1 in the third paragraph shall be deleted in its entirety and the following substituted therefore:

1. reconstruction of a surgically removed breast, including nipple and areola reconstruction and repigmentation; and

VIII. Effective January 1, 2018, the section "**MEDICAL EXPENSE BENEFIT**" shall be amended as follows:

The subsection "**Surcharges**" shall be deleted in its entirety and the following substituted therefore:

SURCHARGES

Any surcharge or assessment (by whatever name called) on ***covered expenses***, required by state or federal law to be paid by the ***Plan*** for services, supplies and/or treatments rendered by a health care provider shall be a ***covered expense*** subject to the ***covered person's*** obligations under the ***Plan***.

IX. Effective March 1, 2017, the following sections shall be added and made part of the ***Plan***:

ONLINE PAYMENT MANAGER

Claim processor offers the CoreSource Online Payment Manager service that enables eligible ***covered persons*** to pay their out-of-pocket obligations directly to providers.

RELAY SERVICES

Relay Network, LLC provides telephonic messaging, including text messaging, to ***covered persons*** who opt into the service. Such messaging shall include, but not be limited to, information about services and benefits available under the ***Plan***, reminders on preventive care, surveys, and educational information.

X. Effective January 1, 2017, the section "**MEDICAL EXCLUSIONS**" shall be amended as follows:

Exclusion #44 shall be deleted in its entirety and the following substituted therefore:

44. Charges for drugs, devices, supplies, treatments, procedures or services that are considered ***experimental/investigational*** by the ***Plan***. The ***Plan*** will consider a drug, device, supply, treatment, procedure or service to be "***experimental***" or "***investigational***":

    a. if, in the case of a device or supply, the device or supply cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device or supply is furnished; or

    b. if the drug, device, supply, treatment, procedure or service, or the patient's informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was reviewed and approved by the treating ***facility's*** institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

c. if the ***plan sponsor*** (or its designee) determines in its sole discretion that the drug, device, supply, treatment, procedure or service is the subject of on-going Phase I or Phase II clinical trials; is the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy, however, a drug, device, supply, treatment, procedure or service that meets the standards set in the section *Medical Expense Benefit Phase III Oncology Clinical Trials* or *Off-Label Drug* Use will not be deemed ***experimental*** or ***investigational*** solely by reason of this subparagraph; or

d. if the ***plan sponsor*** (or its designee) determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

Note: This exclusion does not apply to services, supplies or treatments provided by Sutter Health and its affiliates' facilities and providers when the ***Preferred Provider Organization*** is the Aetna Signature Administrators (ASA) network.

XI. Effective January 1, 2018, the section "**PRESCRIPTION DRUG PROGRAM**" shall be amended as follows:

The following subsection shall be added and made part of the ***Plan***:

GENERIC STEP THERAPY PROGRAM

When more than one prescription drug may be used to treat a condition, the Generic Step Therapy Program requires the use of a generic drug prior to this ***Plan*** providing coverage of a brand name drug.

When a ***covered person*** seeks to purchase a brand name drug at a pharmacy or by a mail order pharmacy, a generic drug may be recommended by the pharmacist after consulting with the prescribing ***physician***. If the ***covered person*** does not purchase such recommended generic drug, the ***covered person*** will be responsible for the full cost of the brand name drug and the brand name drug will be excluded from coverage under this ***Plan***.

XII. Effective January 1, 2018, the section "**PRESCRIPTION DRUG PROGRAM**" shall be amended as follows:

The subsection "**Appealing a Denied Post- Service Prescription Drug Claim**" shall be deleted in its entirety and the following substituted therefore:

APPEALING A DENIED POST- SERVICE PRESCRIPTION DRUG CLAIM

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***claims processor*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person*** for a full and fair review:

1. The ***covered person*** has the right to submit documents, information and comments and to present evidence and testimony.

2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. Before a final determination on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the ***covered person*** a reasonable opportunity to respond. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.
4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
5. The review by the ***claims processor*** will not afford deference to the original denial.
6. The ***claims processor*** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
   a. The ***claims processor*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
   b. The ***professional provider*** utilized by the ***claims processor*** will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
8. If requested, the ***claims processor*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

XIII. Effective January 1, 2017, the section "**PLAN EXCLUSIONS**" shall be amended as follows:

Exclusions #6 and #11 shall be deleted in their entirety and the following substituted therefore:

6. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury***, or which are not recommended and approved by the attending ***physician***, except as specifically stated herein, or to the extent that the charges exceed ***customary and reasonable amount*** or exceed the ***negotiated rate***, as applicable. **Note:** The portion of this exclusion for services, supplies and treatment which are not ***medically necessary*** does not apply to services, supplies or treatments provided by Sutter Health and its affiliates' facilities and providers when the ***Preferred Provider Organization*** is the Aetna Signature Administrators (ASA) network.

11. Charges for services, supplies or treatment that are considered ***experimental/investigational***, except as specified herein. **Note:** This exclusion does not apply to services, supplies or treatments provided by Sutter Health and its affiliates' facilities and providers when the ***Preferred Provider Organization*** is the Aetna Signature Administrators (ASA) network.

XIV. Effective January 1, 2018, the section "**PLAN EXCLUSIONS**" shall be amended as follows:

Exclusion #17 shall be deleted in its entirety and the following substituted therefore:

17. Charges for e-mail consultations, completion of claim forms, charges associated with missed appointments.

XV. Effective January 1, 2018, the section "**MEDICAL CLAIM FILING PROCEDURE**" shall be amended as follows:

Under the heading "**POST-SERVICE CLAIM PROCEDURE,**" the subsection "**Appealing a Denied Post-Service Claim**" shall be deleted in its entirety and the following substituted therefore:

APPEALING A DENIED POST-SERVICE CLAIM

A ***covered person,*** or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***claims processor*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person*** for a full and fair review:

1. The ***covered person*** has the right to submit documents, information and comments and to present evidence and testimony.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. Before a final determination on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination. However there could be circumstances where the new or additional evidence or rationale could be received so late that it would be impossible to provide the ***covered person*** in time to have a reasonable opportunity to respond. In these circumstances, the period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.
4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
5. The review by the ***claims processor*** will not afford deference to the original denial.
6. The ***claims processor*** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
   a. The ***claims processor*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
   b. The ***professional provider*** utilized by the ***claims processor*** will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
8. If requested, the ***claims processor*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

XVI. Effective January 1, 2018, the section "**MEDICAL CLAIM FILING PROCEDURE**" shall be amended as follows:

Under the heading "**PRE-SERVICE CLAIM PROCEDURE,**" the subsection "**Appealing a Denied Pre-Service Claim**" shall be deleted in its entirety and the following substituted therefore:

APPEALING A DENIED PRE-SERVICE CLAIM

A ***covered person*** (or authorized representative) may request a review of a denied Pre-Service claim by making a verbal or written request to the ***claims processor*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied. If the ***covered person*** (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to *Post-Service Claim Procedure* discussion above.)

The following describes the review process and rights of the ***covered person*** for a full and fair review:

1. The ***covered person*** has the right to submit documents, information and comments and to present testimony.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. Before a final determination on appeal is rendered, the ***covered person*** will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the ***Plan*** in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the ***covered person*** a reasonable opportunity to respond. The period for providing notice of final determination on appeal will be tolled until the earliest of the following dates:
   a. The date the ***covered person*** responds to the new or additional rationale or evidence; or
   b. Three (3) weeks from the date the new or additional rationale or evidence was mailed to the ***covered person***.
4. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
5. The review by the ***claims processor*** will not afford deference to the original denial.
6. The ***claims processor*** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
7. If original denial was, in whole or in part, based on medical judgment:
   a. The ***claims processor*** will consult with a ***claims processor*** who has appropriate training and experience in the field involving the medical judgment; and
   b. The ***professional provider*** utilized by the ***claims processor*** will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
8. If requested, the ***claims processor*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

XVII. Effective January 1, 2018, the section "**GENERAL PROVISIONS**" shall be amended as follows:

The subsections "**Assignment**" and "**Legal Actions**" shall be deleted in their entirety and the following substituted therefore:

ASSIGNMENT

Coverage and the ***covered person's*** rights under this ***Plan*** may not be assigned. A direction to pay a provider is not an assignment of any right under this ***Plan*** or of any legal or equitable right to institute any court proceeding.

Payment of Benefits

Benefits will be processed as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. All covered health benefits are payable to the ***covered person***. However, the ***Plan*** has the right to pay any health benefits to the service provider. This will be done unless the ***covered person*** has told the ***claims processor*** otherwise by the time the ***covered person*** files the claim and a reasonable amount of time for the ***claims processor*** to process the ***covered person's*** request.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatments have been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate***, after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider***.

The ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

Additional Provisions

The ***Plan's***, ***plan sponsor's***, ***claim processor's*** failure to implement or insist upon compliance with any provision of this ***Plan*** at any given time or times, shall not constitute a waiver of the right to implement or insist upon compliance with that provision at any other time or times.

LEGAL ACTIONS

The decision by the ***plan administrator/claims processor*** on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. All claim review procedures provided for in this Plan Document must be exhausted before any legal or equitable action is brought. Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the ***Plan***, ***plan administrator/claims processor***, any other fiduciary, or their employees, must be filed within one (1) year from the date all claim review procedures provided for in this Plan Document have been exhausted.

XVIII. Effective January 1, 2018, the section "**DEFINITIONS**" shall be amended as follows:

The definition for "***Professional Provider***" shall be deleted in its entirety and the following substituted therefore:

Professional Provider

A licensed ***physician***; surgeon; or any other licensed practitioner required to be recognized by state law, if applicable, and performing services within the scope of such license, who is not a family member.

Received and accepted for Faulkner County

SERVICE AGREEMENT

THIS SERVICE AGREEMENT is dated and effective as of January 1, 2018 ("Effective Date"), by and between MEDTRAK SERVICES, LLC, a Missouri limited liability company ("MedTrak"), and FAULKNER COUNTY, ARKANSAS, organized under the laws of the State of Arkansas ("Client").

