PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

[Model template for state and governmental plan sponsors — v3.4 CONSOLIDATED (2026-08-28), absorbing the forty-one-item round-10 counsel review. Complete the bracketed blanks and Exhibits A–I from the winning proposal; adapt statutory citations to your jurisdiction. Per Section 14.10, execution is prohibited while any material blank remains. Companion documents: RFP Solicitation Template v2.1; Rationale & Protections Report. This template is a drafting resource, not legal advice.]

This Pharmacy Benefit Management Services Agreement ("Agreement") is entered into as of [EFFECTIVE DATE] by and between [STATE AGENCY / PLAN SPONSOR], an agency of the State of [STATE] ("Plan Sponsor"), administering the [PLAN NAME] (the "Plan"), and [PBM LEGAL NAME], a [STATE OF ORGANIZATION] [ENTITY TYPE] ("PBM"), awarded under Solicitation No. [___].

RECITALS. The Plan is a self-funded governmental health plan covering approximately [___] members with annual prescription drug expenditures of approximately $[___]. PBM represents that it is licensed under [STATE PBM LICENSURE STATUTE] and holds all authorizations required to perform this Agreement. The parties intend a fully transparent, pass-through arrangement in which PBM's sole compensation is stated in Exhibit E.

SECTION 1 — DEFINITIONS

1.1 Affiliation tiers. (a) **"Affiliate"** means any entity controlling, controlled by, or under common control with PBM, including any pharmacy, group purchasing organization, wholesaler, private-label entity, insurer, or rebate aggregator. (b) **"Economically Related Entity"** means any person or entity, whether or not an Affiliate, in which PBM, its ultimate parent, or another PBM Related Entity holds, directly or indirectly, material equity, management rights, profit participation, revenue sharing or revenue participation, purchasing control or purchasing/contracting rights, financial incentives, or any other material shared economics or reciprocal financial interest relating to drugs or services furnished to Plan Members — including minority-owned joint ventures, contractual GPO relationships, white-label and private-label ventures, and entities affiliated through contract rather than equity — excluding only passive investments below [5]% with no purchasing, management, or dispensing-linked economics. (c) **"PBM Related Entity"** means any Affiliate or Economically Related Entity. An ordinary third-party service provider or subcontractor dealing with PBM at arm's length, with no shared economics described in (b), is not a PBM Related Entity by reason of that contract alone. (d) Related Entity status governs the economic, attribution, ledger, disclosure, audit, formulary, steering, and anti-retaliation provisions of this Agreement. The Section 3.2(a) Net Acquisition Cost pricing rule applies to every Affiliate pharmacy and to every pharmacy that is an Economically Related Entity — including any pharmacy in which PBM or any PBM Related Entity has material equity, profit participation, revenue participation, management rights, purchasing control, or material economic benefit from dispensing Plan Claims — and PBM shall structure each such relationship so that the records required by Sections 3.2(c) and 9.2 are available for production per Section 5.2.