WHEREAS, Client is a Plan Sponsor that desires to provide a pharmacy benefit to its Eligible Members;

WHEREAS, MedTrak is engaged in the business of administering pharmacy benefits for Plan Sponsors; and

WHEREAS, Client desires to engage MedTrak to administer the Pharmacy Benefit on behalf of Client in accordance with the terms of this Agreement.

NOW, THEREFORE, in consideration of the mutual covenants set forth herein, the parties agree as follows:

1. DEFINITIONS

1.1 "Agent" shall mean a third party administrator, consultant, trustee(s), or any other party or entity appointed or authorized by Client to represent Client in its relationship with MedTrak.

1.2 "Agreement" shall mean this Service Agreement (including all exhibits, addenda, amendments, and other attachments, if any) between Client and MedTrak, as may be amended or modified from time to time.

1.3 "Cardholder" shall mean an Eligible Member to whom Client (or its Agent) or MedTrak has issued an identification card (or form), whose name and identification number appear on the identification card (or form), and whose identification card (or form) is valid.

1.4 "Claim" shall mean a request from a Participating Pharmacy or a Cardholder to process and adjudicate a Covered Medication for an Eligible Member.

1.5 "Covered Medication" shall mean any Drug Product prescribed by a Physician for an Eligible Member that meets the requirements for coverage as set forth in the Plan.

1.6 "Dependent" shall mean an Eligible Member who is related to a Cardholder, as identified by Client (or its Agent).

1.7 "Drug Product" shall mean a drug whose active ingredient(s), strength(s), and dosage form are listed in the "Approved Drug Products with Therapeutic Equivalence Evaluations" (commonly known as the "Orange Book"), which is an official publication of the U.S. Food and Drug Administration ("FDA").

1.8 "Eligible Member" shall mean an individual who is enrolled in a Plan and who is entitled to receive reimbursement for, or payment of, Covered Medications under the Pharmacy Benefit for the Plan in which the individual is enrolled.

1.9 "Formulary" shall mean a standard preferred list of Covered Medications, as determined by the MedTrak Pharmacy & Therapeutics Committee (or such other Pharmacy & Therapeutics Committee as designated by MedTrak and agreed to by Client), and provided, as necessary, to Physicians, Participating Pharmacies and/or Eligible Members as a guide to the prescribing, dispensing, and purchasing of Covered Medications.

1.10 "Participating Pharmacy" shall mean a duly licensed pharmacy that has signed a Pharmacy Services Agreement (or similarly named agreement) with MedTrak to provide Pharmacy Services to Eligible Members in accordance with the requirements in such agreement.

1.11 "Pharmacy Benefit" shall mean the inclusions, limitations, and exclusions in coverage of Eligible Members, Participating Pharmacies, Physicians, and Covered Medications as set forth in the Plan and as may be amended from time to time by the Plan Sponsor.

MEDTRAK Rx

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1.12 "Pharmacy Services" shall include the dispensing of a Drug Product by a Participating Pharmacy, in accordance with all applicable state and federal laws governing the practice of pharmacy and in accordance with the standards of practice in the communities in which the Participating Pharmacy operates.

1.13 "Physician" shall mean any Doctor of Medicine or other health care practitioner who is legally authorized to prescribe Drug Products in the state(s) in which he/she is licensed.

1.14 "Plan" shall mean the agreement or other arrangement between an Eligible Member and his/her Plan Sponsor that entitles the Eligible Member to receive reimbursement for, or payment of, medical expenses, including, without limitation, Covered Medications.

1.15 "Plan Sponsor" shall mean an employer, employer coalition, health insurer, managed care organization, association, union health and welfare trust, government agency, third party administrator, or other such organization that is obligated to pay for Covered Medications dispensed to Eligible Members.

1.16 "Point-of-Sale" or "POS" shall mean the on-line, real-time telecommunication system used by MedTrak to communicate information regarding eligibility, Claims, drug utilization, and other information to a Participating Pharmacy.

1.17 "System" shall mean the hardware and the software used to process Claims.

2. DUTIES OF MEDTRAK

2.1 MedTrak agrees to provide, through its Participating Pharmacies, Covered Medications to Eligible Members in accordance with the terms of this Agreement, if such Eligible Members present a prescription order or refill from a Physician and a valid identification card (or form) at Participating Pharmacies signifying their entitlement to such Covered Medications.

2.2 MedTrak agrees to provide "Administration Services", as described in Exhibit A, including, but not limited to, the processing and adjudication of Claims for Covered Medications submitted by Participating Pharmacies for Eligible Members.

2.3 MedTrak shall allow Client (and its Agent) to use the name of MedTrak for purposes of marketing, informing Eligible Members and others of the identity of Participating Pharmacies, and as otherwise necessary to carry out the terms of this Agreement. Notwithstanding the foregoing, MedTrak hereby reserves the right, in its sole discretion, to require Client (and/or its Agent) to cease using the name of MedTrak for any reason whatsoever.

2.4 MedTrak shall use reasonable efforts to provide Client with assistance in coordinating and responding to formal complaints or appeals from Eligible Members under the Plan; however, MedTrak will not be responsible or liable in any manner for Client's compliance or non-compliance with the terms and conditions of the Plan or applicable laws or regulations regarding responding to Eligible Members' complaints or appeals. Client is solely responsible for the review and final resolution of complaints from Eligible Members. MedTrak shall review the appeal of eligible denied claims pursuant to the process set forth on Exhibit C.

2.5 MedTrak acknowledges that in administering Client's Pharmacy Benefit, MedTrak will receive health information from Client such that MedTrak will be considered to be Client's "Business Associate," as that term is defined by the Health Insurance Portability and Accountability Act of 1996, and the implementation regulations governing privacy and security of certain information thereunder ("HIPAA"). Specifically, with respect to protected health information ("PHI") as that term is defined by HIPAA, MedTrak agrees to comply with the provisions in the Business Associate Addendum set forth on Exhibit B, attached hereto and incorporated by this reference.

2.6 MedTrak may, at its sole discretion, audit Participating Pharmacies to ensure the Participating Pharmacies' compliance with their contracts with MedTrak. Selection of Participating Pharmacies and the method of audit shall be determined solely by MedTrak. MedTrak, in its discretion, may perform the audit or select an outside firm to perform the audit. To compensate MedTrak for the cost of conducting such audits, MedTrak shall be entitled to retain twenty percent (20%) of any overpayment to any Participating Pharmacy that is detected and recovered as a result of any such audit, and which is attributable to a Plan or its Eligible Members; provided that MedTrak shall pay the balance of any such recovered overpayment to Client, prorated to the amount attributable to Client's Plan or Eligible Members.

3. DUTIES OF CLIENT

3.1 Client agrees and expressly acknowledges that—in the event Client appoints an Agent—MedTrak shall be authorized to deal with Agent in all respects as if it were the Client for purposes of this Agreement, and Client waives any right to the contrary. Client further expressly acknowledges any act or omission by such Agent shall be within the scope and authority of such Agent and binding upon Client and that any agreement Client shall have with Agent shall have no bearing or effect on this Agreement.

3.2 Client (or its Agent) has provided MedTrak, thirty (30) days prior to the Effective Date (and will provide as necessary thereafter), Eligible Member information, including, but not limited to, Cardholder name, Cardholder identification number, Cardholder address, Cardholder birth date, Cardholder eligibility begin date, Cardholder eligibility end date, Dependent name(s), Dependent birth date(s), Dependent eligibility begin date, and Dependent eligibility end date. Client (or its Agent) shall provide such information in a format agreeable to MedTrak. Client agrees that MedTrak may act in reliance upon the accuracy of all Eligible Member information received from Client (or its Agent).

3.3 Client (or its Agent) agrees to distribute, or pay MedTrak to distribute in accordance with Exhibit D, the "Cardholder Information" described in Exhibit A to Cardholders upon receipt from MedTrak or Agent.

3.4 Client (and its Agent) agrees to grant Participating Pharmacies the status of "Client Participating Pharmacies" and to identify such Participating Pharmacies as "Preferred Pharmacies", or other language of like import, on informational materials distributed to Eligible Members and others.

3.5 Client (and its Agent) understands and agrees that MedTrak shall have the right to collect and use aggregate data on Covered Medications and that MedTrak shall have ownership rights to all such data and statistics. Client (and its Agent) further understands and agrees that, in order to provide services hereunder, MedTrak may be required to submit data on Covered Medications to pharmaceutical manufacturers pursuant to the terms of agreements with those pharmaceutical manufacturers; provided, however, that such information furnished to pharmaceutical manufacturers shall not identify Eligible Members by name or otherwise, except in connection with any audit required by such pharmaceutical manufacturers.

3.6 Client (and its Agent) shall not constrain MedTrak from communicating with Eligible Members and/or their Physicians, when necessary, to carry out its obligations as set forth in this Agreement.

3.7 With respect to all services and programs provided under this Agreement, MedTrak shall not be liable in the event any such services or programs do not provide the intended savings to Client, unless such savings amounts are explicitly stated in this Agreement.

3.8 Client shall comply with the HIPAA provisions included in the Business Associate Addendum set forth on Exhibit B, attached hereto and incorporated by this reference.

4. MEDTRAK COMPENSATION

4.1 Client agrees to pay MedTrak by ACH or other form of electronic funds transfer the "Paid Claim Charges", "Miscellaneous Charges", "Program Charges", and all other applicable charges as set forth in Exhibit D. Client shall make all such payments twice a month within ten (10) days of the invoice statement date. Client agrees to pay interest at a rate of one and one-half percent (1.5%) per month on any balance due at the time of the next billing; however, in no event shall such interest rate be greater than the highest rate permitted by applicable law. Client acknowledges that, in the event Client fails to pay any Paid Claim Charges, Miscellaneous Charges, Program Charges, other applicable charges, or interest due within thirty (30) days of the invoice statement date, MedTrak reserves the right to immediately suspend all POS system activity until Client makes payment to MedTrak in full and/or to offset any amounts owed by MedTrak to Client pursuant to this Agreement.

4.2 Client acknowledges that, in the event Client requests MedTrak to provide services that are not defined in this Agreement, Client shall pay additional charges, which shall be mutually agreed upon by both parties in writing.

4.3 Notwithstanding anything contained in this Agreement to the contrary, if the Faulkner County Quorum Court fails to appropriate funds for a subsequent period within the term of this Agreement, Client shall not be obligated to make payments beyond the then current fiscal appropriations period. If MedTrak shall have received a written notification of the occurrence of the following events:

4.3.1 Funds are not appropriated for a subsequent period during the Term of this Agreement for the use or acquisition of products, services and functions which are the subject of the Agreement;
4.3.2 County has exhausted all funds legally available for all payments due under this Agreement; and
4.3.3 Such non-appropriation did not result from any act or failure to act of the County Judge's Office.

Then, MedTrak's only remedy shall be to terminate this Agreement at the end of the period which notice is given and take possession of any equipment owned by MedTrak. MedTrak shall be entitled, however, to any payments and other payments due and owing during any previous period.

4.4 MedTrak uses Average Wholesale Price (often referred to as AWP, and as defined on Exhibit D) as its Drug Product pricing statistic to calculate "Paid Claim Charges," as defined and described in Exhibit D. If, for any reason, MedTrak decides to change its Drug Product pricing statistic ("Change Event"), then MedTrak shall notify Client sixty (60) days prior to the implementation date of such change ("Change Date"). If the methodology for calculating Paid Claim Charges using the new Drug Product pricing source would result in a material increase or decrease in Paid Claim Charges to Client, the parties shall mutually agree on an adjustment factor to be applied to the Paid Claim Charges incurred on and after the Change Date that is equivalent to the Paid Claim Charges increase or decrease experienced by Client due to the Change Event. If the parties cannot mutually agree to an adjustment factor by the Change Date, then either party hereto may terminate this Agreement upon thirty (30) days' prior written notice.

5. TERM

5.1 The term of this Agreement shall commence on the Effective Date and continue for a period of three (3) years (the "Initial Term"). At the end of the Initial Term, this Agreement shall automatically renew for successive one (1) year periods (each, a "Renewal Term"), unless either party hereto provides written notice to the other party at least ninety (90) days prior to the expiration of the then-current term of its intent to either terminate or renegotiate this Agreement.

5.2 Either party hereto may terminate this Agreement if the other party materially breaches its obligations. The termination must be by written notice specifically identifying the breach, and such termination shall become effective thirty (30) days after the notice, unless the breach is corrected during the thirty (30)-day period (the "Cure Period"). MedTrak shall provide Pharmacy Benefit Administration Services on all Covered Medications submitted prior to the termination date.

5.3 MedTrak is the exclusive provider to Client of the Pharmacy Benefit Administration Services as described in this Agreement. During the term of this Agreement, Client shall not directly or indirectly engage any individual, proprietorship, partnership, or corporation operating the same or similar business as MedTrak, including, without limitation, Pharmacy Services provided through the mail or other similar delivery system. In the event Client breaches this or any other section in this Agreement, MedTrak shall have the right to withhold all amounts due to Client under this Agreement to offset the damages related to such breach.

5.4 In the event this Agreement is terminated due to (i) Client's breach pursuant to Section 5.2 of the Agreement, (ii) Client's early termination of this Agreement, or (iii) Client's ceasing to use MedTrak's Pharmacy Benefit Administration Services prior to the expiration of the Initial Term or any Renewal Term hereof (each, a "Client Wrongful Termination"), MedTrak and Client acknowledge and agree that MedTrak will suffer damages (including without limitation lost profits), which will be difficult to determine during any subsequent litigation. In order to compensate MedTrak for such difficult-to-determine damages, MedTrak shall be entitled to recover liquidated damages from Client as calculated in this Section 5.4, and which liquidated damages are intended as a measure of compensation to MedTrak rather than as a penalty or punishment to Client. The amount of liquidated damages to which MedTrak shall be entitled hereunder shall be the estimated amount of net revenue ("Net Revenue") MedTrak would have received under this Agreement, if not for the Client Wrongful Termination. This amount shall be calculated by multiplying the Average Monthly Net Revenue (as defined below) by the number of months remaining under the Initial Term or Renewal Term, as applicable. The "Average Monthly Net Revenue" shall equal the amount of Net Revenue received by MedTrak from Client during the twelve-month period immediately preceding the Client Wrongful Termination, divided by twelve (12); provided, however, in the event the Client Wrongful Termination occurs less than twelve (12) months after the Effective Date, the Average Monthly Net Revenue shall equal the amount of Net Revenue received by MedTrak from Client since the Effective Date, divided by the number of full calendar months since the Effective Date. The parties acknowledge and agree that nothing contained in this Section 5.4 shall be deemed to restrict Client's rights to recover damages from MedTrak in the event of MedTrak's breach of this Agreement.

5.5 A breach by MedTrak of any material provision of this Agreement shall constitute a material breach of the Agreement and shall provide grounds for termination of the Agreement by the Client; provided MedTrak is unable to cure such breach within the applicable cure period provided in the Agreement. Notwithstanding the foregoing, Client may terminate the Agreement, without penalty, effective immediately, if (i) MedTrak is named as a defendant in a criminal proceeding for a material violation under HIPAA; or (ii) a finding or stipulation that MedTrak violated any standard or requirement of HIPAA or any other applicable laws relating to the security or privacy of PHI, or which is entered against MedTrak in any administrative or civil proceeding in which MedTrak has joined.

6. CONFIDENTIALITY

6.1 MedTrak retains the exclusive rights to the names MedTrak Services, LLC, MedTrak Services, MedTrakRx, and MedTrak, together with any distinctive trademark and/or service mark that may hereinafter be adopted.

6.2 All confidential and proprietary information of MedTrak ("MedTrak Confidential Information") includes, but is not limited to, MedTrak's System information, reporting packages, proprietary software and user documentation, manuals, Formulary documents, Participating Pharmacy agreements, any information about MedTrak's rates, fees or charges, this Agreement and its terms and conditions, and any additional information typically considered confidential and proprietary. Client (and its Agent) shall not use any MedTrak Confidential Information or disclose it to any third party, at any time during or after termination of this Agreement, except as specifically contemplated in this Agreement or upon MedTrak's prior written consent. Upon termination of this Agreement, Client (and its Agent) shall cease using all MedTrak Confidential Information provided to Client (or its Agent) by MedTrak and shall return the same to MedTrak immediately upon MedTrak's request. Not withstanding the foregoing or anything to the contrary contained in this Agreement, Client shall be permitted to disclose Confidential Information pursuant to any required disclosure under the Freedom of Information Act which cannot legally be redacted or withheld.

6.3 The parties shall maintain the confidentiality of any information relating to Eligible Members in accordance with any applicable laws and regulations. However, the parties acknowledge that—in providing services under this Agreement—MedTrak shall obtain confidential information about Eligible Members and may distribute such confidential information to Client (and its Agent), Participating Pharmacies, and Physicians. Client shall ensure that there is adequate release from Eligible Members, or that release of confidential information relating to Eligible Members is otherwise proper, in regard to any information about Eligible Members provided to MedTrak or by MedTrak to Client (or its Agent), Participating Pharmacies, or Physicians. Client (and its Agent) shall also ensure that its use of Eligible Member information is in compliance with applicable laws and regulations.

6.4 The parties hereto shall maintain appropriate records relating to their responsibilities under this Agreement. Annually during the term of this Agreement and once during the year immediately following termination of this Agreement upon reasonable prior notice and during normal business hours, each party hereto may have reasonable access to the records of the other party directly relating to such other party's responsibilities and performance under this Agreement. The scope of such audit will be limited to Eligible Member Claims adjudicated in the Agreement year immediately preceding the year in which the audit is conducted. Each party hereto shall pay the reasonable cost of copying records requested from the other party during an audit hereunder, and any other reasonable reproduction costs incurred by the other party in complying with the audit request. A third party may be allowed or designated by the auditing party hereunder to conduct an audit with the prior written consent of the party hereto whose records are to be audited, which consent shall not be unreasonably withheld; provided, however, that the audited party shall have the right to refuse the auditing party's auditor if the proposed auditor reasonably may acquire a competitive advantage by gaining access to the audited party's confidential information as described in this Section 6. In addition, the third party auditor shall enter into a reasonable confidentiality agreement with the audited party prior to conducting any audit hereunder.

7. RELATIONSHIP OF THE PARTIES

7.1 Client specifically acknowledges that MedTrak shall have no fiduciary duties whatsoever to Client or any Eligible Member either arising under this Agreement or under any Plan. Client and MedTrak acknowledge and agree that MedTrak has no discretionary authority or discretionary control to negotiate on behalf of Client (or its Agent, any Plan, or Plan Sponsor) any prices, rates, rebates, discounts or other terms for Pharmacy Services. Client acknowledges that it, or its Agent or Plan Sponsor, will retain at all times sole authority to control and administer its Plan and its Pharmacy Benefit, including without limitation any Eligible Member complaints or appeals under such Plan.

7.2 Client and MedTrak are separate and independent entities. They recognize that they are neither partners nor joint venturers and that they are not liable for, assuming, or guaranteeing the debts and obligations of each other. No provision of this Agreement is intended to create, nor shall be deemed or construed to create, any relationship between Client and MedTrak other than that of independent entities contracting with each other solely for the purpose of fulfilling the provisions of this Agreement. Neither of the parties hereto, nor any of their respective representatives, shall be construed to be the agent, the employer, or the representative of the other except for the limited purpose stated in Section 7.3 below.

7.3 Nothing expressed or implied in this Agreement is intended to confer—nor shall anything herein confer—any rights, remedies, obligation, or liabilities whatsoever upon any person other than the Client, MedTrak, and their respective successors and assigns.

7.4 Client acknowledges and agrees that MedTrak is acting solely in the capacity as Client's paying agent in processing claims and making payments from funds provided by Client as part of its Administrative Services as described in Exhibit A. The Client shall be responsible for filing all state and federal reporting forms, if any, with respect to such claim payments.