1.2 "AWP" means Average Wholesale Price per unit for a product's NDC-11 on the date of dispensing, per the most current Medi-Span file, on a post-rollback basis. PBM has no discretion over the AWP source or value. If Medi-Span ceases publishing AWP, or AWP otherwise ceases to be available: (a) every AWP-stated guarantee and term automatically operates on its WAC-stated equivalent per the dual statement required by Section 3.6 and Exhibit A-3, with no amendment, negotiation, or agreement required; and (b) for any residual use of AWP, the successor benchmark is the equivalent field of a nationally recognized pricing compendium designated in writing by the Plan Sponsor, with the Plan Sponsor's independent auditor certifying economic equivalence using the prevailing brand AWP-to-WAC relationship at cessation. PBM's agreement is not required for either step, and no cessation or successor event may change any economic outcome for the Plan.
1.3 "Brand Drug" / "Generic Drug" are determined exclusively by the Medi-Span Multisource, Brand Name, and DAW code criteria set forth in Exhibit A-1. PBM shall not apply any proprietary classification algorithm, and a drug's classification shall be identical for member cost share, claim pricing, and every guarantee reconciliation.
1.4 "NADAC" means the National Average Drug Acquisition Cost benchmark published by CMS, per unit, current as of the date of dispensing (or its federal successor). **"WAC"** means Wholesale Acquisition Cost per unit for the NDC-11 per the most current Medi-Span file on the date of dispensing.
1.5 "Net Acquisition Cost" means the actual net cost of a product to the dispensing pharmacy or its purchasing Affiliate or PBM Related Entity after all discounts, rebates, credits, chargebacks, volume or bulk-purchase credits, stocking allowances, prompt-pay discounts, free goods, and price concessions of any kind received from any source by PBM or any PBM Related Entity, determined with: (a) enterprise-level or cross-client credits allocated per Section 5.4; and (b) any purchase from a PBM Related Entity priced at the true third-party cost of the underlying product.
1.6 "Manufacturer Revenue" means all compensation of any kind received by PBM or any PBM Related Entity or subcontractor, directly or indirectly, related to Plan utilization, regardless of how categorized, including formulary rebates, incentive and market-share payments, administrative, service, and data fees, price protection payments, outcome payments, and all new forms of revenue created during the Term. Any economic value received by PBM or any PBM Related Entity from any manufacturer, wholesaler, supplier, purchasing entity, rebate aggregator, or other drug-channel counterparty that relates to products, manufacturers, markets, utilization, formulary access, purchasing activity, data, or services that include Plan utilization is presumed attributable to Plan utilization and subject to the Section 5.4 allocation; PBM may rebut the presumption only as to specific amounts, by contemporaneous third-party records demonstrating no relationship to Plan utilization, and bears the burden of proof as to every dollar. Neither the Plan Sponsor nor its auditor bears any burden to trace attribution. Enterprise-level amounts are allocated to the Plan per Section 5.4, so that the Plan's share cannot be diluted across PBM's book of business.
1.7 "Pass-Through." Every dollar paid by the Plan, and every economic event attributable to Plan utilization, must reconcile through the six buckets of Section 2.5 and the Exhibit I interfaces, which together constitute the operative pass-through test of this Agreement; no residual economic value may be retained by PBM or any PBM Related Entity other than the Administrative Fee defined in Section 2.3. Prohibited spread at the claim level is governed by Sections 3.1 and 3.2. If Pharmacy Reimbursement exceeds Plan Claim Cost because of a pricing guarantee, benchmark ceiling, reimbursement floor, or other obligation of PBM under this Agreement, the excess is a PBM Price Guarantee Differential borne solely by PBM from its own

resources, without limitation to the amount of its compensation, shall not be invoiced to or recovered from the Plan, any Member, any pharmacy, or any Plan vendor, and is not prohibited spread. For the avoidance of doubt, PBM shall not retain any difference between mail order or specialty acquisition costs and any amount guaranteed or invoiced to the Plan.

1.8 "Specialty Drug" means a drug that (a) has a monthly cost at or above the threshold of $[___] per 30-day supply, AND (b) meets the handling, administration, or REMS criteria in Exhibit A-2, AND (c) has been approved in writing by the Plan Sponsor for inclusion on the Specialty Drug List, which the Plan Sponsor owns. No drug is a Specialty Drug absent the Plan Sponsor's affirmative written approval; silence or inaction never adds a drug to the List. No drug shall be deemed a Specialty Drug solely because of its price, manufacturer distribution arrangement, rebate status, PBM contracting arrangement, or availability through a PBM Related Entity, and PBM bears the burden of demonstrating that every proposed Specialty Drug satisfies the criteria. The List shall be re-certified annually, and any listed drug shall be removed automatically upon commercial launch of a Generic Drug or Biosimilar equivalent unless the Plan Sponsor affirmatively retains it. "New to Market" status expires ninety (90) days after commercial launch, affects guarantee categorization under Exhibit A-3 only, and never alters the pricing rules of Section 3, which apply to every drug from commercial launch.

1.9 "Benchmark Site" means CostPlusDrugs.com and any other publicly transactable pharmacy, manufacturer-direct, wholesaler-direct, or governmental drug purchasing source designated in writing by the Plan Sponsor. A source is "publicly transactable" if the product can be purchased on its published terms by any of: PBM; the Plan; a Plan-designated purchasing entity; or the dispensing pharmacy — or where PBM could obtain such access through commercially reasonable enrollment, credentialing, or purchasing arrangements. PBM's refusal or failure to take commercially reasonable steps to establish access shall not render a Benchmark Site unavailable. "Published Benchmark Cost" means, for CostPlusDrugs.com, the published drug cost plus fifteen percent (15%) markup component for the product (exclusive of any pharmacy labor or shipping components), and for any other designated source, the analogous published drug-cost component the Plan Sponsor specifies at designation — in each case as of the date of adjudication, matched on drug, strength, dosage form, quantity, and package configuration per the normalization rules in Exhibit I. Where multiple Benchmark Sites list a product, the lowest applicable Published Benchmark Cost governs.

1.10 "Benchmark Rate" means, for any Claim at a non-Affiliate pharmacy priced under Section 3.1: the lesser of NADAC plus the applicable professional dispensing fee in Exhibit D and MAC plus that fee, where both exist for the product; otherwise whichever of the two exists; otherwise WAC minus the percentage bid in Exhibit D plus that fee — and never any AWP-based rate. The Benchmark Rate is subject to the Section 3.5 appeal process.