7.5 MedTrak shall indemnify and hold Client harmless from and against any liabilities, claims, damages, injuries, costs, expenses and fees, including reasonable attorneys' fees, whether relating to persons or property (collectively, "Losses") related to any claim, order, suit, investigation, or action by a third party (a "Claim") which arises out of (i) the willful misconduct or negligent acts or omissions of MedTrak, or (ii) any breach of this Agreement by MedTrak.

7.6 Client shall indemnify and hold MedTrak harmless from and against any Losses related to any Claim which arises out of (i) the willful misconduct or negligent acts or omissions of Client, (ii) any breach of this Agreement by Client, or (iii) the benefit design or coverage decisions under the Plan.

7.7 In the event either party intends to seek indemnification under Section 7.5 or 7.6, such party shall promptly notify the other party in writing upon learning of a Claim for which indemnification will be sought. However, a failure to provide such notice will only limit the indemnifying party's obligation to indemnify to the extent the ability to defend was jeopardized due to the failure to provide prompt notice.

7.8 Except as provided in Section 5.4 hereof, neither party (nor their respective employees, directors, affiliates, or agents) shall be liable to the other for any special, consequential, incidental, indirect, punitive, or exemplary damages. Except as set forth in Sections 7.5 and 7.6, neither party's liability to the other shall exceed the direct, actual Losses related to a breach of this Agreement

8. MISCELLANEOUS

8.1 The terms of this Agreement shall be governed by the laws of the state of Arkansas.

8.2 This Agreement may not be amended, supplemented or changed in any manner except by a written instrument executed by both parties.

8.3 This Agreement shall be binding upon, and shall inure to the benefit of, the parties hereto and their respective heirs, personal representatives, executors, administrators, successors and assigns. Either party hereto may assign its respective rights hereunder to any successor or assign as long as such successor or assign also assumes all of the obligations of the party making such assignment. Client acknowledges that persons and entities under contract with MedTrak may perform certain administrative services pursuant to this Agreement, provided that MedTrak (or its assignee) shall remain responsible for the proper performance of its obligations in accordance with the terms of this Agreement. The obligations of Client hereunder may not be assigned nor any portions of Client's duties subcontracted without the prior written consent of MedTrak, which shall not be unreasonably withheld.

8.4 This Agreement and any schedules, exhibits, and/or addenda referred to herein or attached hereto constitute the entire contract between the Parties with regard to the subject matter hereof, and supersede all prior agreements and understandings between the Parties, both written and oral, relating to the subject matter hereof. Any waiver of any breach of any provision of this Agreement shall not be a waiver of any subsequent breach of any provision of this Agreement. The terms and conditions of this Agreement are the result of an arm's length negotiations between the Parties and each Party has had the opportunity to obtain the advice of legal counsel regarding the negotiations and execution of this Agreement.

8.5 The use of the masculine, feminine or neuter gender and the use of the singular and plural shall not be to give the effect of any exclusion or limitation herein.

8.6 Any notices required to be given pursuant to this Agreement shall be sent by certified mail, return receipt requested, postage prepaid. Any such notice from Client shall be sent to the office of MedTrak. Any such notice from MedTrak shall be sent to the office of Client.

8.7 In the event of the unenforceability or invalidity of any section or provision of this Agreement, such section or provision shall be enforceable in part to the fullest extent permitted by law, and such invalidity or unenforceability shall not otherwise affect any other section or provision of this Agreement, and this Agreement shall otherwise remain in full force and effect.

[Signature Page Follows]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first set forth above.

FAULKNER COUNTY, ARKANSAS:

By: Jim Baker

Name: Jim Baker

Title: Faulkner County Judge

Date: 6-5-2018

MEDTRAK SERVICES, LLC:

By: D L

Name: Dan Robson

Title: CM Sales

Date: 06/15/18

Exhibit A
Administration Services

MedTrak will:

1. Maintain a network of independently contracted Participating Pharmacies to provide Covered Medications to Eligible Members.

2. Design the Pharmacy Benefit in the System and activate the POS system on the Effective Date.

3. Load and test Eligible Member information in the System. MedTrak requires a minimum of two weeks to test the accuracy of the initial Eligible Member information provided. MedTrak is not responsible for inaccuracies in initial Eligible Member information in the System until such time as MedTrak has tested it.

4. Process and adjudicate Claims for Covered Medications submitted by Participating Pharmacies for Eligible Members, including:
   a. Verification that the Eligible Member is eligible on the date the Drug Product is dispensed.
   b. Verification that the Drug Product dispensed is a Covered Medication.
   c. Verification that the supply of the Drug Product dispensed is in the quantity permitted under the Plan Sponsor's Plan.
   d. Pricing of the Claim.
   e. Production and issuance of explanations of benefits (EOBs) for out-of-network Claims.
   f. Production and issuance of Claims checks.
   g. Tracking or application of any Eligible Member Deductible (as defined on Exhibit D), Copayment (as defined on Exhibit D), or Pharmacy Benefit maximum.

5. Maintain the Claims data supporting the invoice statements for Covered Medications dispensed by Participating Pharmacies and by non-Participating Pharmacies.

6. Provide Plan Sponsor with access to standard management reports.

7. Produce and distribute Cardholder Information, which includes:
   a. Identification Cards (or Forms)
   b. Plan information
   c. Participating Pharmacy directory
   d. Formulary (if necessary)

8. Conduct retrospective and concurrent drug utilization review and coordinate with Physicians to identify instances of misuse and abuse and prevent future misuse and abuse.

9. When specifically requested by Client, implement a Therapeutic Intervention Program, which is a proprietary program created by MedTrak to educate Eligible Members and their Physicians about preferred Drug Products on the Formulary and encourage Physicians to prescribe, and Eligible Members to use, said Drug Products.

10. Conduct an annual member satisfaction survey and report results to Client if Client agrees to distribute the survey instrument through Client's internal email system.

11. Provide prior authorization ("Prior Authorization") services as set forth and directed by the Client for the Drug Products designated in Pharmacy Benefit implementation documents, as may be updated by the Client from time to time. Drug Products subject to Prior Authorization must meet Client-approved coverage criteria for any such Drug Product to qualify as a Covered Medication. To determine whether any Drug Product should be authorized for coverage under the Plan, MedTrak will apply the applicable coverage criteria and rely on information provided by the Eligible Member's prescriber. MedTrak will not attempt to make a determination of medical necessity and shall rely on the medical determination made by the prescriber to make a coverage determination.

Exhibit B

Business Associate Addendum

THIS BUSINESS ASSOCIATE ADDENDUM ("Addendum") is effective as of the date of the agreement between Client (a Covered Entity) and MedTrak (a Business Associate) to which this Addendum is attached (the "Agreement"). Pursuant to the Agreement, MedTrak performs certain services for Client, in connection with which MedTrak may receive from, or create or receive on behalf of, Client health information that is considered PHI (as defined below). To the extent that such PHI is shared between the parties, this Addendum shall apply and shall set forth each party's obligations with respect to such PHI. In consideration of the mutual covenants and agreements contained herein, the parties agree as follows:

TERMS

1. Definitions

Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the HIPAA Rules (as defined below), the HITECH Standards (as defined below) or any future regulations promulgated or guidance issued by the Secretary (as defined below) thereunder.

a) Breach. "Breach" shall have the same meaning as the term "breach" at 45 C.F.R. § 164.402.

b) Electronic Health Record. "Electronic Health Record" shall mean an electronic record of health-related information on an Individual (as defined below) that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

c) Electronic PHI. "Electronic PHI" shall have the same meaning as the term "electronic protected health information" at 45 C.F.R. § 160.103, limited to the information created or received by MedTrak from or on behalf of Client.

d) HIPAA. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended, and the implementation regulations thereunder, including without limitation the HIPAA Rules (as defined below) and the HITECH Standards (as defined below), and all future regulations promulgated thereunder.

e) HIPAA Rules. "HIPAA Rules" means each of the Privacy Rule (as defined below), the Security Rule (as defined below), the Breach Notification Rule, and the Enforcement Rule at 45 CFR Part 160 and Part 164.

f) HITECH Standards. "HITECH Standards" means Subtitle D of the Health Information Technology for Economic and Clinical Health Act ("HITECH"), found at Title XIII of the American Recovery and Reinvestment Act of 2009, and any regulations promulgated thereunder, including all amendments to the HIPAA Rules.

g) Individual. "Individual" shall have the same meaning as the term "individual" at 45 C.F.R. § 160.103, and any amendments thereto, and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

h) Privacy Rule. "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Parts 160 and 164.

i) Protected Health Information. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" at 45 C.F.R. § 160.103, and any amendments thereto, limited to the information created or received by MedTrak from or on behalf of Client.

j) Required By Law. "Required By Law" shall have the same meaning as the term "required by law" at 45 C.F.R. § 164.103.

k) Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his/her designee.

l) Security Incident. "Security Incident" shall have the same meaning as the term "security incident" at 45 C.F.R. § 164.304.

m) Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic PHI at 45 C.F.R. Parts 160, 162, and 164.

n) Unsecured PHI. "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" at 45 C.F.R. § 164.402.

2. **Relationship of Parties**

In the performance of the work, duties, and obligations described in this Addendum, the Agreement, or under any other agreement between the parties, the parties acknowledge and agree that each party is at all times acting and performing as an independent contractor and at no time shall the relationship between the parties be construed as a partnership, joint venture, employment, principal/agent relationship, or master/servant relationship.

3. **Obligations and Activities of MedTrak**

a) MedTrak agrees to not use or disclose PHI other than as permitted or required by this Addendum, the Agreement, any other agreement between the parties, or as Required By Law.

b) MedTrak will make reasonable efforts, to the extent practicable, to limit requests for and the use and disclosure of PHI to a Limited Data Set (as defined in 45 C.F.R. § 164.514(e)(2)) or, if needed by MedTrak, to the minimum necessary PHI to accomplish the intended purpose of such use, disclosure or request, and as applicable, in accordance with the regulations and guidance issued by the Secretary on what constitutes the minimum necessary for MedTrak to perform its obligations to Client under this Addendum, the Agreement, any other agreement between the parties, or as Required By Law.

c) MedTrak agrees to use appropriate safeguards to prevent the use or disclosure of PHI it creates, receives, maintains, or transmits on behalf of Client, other than as provided for by this Addendum or the Agreement.

d) MedTrak agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall comply with the applicable requirements of the Security Rule in the same manner such provisions apply to Covered Entity.

e) MedTrak agrees to mitigate, to the extent practicable, any harmful effect that is known to MedTrak of a use or disclosure of PHI by MedTrak in violation of the requirements of this Addendum.

f) Following MedTrak's discovery of a Breach of Unsecured PHI, MedTrak shall notify Client of the Breach without unreasonable delay, and in no event later than ten (10) days after MedTrak, or any of its employees or agents, discovered the Breach. To the extent that MedTrak creates, receives, maintains or transmits Electronic PHI, MedTrak agrees to report as soon as practicable to Client any Security Incident, as determined by MedTrak, involving PHI of which MedTrak becomes aware. Notwithstanding the foregoing, MedTrak and Client acknowledge the ongoing existence and occurrence of attempted but unsuccessful Security Incidents that are trivial in nature, such as pings and port scans, and Client acknowledges and agrees that no additional notification to Client of such unsuccessful Security Incidents is required. However, to the extent that MedTrak becomes aware of an unusually high number of such unsuccessful Security Incidents due to the repeated acts of a single party, MedTrak shall notify Client of these attempts and provide the name, if available, of said party. At the request of Client, MedTrak shall identify the date of the Security Incident, the scope of the Security Incident, MedTrak's response to the Security Incident, and the identification of the party responsible for causing the Security Incident, if known.

g) In accordance with 45 C.F.R. §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable , MedTrak agrees to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of MedTrak agree to the same restrictions, conditions, and requirements that apply through this Addendum to MedTrak with respect to such information.

h) MedTrak shall provide access, at the request of Client and in a time and manner mutually acceptable to MedTrak and Client, to PHI in a Designated Record Set to Client, or, as directed by Client, to an Individual or another person properly designated by the Individual, as necessary to satisfy Client's obligations under 45 C.F.R. § 164.524. If MedTrak maintains PHI electronically in a Designated Record Set and if an Individual requests an electronic copy of such information, MedTrak must provide Client, or the Individual or person properly designated by the Individual, as directed by Client, access to the PHI in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by MedTrak, Client, and the Individual. Any fee that MedTrak may

charge for such electronic copy shall not be greater than MedTrak's labor and supply costs in responding to the request.

i) MedTrak agrees to make any amendment(s) to PHI in its possession contained in a Designated Record Set as directed or agreed to by Client pursuant to 45 C.F.R. § 164.526, or take other measures as necessary to satisfy Client's obligations under 45 CFR 164.526, in a time and manner mutually acceptable to MedTrak and Client.

j) MedTrak agrees to document disclosures of PHI and information related to such disclosures as would be required for Client to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. As of the compliance date set forth in the regulations promulgated under HITECH or as otherwise determined by the Secretary, in addition to the accounting of disclosure obligations required under 45 C.F.R. § 164.528, MedTrak shall account for all disclosures of PHI made through an Electronic Health Record in accordance with the HITECH Standards and any future regulations promulgated thereunder.

k) Within ten (10) business days (or such other date that MedTrak and Client may reasonably agree upon) of receiving written notice from Client that Client has received a request for an accounting of disclosures of PHI, MedTrak agrees to make available the information collected as required to permit Client to provide an accounting of disclosures as necessary to satisfy Client's obligations under 45 C.F.R. § 164.528.

l) MedTrak shall make its internal practices, books, and records, relating to the use and disclosure of PHI received from, or created or received by MedTrak on behalf of Client, available to the Secretary for purposes of determining Client's or MedTrak's compliance with the HIPAA Rules.

m) To the extent MedTrak is to carry out one or more of Client's obligation(s) under Subpart E of 45 CFR Part 164, MedTrak shall comply with the requirements of Subpart E that apply to Client in the performance of such obligation(s).

4. **Permitted Uses and Disclosures**

Except as otherwise limited in this Addendum:

a) MedTrak reserves the right to **use** PHI for the proper management and administration of MedTrak, to carry out the legal responsibilities of MedTrak, and to provide data aggregation services to Client.

b) MedTrak may **use or disclose** PHI to perform functions, activities, services, Payment activities, or Health Care Operations for, or on behalf of, Client provided that such use or disclosure would not violate the Privacy Rule if done by Client.

c) MedTrak may **disclose** PHI in its possession for the proper management and administration of MedTrak, provided that disclosures are Required by Law, or MedTrak obtains reasonable assurances from the third party to whom the information is disclosed that such PHI will be held confidentially and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the third party, and the third party notifies MedTrak of any instances of which it is aware in which the confidentiality of the PHI has been breached.

5. **Obligations of Client**

a) Client shall notify MedTrak in writing of any limitation(s) in its notice of privacy practices, to the extent that such limitation may affect MedTrak's use or disclosure of PHI.

b) Client shall notify MedTrak, in writing and in a timely manner, of any change in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such change may affect MedTrak's permitted or required use or disclosure of PHI.

c) Client shall notify MedTrak, in writing and in a timely manner, of any restriction to the use and/or disclosure of PHI, which Client has agreed to or is required to abide by under 45 C.F.R. § 164.522, to the extent that such restriction may affect MedTrak's use or disclosure of PHI.

d) Client shall have entered into a "Business Associate Agreement" with any third parties (e.g., case managers, brokers or third party administrators) to which Client directs and authorizes MedTrak to disclose PHI.

6. **Permissible Requests by Client**

Client shall not request MedTrak to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by Client.

7. **Termination**

a) Termination for Cause. Upon Client's knowledge of a material breach of this Addendum by MedTrak, Client may either:

i) Provide an opportunity for MedTrak to cure the breach or end the violation and, if MedTrak does not cure the breach or end the violation within the time specified by Client, terminate this Addendum; or

ii) Immediately terminate this Addendum if MedTrak has breached a material term of this Addendum and cure is not possible.

MedTrak shall ensure that it maintains the termination rights in this Section in any agreement it enters into with a subcontractor pursuant to Section 3(h) hereof.

b) Effect of Termination.

i) Except as provided in paragraph (b)(ii) of this Section, upon termination of this Addendum, for any reason, MedTrak, with respect to PHI received from Client, or created, maintained, or received by MedTrak on behalf of Client, shall:

1. Retain only that PHI which is necessary for MedTrak to continue its proper management and administration or to carry out its legal responsibilities;

2. Return to Client or, if agreed to by Client, destroy the remaining PHI that MedTrak still maintains in any form;

3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as MedTrak retains the PHI; and

4. Not use or disclose the PHI retained by MedTrak other than for the purposes for which such PHI was retained and subject to the same conditions set out in paragraphs (a) and (c) above under "Permitted Uses and Disclosures" which applied prior to termination.

ii) In the event MedTrak determines that returning or destroying the PHI is not feasible, MedTrak shall provide to Client notification of the conditions that make return or destruction not feasible. MedTrak shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction not feasible, for so long as MedTrak maintains such PHI.

iii) MedTrak's obligations under this Section shall survive the termination of this Addendum.

8. **Miscellaneous**

a) Regulatory References. A reference in this Addendum to a section in the Privacy Rule or the Security Rule means the section as in effect or as amended and for which compliance is required.

b) Amendment. No change, amendment, or modification of this Addendum shall be valid unless set forth in writing and executed by both parties. Notwithstanding the foregoing, the parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to ensure compliance with such developments. The parties specifically agree to take such action as may be necessary from time to time for the parties to comply with the requirements of HIPAA. Client shall provide written notice to MedTrak to the extent that any final regulation or amendment to final regulations promulgated by the Secretary under HITECH requires an amendment to this Addendum to comply with HIPAA. The parties agree to negotiate an amendment to the Addendum in good faith.

c) Interpretation. Any ambiguity in this Addendum shall be resolved to permit Client and MedTrak to comply with HIPAA.

Exhibit C
Appeals Process

The following is a summary of MedTrak's appeals process related to the Pharmacy Benefit of an Eligible Member, which may be updated from time to time at the discretion of MedTrak or as required by applicable law. The most current version of MedTrak's appeals process is available upon request.

1. Appealing a Denied Claim

If a claim for benefits is denied, you may call MedTrak toll free at (800)771-4648 to resolve your issue over the phone. If MedTrak is unable to resolve your issue, you have the right to file a formal appeal as described below. If you wish to appeal a denied request for benefits or a rescission of coverage, you or your authorized representative must submit your appeal in writing as described below within 180 days of receiving the adverse benefit determination.
This written request should include:

1. the participant's name and ID number as shown on the prescription benefits card;
2. the provider's name;
3. the date of service;
4. the reason you disagree with the denial or coverage decision; and
5. any documentation or other written information to support your appeal.

You or your authorized representative may send a written appeal to: MedTrak Services, Clinical Care Center, 7101 College Blvd, Suite 1000, Overland Park, KS 66210; or fax your request to: (866)552-8939.
For denied urgent claims for benefits, your provider may submit a written appeal as described above or call MedTrak toll free at (800)771-4648 to request an appeal.
Note: You may designate an authorized representative who has the authority to represent you in all matters concerning your claim or appeal of a claim determination. If you have an authorized representative, any references to "you" or "participant" herein will also refer to the authorized representative.

2. Internal Appeal

MedTrak will conduct a full and fair review of your appeal. The appeal may be reviewed by two pharmacists who did not make the initial benefit determination. If MedTrak upholds the denial, you will receive a written explanation of the facts and basis for the denial and a description of additional appeal procedures, if applicable. If MedTrak overturns the denial and approves the Claim, you will receive notification and Benefits will be paid, as appropriate.

If your urgent care claim was denied, you may request an expedited external review at the same time that you request an expedited internal appeal to MedTrak. Immediately upon receipt of your request for an expedited external review, MedTrak will determine whether the request meets the reviewability requirements for an external review. Immediately upon completing this review, MedTrak will (i) submit the request to an independent review organization for external review; (ii) notify you or your provider that the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) notify you and/or your provider that the request is complete, but not eligible for review.

3. Reconsideration – Failure to Meet Coverage Criteria

MedTrak applies a review process to certain drugs to define the conditions ("Coverage Criteria") under which such drugs will be covered under your pharmacy benefits. These Coverage Criteria are developed by the MedTrak Clinical Care Center and are subject to review and revision from time to time. In the event such Coverage Criteria are not met, the benefit or claim is not a covered benefit, and therefore not eligible for the other appeal rights provided herein. However, you or your provider may request that MedTrak reconsider the application of the Coverage Criteria. Upon receipt of such request, two pharmacists not involved in the initial review will reconsider the Coverage Criteria denial and provide notice to you of the outcome of such reconsideration.

4. External Review

If you are not satisfied with the determination made during the internal review, or if MedTrak fails to respond to your appeal within the applicable time, you may be entitled to request an immediate external review of the determination made by MedTrak. If one of the above applies, you may request a free external review of an adverse benefit determination if (i) the determination involves a question of medical judgment; (ii) coverage was terminated retroactively; or (iii) if it is otherwise required by applicable law. You may also have the right to pursue external review in the event that MedTrak has failed to

comply with the internal claims and appeals process, except if such failure is related to minor violations that did not cause, and are not likely to cause, you harm.

You may request (i) a standard external review by sending a written request to the address set out in the determination letter or (ii) an expedited external review, in urgent situations as detailed below, by calling MedTrak toll free at (800)771-4648 or by sending a written request to the address set out in the determination letter. A request must be made within 120 days from the date of the final internal determination from MedTrak. An external review request should include (i) a specific request for an external review; (ii) the participant's name, address, and insurance ID number; (iii) your authorized representative's name and address, when applicable; (iv) the service that was denied, the date of service, the provider's name; and (iv) any new, relevant information that was not provided during the internal appeal. An external review will be performed by an Independent Review Organization (IRO). MedTrak has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available, a standard external review and an expedited external review.

5. Standard External Review

Within the applicable time frame, MedTrak will review the external review request to determine whether (i) the applicable member was covered under the Plan at the time the prescription drug product or service at issue in the request was provided or requested; (ii) the applicable internal appeals have been exhausted; and (iii) all the information and forms required to process the request have been provided. Following review, MedTrak will forward the information to the appropriate IRO, which is determined by rotating review assignments among the IROs. MedTrak will provide the assigned IRO with the documents and information considered in making the determination. The documents include (a) all relevant medical records; (b) all other documents relied upon by MedTrak; (c) all other information or evidence that you or your provider submitted regarding the claim; and (d) all other information or evidence that you or your provider wish to submit regarding the claim, including, as explained below, any information or evidence that was not previously provided. If your claim involves an issue of medical judgment or rescission that is subject to external review, you may submit in writing to the IRO within ten (10) business days following the date you receive notice from the IRO, any additional information that you want the IRO to consider when conducting the external review. In reaching a decision, the IRO will review the claim without regard to any decisions or conclusions reached by MedTrak. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless the IRO requests additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and MedTrak, including the basis for its determination. Upon receipt of a Final External Review Decision reversing the determination by MedTrak, MedTrak will notify you within 48 hours of receiving the IRO's decision. The Plan will immediately provide coverage or payment of the Benefits at issue in accordance with the terms and conditions of the Plan. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the prescription drug product or service and you will have exhausted your appeal rights. All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

6. Expedited External Review

An expedited external review is similar to a standard external review, except with certain shorter time periods, and the timeframe for you or your provider to submit additional information to the IRO is eliminated. In some instances you may file an expedited external review before completing the internal appeals process. You may make a written or verbal request for an expedited external review if you receive either (i) an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which, in the opinion of your prescriber, the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function and you have filed a request for an expedited internal appeal; or (ii) a final appeal decision, if the determination, in the opinion of your prescriber, involves a medical condition where the time frame for completion of a standard external review would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or prescription drug product or service for which the participant received emergency services, but has not been discharged from a facility. Immediately upon receipt of the request, MedTrak will determine whether the participant (i) was covered under the Plan at the time the prescription drug product or service that is at issue in the request was provided; and (ii) has provided all the information and forms required so that MedTrak may process the request. After completing the review, MedTrak will immediately assign an IRO in the same manner MedTrak utilizes to assign standard external reviews to IROs. The IRO will determine if the matter contains an issue involving medical judgment and, upon a determination that a request is eligible for expedited external review. MedTrak will provide all necessary documents and information considered in making the determination to the assigned IRO. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information

and documents considered in a standard external review. In reaching a decision, the IRO will review the claim without regard to any decisions or conclusions reached by MedTrak. The IRO will provide notice of the Final External Review Decision for an expedited external review as expeditiously as the participant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the IRO's notice of the Final External Review Decision is not in writing, within 48 hours of providing such notice, the assigned IRO will provide written confirmation of the decision to you and to MedTrak. All Final External Review Decisions by an IRO are final and binding on all parties and not subject to further appeal rights.

7. **Time Frames**

The following list provides the required timing for the corresponding actions. The timing is based on when the request is received, unless otherwise noted below.

a. **Urgent Care Claims**
   i. If your Request is complete, MedTrak must notify you and your provider of the benefit determination within 72 hours.
   ii. If your request is incomplete, MedTrak must notify you that it is incomplete within 24 hours.
      1. You must then provide the completed request to MedTrak within 48 hours after receiving the notice requiring additional information.
      2. MedTrak must notify you and your provider of the benefit determination within 48 hours after receiving the additional information.
   iii. If MedTrak denies your request for benefits, you must appeal an adverse benefit determination no later than 180 days after receiving such determination.
   iv. MedTrak must notify you of the internal appeal decision within 72 hours of receiving the appeal.

b. **Pre-Service Claims** (a Claim submitted prior to receiving the benefit)
   i. If your request for benefits is filed improperly, MedTrak must notify you within 5 days.
   ii. If your request for benefits is incomplete, MedTrak must notify you within 15 days.
   iii. You must then provide completed request for benefits information to MedTrak within 45 days.
   iv. MedTrak must notify you of the benefit determination within 15 days of a completed request or upon the receipt of all additional required information if your initial request was incomplete.
   v. You must appeal an adverse benefit determination no later than 180 days after receiving such determination.
   vi. MedTrak must notify you of the internal appeal decision within 15 days of receiving such appeal.

c. **Post-Service Claims** – a claim submitted after receiving the benefit
   i. If your claim is incomplete, MedTrak must notify you within 30 days.
   ii. You must then provide completed claim information to MedTrak within 45 days.
   iii. MedTrak must notify you of the benefit determination 30 days of a completed claim filing or upon the receipt of all additional required information if your initial claim was incomplete.
   iv. You must appeal an adverse benefit determination no later than 180 days after receiving such determination.
   v. MedTrak must notify you of the internal appeal decision within 15 days of receiving such appeal.

d. **External Review**
   i. You must submit a request for external review to MedTrak within 120 days after receiving the internal appeal determination.
   ii. For an expedited external review, the IRO will provide notice of its determination within 72 hours.
   iii. For a standard external review, MedTrak will complete a preliminary review to ensure the request meets requirements for an external review within 5 business days.
   iv. You may submit in writing to the IRO any additional information that you want the IRO to consider within 10 business days.
   v. For a standard external review, the IRO will provide written notice of its determination within 45 days.

Exhibit D
Financial Terms

1. Definitions

   a. "Average Wholesale Price" or "AWP" means the current wholesale price of a "Drug Product" as established by its manufacturer and as reported in a nationally recognized drug database.

   b. "Brand Drug Product" means a "Drug Product" that is not classified as a "Generic Drug Product".

   c. "Compound Drug" means a formulation containing one or more "Drug Products", which is extemporaneously prepared by a Participating Pharmacy in accordance with a Physician's prescription order.

   d. "Copayment" or "Deductible" means the amount an Eligible Member is required to pay a Participating Pharmacy, in accordance with the terms of the Plan, for a Covered Medication dispensed by the Participating Pharmacy.

   e. "Generic Drug Product" means a Drug Product with an FDA-approved "Abbreviated New Drug Application" (or "ANDA"), provided such Drug Product (i) is available from more than two (2) Drug Product manufacturers and/or (ii) has a "Maximum Allowable Cost".

   f. "Limited Distribution Drug" or "LDD" means a Drug that is only available through a limited number of specialty pharmacies.

   g. "Maximum Allowable Cost" or "MAC" means the maximum cost allowed for a Generic Drug Product, as set by MedTrak from time to time.

   h. "Orphan Drug" means a drug intended for use in a rare disease or condition as defined by the Orphan Drug Act.

   i. "PMPM" means per member per month.

   j. "Single-Source Generic Drug Product" means a Drug Product which is indicated when using Medi-Span by (i) a code identifier of "M" or "N" with a Brand Name Code "G" or "B", or (ii) a code identifier of "Y" which is available from one (1) manufacturer.

   k. "Specialty Drug" means a high-cost, complex pharmaceutical that has unique clinical, administration, distribution, or handling requirements and is not commonly available through traditional retail or mail pharmacies; excluding, however, all Limited Distribution Drugs and Orphan Drugs.

   l. "Specialty Drug List" means a list of Specialty Drugs, Limited Distribution Drugs, and Orphan Drugs maintained by MedTrak and updated from time to time in the sole discretion of MedTrak.

   m. "Usual and Customary Charge" or "U&C" means the Pharmacy Services price Pharmacy would charge a patron who is not an Eligible Member, if that patron were to pay cash for a Covered Medication. Such price shall reflect any incentive or other discounts that would be offered by Pharmacy to such an individual.

2. Retail Pharmacy Paid Claim Charge

   For each Covered Medication dispensed by a retail Participating Pharmacy to an Eligible Member, Client agrees to pay MedTrak the "Retail Pharmacy Paid Claim Charge", plus any applicable sales or excise tax or other handling or governmental charge (as determined by law), less any applicable Copayment or Deductible, as described in the Plan. The Retail Pharmacy Service Charge is:

   a. For Brand Drug Products, 30-Day's Supply, the lesser of: (i) AWP – 17% plus a $0.75 dispensing fee, or (ii) the U&C.

b. For Generic Drug Products, 30-Day's Supply, the lesser of: (i) MAC plus a $0.75 dispensing fee, (ii) AWP – 17% plus a $0.75 dispensing fee; or (iii) the U&C.
c. For Brand Drug Products, 90-Day's Supply, the lesser of: (i) AWP – 20% plus a $0.00 dispensing fee, or (ii) the U&C.
d. For Generic Drug Products, 90-Day's Supply, the lesser of: (i) MAC plus a $0.00 dispensing fee, (ii) AWP – 20% plus a $0.00 dispensing fee, or (iii) the U&C.
e. For Compound Drugs, the U&C, not to exceed one-hundred and fifty percent (150%) of the AWP of the submitted Drug Product.

For purposes of the foregoing provisions in this Exhibit D, any reference to "Retail 30" or "30-Days' Supply" or "30-day supplies" shall mean any Covered Medication dispensed in a 1- to 83-day supply; and, provided further, any reference to "Retail 90" or "90-Days' Supply" or "90-day supplies" shall mean any Covered Medication dispensed in a days' supply of 84 or more.

Subject to the terms and conditions herein, MedTrak shall provide Client with the following dollar-for-dollar minimum financial guarantees with respect to Retail Pharmacy Paid Claim Charges:

Post-AWP Settlement Minimum Discount Guarantees & Maximum Dispensing Fees	
Type	**Retail**
Retail 30 Brand Drug Products	**AWP – 17% Discount** **$0.75 Dispensing Fee**
Retail 90 Brand Drug Products	**AWP – 20% Discount** **$0.00 Dispensing Fee**
Retail Generic Drug Products (30-day supplies)	**AWP – 79% Discount** **$0.75 Dispensing Fee**
Retail Generic Drug Products (90-day supplies)	**AWP – 79% Discount** **$0.00 Dispensing Fee**

With respect to the foregoing Generic Drug Product guarantees, the effective generic discount and the generic discount guarantee calculation includes the following: MAC generics, multi-source generics, generics in their FDA-granted exclusivity period, patent litigated generics, generics with limited supply, U&C Claims, and generic medications prescribed and/or dispensed in conjunction with a specialty medication. The above generics will NOT be included in the brand discount guarantees.

The following types of Claims shall be excluded from the foregoing guarantees: Specialty Drug Claims, Single-Source Generic Drug Products, Compound Drug Claims, vaccine Claims, reversed Claims, and OTC Drug Products.

100% member paid claims (zero balance due claims) will be included in the foregoing guarantees, with discounts for these claims calculated based on the ingredient cost prior to the application of member paid amount.

All non-MAC generic claims will be included in the forgoing Brand Drug Product discount guarantees, not the Generics Drug Product discount guarantees.

Additionally, if Client requires MedTrak to include any currently non-contracted pharmacies as Participating Pharmacies, and MedTrak is unable to obtain rates from such pharmacies as favorable as those guaranteed by MedTrak hereunder, then Claims from such pharmacies shall also be excluded from the financial guarantees hereunder. If at any time applicable laws, regulations or administrative or judicial interpretations or rulings increase the amounts MedTrak must pay to Participating Pharmacies, the foregoing financial guarantees will be amended by mutual agreement of the parties to reflect such increase.

3. Mail Pharmacy Paid Claim Charge

The mail Participating Pharmacy designated by MedTrak and approved by Client is the exclusive provider of mail Pharmacy Services. For each Covered Medication dispensed by the mail Participating Pharmacy to an Eligible Member, Client agrees to pay MedTrak the mail pharmacy Paid Claim Charge, plus any applicable sales or excise tax or other handling or governmental charge (as determined by law), less any applicable Copayment or Deductible, as described in the Plan. The Mail Pharmacy Service Charge is:

a. For Brand Drug Products, the greater of: (i) $10.00; or (ii) AWP – 24% plus a $0.00 dispensing fee.
b. For Generic Drug Products, the greater of: (i) $10.00; or (ii) AWP – 79% plus a $0.00 dispensing fee.
c. For Compound Drugs, the U&C, not to exceed one hundred fifty percent (150%) of the AWP of the dispensed medication (including AWPs of all submitted Drug Products).

4. Best-In-Class Specialty Pharmacy Paid Claim Charge

The "Best-In-Class Specialty" Participating Pharmacies designated by MedTrak and approved by Client are the exclusive providers of specialty Pharmacy Services. If and when Client elects to participate in MedTrak's Best-In-Class Specialty Pharmacy program, for each Covered Medication that is a Specialty Drug, and dispensed by a Best-In-Class Specialty Participating Pharmacy, Client agrees to pay MedTrak the "Best-In-Class Specialty Pharmacy Paid Claim Charge", expressed as an AWP discount, plus any applicable sales or excise tax or other handling or governmental charge (as determined by law), less any applicable Copayment or Deductible, as described in the Plan. The Best-In-Class Specialty Pharmacy Service Charge is maintained by MedTrak on the Specialty Drug List, which may be updated from time to time in MedTrak's discretion and provided to Client upon request. The Best-In-Class Specialty Pharmacy Service Charge includes the cost of certain "Ancillary Supplies", including syringes, needles, and alcohol swabs. The Best-In-Class Specialty Pharmacy Service Charge does not include the cost of home infusion supplies, devices and in-home nursing services. MedTrak reserves the right to modify the Specialty Drug List from time to time.

Notwithstanding the foregoing, and subject to the terms and conditions herein, with respect to Specialty Drugs dispensed by authorized BIC Specialty Pharmacies only, MedTrak shall provide Client with the following minimum financial guarantee with respect to Best-In-Class Specialty Pharmacy Service Charge:

Post-AWP Settlement Minimum Discount Guarantees & Maximum Dispensing Fees	
Type	**Best-in-Class (BIC) Network**
Specialty Drugs	**AWP – 18% Discount** **$0.00 Dispensing Fee**

The following types of Claims shall be excluded from the foregoing BIC Specialty guarantees: Compound Drug Claims; reversed Claims; OTC Drug Products; Limited Distribution Drugs (which may include Orphan Drugs); U&C Claims; and Claims for any Specialty Drug Products dispensed by a pharmacy that is not a BIC Specialty Pharmacy awarded that particular Specialty Drug Product. Note that with respect to Specialty Drug Products dispensed by a pharmacy that is not a BIC Specialty Pharmacy awarded that particular Specialty Drug Product, MedTrak will bill to Client, and Client shall pay MedTrak, the Non Best-In-Class Specialty Pharmacy Paid Claim Charge specified further below in this Exhibit D.

This rate includes the cost of certain "Ancillary Supplies", including syringes, needles, and alcohol swabs. The rate does not include the cost of home infusion supplies, devices and in-home nursing services. This rate also does not apply to Limited Distribution Drugs, which are negotiated separately.

The above BIC Specialty guarantee assumes and is conditional upon Client maintaining a fifteen percent (15%) Specialty Drug coinsurance and Client's participation in the following two MedTrak programs: (i) BIC Specialty Copay Assistance Trakker program; and (ii) the BIC Align Program. The calculated savings from each of these programs may be credited by MedTrak toward the achievement of the above guaranteed BIC Specialty discount. If at any time Client's participation in either or both programs ends, then the BIC Specialty guarantee shall be reduced to sixteen percent (16%).

5. Non-Best-In-Class Specialty Pharmacy Paid Claim Charge

In the event that a Specialty Drug, Limited Distribution Drug, or Orphan Drug is dispensed from a pharmacy other than the Best-In-Class Specialty Participating Pharmacy listed on the Specialty Drug List, Client agrees to pay MedTrak the "Non-Best-In-Class Specialty Pharmacy Paid Claim Charge", plus any applicable sales or excise tax or other handling or governmental charges (as determined by law), less any applicable Copayment and/or Deductible, as described in the Plan. The Non-Best-In-Class Specialty Pharmacy Service Charge is:

a. For Brand Drug Products, AWP – 14% plus a $0.75 dispensing fee.
b. For Generic Drug Products, AWP – 14% plus a $0.75 dispensing fee.

The Non-Best-In-Class Specialty Pharmacy Service Charge includes the cost of certain "Ancillary Supplies", including syringes, needles, and alcohol swabs. The Non-Best-In-Class Specialty Pharmacy Service Charge does not include the cost of home infusion supplies, devices and in-home nursing services.

The Non-Best-In-Class Specialty Pharmacy Paid Claim Charge does not apply to Limited Distribution Drugs. MedTrak will submit all Claims for Limited Distribution Drugs by Non-Best-In-Class Specialty Pharmacies to Client for authorization.

6. Discount Guarantee Methodology

The parties hereby acknowledge and agree that with respect to all guaranteed discounts off of AWP set forth in this Exhibit, (i) MedTrak's performance with respect to all such discount guarantees in this Exhibit will be measured and reconciled independently and annually by MedTrak within 180 days after each contract year during the Term of the Agreement; and (ii) to the extent MedTrak outperforms any one or more of these discount guarantees, MedTrak may use the cost savings associated with such outperformance and apply those savings to offset any underperformance by MedTrak with respect to any other discount guarantee in this Exhibit. MedTrak will pay 100% of each individual guarantee's shortfall value on a dollar-for-dollar basis within 180 days after each contract year; provided, however, the guarantees provided in this Exhibit shall not be effective until the date this Agreement is executed by both parties.

7. Miscellaneous Charges

Client shall pay the Miscellaneous Charges to MedTrak listed below:

a. Administration Fee: $0.00 per paid Claim.
b. Direct member reimbursement Claims: $2.50 per such Claim.
c. Prior Authorizations:
    i. Simple Review (prescriber outreach & BIC member advocacy referral): $5.00 per review.
    ii. Complex Criteria Review (pharmacist review of coverage criteria involving physician): $25.00 per review.
    iii. Pharmacist Clinical Review (review of experimental/investigational Drug Product): $25.00 per review.
d. External Appeal of Coverage Denial – Pursuant to the Appeals Process set forth on Exhibit C, MedTrak may request an external appeal review from an accredited independent review organization ("IRO") in the event of a coverage denial. MedTrak will pass through all costs of the IRO to Client as a billed charge pursuant to the payment terms of this Agreement, as well as a $100.00 fee paid to MedTrak for the administration of such review.
e. For each Vaccine Claim covered by Client and processed through a Participating Pharmacy contracted with MedTrak to administer Vaccines, Client agrees to pay an additional Vaccine Administration Charge of up to, but not more than, $25.00 per Claim.
f. Cardholder Identification ("ID") Cards – MedTrak issues initial Cardholder ID Cards to Client prior to the Effective Date at $1.00 per ID Card. After the Effective Date, MedTrak issues Cardholder ID Cards to Client at $1.00 per ID Card. If Client requests MedTrak to send Cardholder ID Cards to each Cardholder, Client agrees to pay MedTrak's applicable postage costs.

8. Program Charges

If Client elects to implement any of the below listed MedTrak Programs, Client shall pay the corresponding Program Charges to MedTrak listed below:

a. RightCHOICE Program: $0.05 PMPM.
b. Medical Channel Management Program: $0.10 PMPM.
c. All MedTrak Step Therapy Programs: $0.20 PMPM.
d. BIC Align Program: $0.20 PMPM.
e. Rx-OTC Program: $0.05 PMPM.
f. CareTrakRx-Pain Management Program: $0.10 PMPM.

9. Formulary Program Discounts

Under certain conditions, MedTrak will pay Formulary Program (as defined below in Exhibit E to this Agreement) discounts, in the form of Rebates, to Client subject to Client's participation in the Formulary Program and overall compliance with Exhibit E to this Agreement. Client agrees that Rebate payments are based upon Plan design over which MedTrak has no discretionary control or authority, and such Rebate payments are subject to change due to various factors, as described in this Agreement. Rebate payments are made within thirty days after six months from the end of the quarter in which Paid Claims were incurred. Rebates will be paid to Client as follows:

a. For each eligible Brand Drug Product, as described in Exhibit E, that is a Covered Medication dispensed through a retail pharmacy for a 30-day supply, MedTrak shall pay Client the greater of: (i) fifty percent (50%) of related Rebates or (ii) $50.00.
b. For each eligible Brand Drug Product, as described in Exhibit E, that is a Covered Medication dispensed through a retail pharmacy for a 90-day supply, MedTrak shall pay Client the greater of: (i) fifty percent (50%) of related Rebates or (ii) $125.00.
c. For each eligible Brand Drug Product, as described in Exhibit E, that is a Covered Medication dispensed through a mail pharmacy, MedTrak shall pay Client the greater of: (i) fifty percent (50%) of related Rebates or (ii) $200.00.
d. For each eligible Brand Drug Product, as described in Exhibit E, that is a Specialty Drug Covered Medication dispensed through a contracted pharmacy, MedTrak shall pay Client the greater of: (i) fifty percent (50%) of related Rebates or (ii) $350.00.

10. Third-Party Fee Disclosure

Client acknowledges that it has retained CoreSource ("Consultant") as a consultant with respect to Client's Pharmacy Benefit Plan and/or this Agreement (the "Consultant Services"); and, for so long as Client authorizes Consultant as such, MedTrak is hereby directed to pay Consultant on Client's behalf, from any amounts received from Client under this Agreement, the amount set forth below, which will be paid generally by MedTrak on a quarterly or other periodic basis agreeable to the parties (the "Consultant Fee"). The Consultant Fee will compensate Consultant for such Consultant Services performed on behalf of Client, and will be calculated and paid $3.50 per paid Claim.

Exhibit E
Formulary Program

1. Definitions

   a. "Formulary Program" shall mean a program established by MedTrak under which pharmaceutical manufacturers provide MedTrak with discounts, which are (i) due and payable to MedTrak pursuant to the terms of contracts with pharmaceutical manufacturers; and (ii) directly attributable to the dispensing of Covered Medications on the Formulary to Eligible Members.

   b. "Formulary Program Claim Exclusions" shall mean (i) Claims for Brand Drug Products that are also available as Generic Drug Products, (ii) 100% Copayment Claims, (iii) Claims submitted by Eligible Members, (iv) Claims where MedTrak is the secondary payer, (v) Claims for Compound Drugs, Specialty Drugs, and over-the-counter Drug Products, and (vi) Claims for Covered Medications filled at Participating Pharmacies that qualify for 340B pricing under Section 340B of the Public Health Services Act.

   c. "Rebates" shall mean retrospective rebates paid to MedTrak that are directly attributable to the utilization of certain pharmaceuticals by Eligible Members. Rebates do not include administrative fees paid by pharmaceutical manufacturers to MedTrak in connection with MedTrak's administration of Formulary Program discounts.

2. Terms of Formulary Program

   a. MedTrak agrees to allow Client to participate in the Formulary Program in Client's sole discretion, and MedTrak agrees to pay certain Formulary Program discounts to Client to the extent such Formulary Program discounts are attributable to Client's participation in the Formulary Program and Eligible Members' use of the Formulary, and as are described in Exhibit D, but if and only if Client meets its obligations under Exhibit D and this Exhibit E of this Agreement, and if and only if Client meets such other reasonable and generally applicable requirements for participation in the Formulary Program and associated parameters as may be communicated by MedTrak to Client from time to time.

   b. Client (or its Agent) shall have sole discretion regarding participation in MedTrak's Formulary Program, which may include, but is not limited to, the distribution of Formularies to Cardholders prior to the Effective Date and as necessary thereafter, and which participation shall require Client's conformance to the Formulary. By choosing to participate in the Formulary Program, Client further warrants that Client is not participating in any other formulary program and that Client's Agent is not participating in any other formulary program on behalf of Client.

   c. Client understands that its eligibility to receive any payments from MedTrak under this Exhibit E may change from time to time due to changes in Client's Plan; changes in MedTrak's contracts with pharmaceutical manufacturers or Rebate intermediaries; changes in laws, including but not limited to laws affecting prescription drug benefits, benefits structure, or pricing (including Rebates); the selection of certain services, such as prior authorization or open formulary management; or any change in the Formulary Program. Client acknowledges and agrees that only Claims for Brand Drug Products (as defined on Exhibit D) with an FDA-approved "New Drug Application" ("NDA") are eligible for such payments. Client further acknowledges and agrees that Formulary Program Claim Exclusions are not eligible for such payments.

   d. Subject to Client's participation in the Formulary Program and compliance with Sections 2.b. and 2.c., above, MedTrak shall pay to Client certain amounts received by MedTrak as discounts or Rebates, pursuant to the Formulary Program, from drug manufacturers or intermediaries, which amounts are denominated as discounts or Rebates by such manufacturers or intermediaries and which are attributable to Pharmacy Services utilized by Eligible Members, and consistent with the amounts provided for in accordance with Exhibit D hereto. Client acknowledges and agrees that it shall not have a right to interest on, or the time value of, any discount, Rebate or other payments received by MedTrak during the collection period for monies payable to Client under this Exhibit E. Client acknowledges that Rebate payments from

manufacturers or intermediaries are received on a periodic basis by MedTrak and relate to earlier months' claims. MedTrak reserves the right to delay payment to Client of any amounts hereunder, and to offset any Rebate payments otherwise due hereunder.

e. Client acknowledges that it may be eligible for Rebate payments under this Agreement only so long as Client (or its Agent) does not contract directly or indirectly with anyone else for discounts, utilization limits, rebates or other financial incentives on pharmaceutical products or formulary programs without MedTrak's prior written consent. In the event that Client negotiates or arranges with a pharmaceutical manufacturer or intermediary for rebates or similar discounts, without limiting MedTrak's right to other remedies, MedTrak may immediately terminate Client's participation in the Formulary Program, terminate this Agreement according to the terms of Section 5.2 hereof, and/or recover from Client all amounts paid by MedTrak to Client for Rebates on claims submitted by Client (or on behalf of Client) for Rebates other than through MedTrak.

f. Client hereby represents and warrants, and shall recertify on a periodic basis in a form acceptable to MedTrak, with respect to any Plan which receives funding from Medicare/Medicaid, Title V, Children's Medical Services, or another government healthcare program as defined in Section 1128(h) of the Social Security Act (or any successor thereto) ("Government Programs") and for which the Client receives amounts hereunder that are attributable to such Plan, each such Plan is operating under a risk contract with the Centers for Medicare and Medicaid Services ("CMS") or a state Medicaid program, and operates in accordance with §§ 1876(g) or 1903(m) of the Social Security Act, under a federal statutory demonstration authority or successor statute or authority. Client agrees to notify MedTrak in writing of any such Plan that does not meet any of the criteria set forth herein, and MedTrak, in compliance with applicable law, shall not submit prescription drug claims for any Eligible Members in such Plan for prescriptions filled by a Participating Pharmacy. Nothing herein prohibits a Client that receives the retiree drug subsidy ("RDS") from CMS for eligible Plan Participants under the Medicare Part D Rules (42 C.F.R. Part 423, Subpart R) from receiving Rebates relating to such eligible Plan Participants' prescription drug claims under this Agreement. The parties hereto acknowledge and agree that any Rebate reimbursement provided to Client pursuant to this Agreement is a "discount" under 42 U.S.C. § 1320a-7b(b)(3) and 42 C.F.R. § 1001.952(h) (the "Discount Safe Harbor"). For the purpose of complying with the Discount Safe Harbor, MedTrak shall clearly denote in invoices and other statements amounts that constitute Rebate reimbursement hereunder. Client shall properly disclose and appropriately reflect all Rebate reimbursement in the costs claimed or the charges made to any Government Program. Without limiting the foregoing, if Client claims a subsidy from CMS for eligible Plan Participants under the Medicare Part D Rules (42 C.F.R. Part 423, Subpart R), Client shall properly disclose and appropriately reflect any Rebate reimbursement paid by MedTrak to Client in the Allowable Retiree Costs (as defined at 42 C.F.R. § 423.882) and other information submitted to CMS for payment of such subsidy in accordance with the Medicare Part D Rules, all applicable sub-regulatory guidance and CMS policies.