1.11 "Late Remittance Damages" means liquidated damages on any amount not remitted when due, at [one percent (1%)] [one and one-half percent (1.5%)] per month simple [ALTERNATE: SOFR plus ten percent (10%) per annum], not to exceed the maximum permitted by applicable law. The parties agree this is a reasonable pre-estimate of the Plan's loss from delayed remittance — lost investment return on public funds, administrative burden, and enforcement cost — which is difficult to fix precisely, and not a penalty.

1.12 "Plan Claim Cost" means the amount the Plan owes for a Claim, determined under Section 3. **1.13 "Pharmacy Reimbursement"** means the amount the dispensing pharmacy actually receives and finally retains for a Claim, determined under Sections 3 and 7.2. **1.14 "PBM Price Guarantee Differential"** means any amount by which Pharmacy Reimbursement exceeds Plan Claim Cost, treated as provided in Section 1.7.

1.15 "Claim," "Member," "Member Cost Share," "MAC," "U&C," "Participating Pharmacy," and

other capitalized terms have the meanings in Exhibit A-1, provided that pharmacy and channel classifications take their meaning exclusively from Section 1.16, and Exhibit A-1 supplies identifiers only, never classifications. "U&C," "submitted cost," and every other claims-level pricing input take their exact values from the NCPDP fields and calculation rules specified in Exhibit I, which shall state for each: the field identifier; inclusion or exclusion of ingredient cost, dispensing fee, tax, and incentive amounts; and quantity normalization. Exhibit A-1 [or Exhibit D] shall include a single order-of-operations schedule showing the calculation sequence for every pricing concept in this Agreement (Net Acquisition Cost, NADAC, MAC, WAC-minus, U&C, submitted cost, Benchmark Ceiling, specialty ceiling, Member Cost Share).

1.16 Pharmacy and Channel Classification (function over label). (a) "Pharmacy" means an entity licensed as a pharmacy under applicable state law, identified on every Claim by its NPI and NCPDP number, which PBM shall carry in every Exhibit I record together with the dispensing facts in (b). (b) Channel is determined by how the Claim was actually dispensed, never by label: a "Retail Claim" is dispensed at a licensed pharmacy's physical location to a Member (or the Member's agent) in person or by that pharmacy's own local delivery; a "Mail Order Claim" is dispensed by common-carrier shipment from any facility, including central-fill, regardless of how the pharmacy or PBM designates itself; specialty pricing attaches to the Drug under Section 1.8 and Exhibit A-3, not to any pharmacy's self-designation; and Affiliate or Economically Related Entity pharmacy status under Section 1.1 controls over every channel label — every Claim dispensed by such a pharmacy in any channel prices under Section 3.2(a). (c) Channel coding is auditable against dispensing facts through Exhibit I; network-contract labels, marketing designations, and self-classification have no pricing effect. (d) Misclassification default: any Claim whose recorded channel does not match its dispensing facts, or whose coding PBM cannot substantiate, reprices at whichever applicable rule produces the lowest Plan Claim Cost, with refund and Late Remittance Damages from the original payment date; recurring misclassification is reportable in the Section 9.4(b)(7) exception reports and, if persistent, a material breach.

1.17 "Cheapest Lawful Option" means, for any Claim, the lowest amount available for the same drug, strength, dosage form, and quantity through: Plan Claim Cost; the dispensing pharmacy's U&C or cash price; a Benchmark Site; or a Plan Sponsor-designated Alternative Drug Source.

SECTION 2 — SERVICES AND STANDARD OF CONDUCT

2.1 PBM shall provide claims adjudication, network administration, mail and specialty dispensing arrangements, formulary support, clinical and utilization management as directed by the Plan Sponsor, rebate contracting and collection, eligibility, member services, reporting, and EGWP administration if elected, all as specified in Exhibit B (Statement of Work). 2.2 The Plan Sponsor retains final authority over the formulary, plan design, Specialty Drug List, MAC methodology (per Section 3.5), and all clinical programs; PBM implements. **2.3 Administrative Fee.** PBM's sole compensation, and the only residual value PBM or any PBM Related Entity may retain in connection with the Plan, is the "Administrative Fee" stated in Exhibit E, inclusive of all direct and indirect costs, overhead, and profit. The Administrative Fee excludes, and shall not be deemed to include or embed, any amount received from any pharmacy, manufacturer, GPO, wholesaler, switch, aggregator, PBM Related Entity, subcontractor, Member, or other third party; no such amount is compensation PBM may retain under any characterization. No other

fee, charge, or revenue of any kind may be added during the Term. Bidders shall separately disclose in Exhibit E the portion of the Administrative Fee attributable to PBM Price Guarantee Differential risk.

2.4 Duties of Loyalty and Disclosure; Fiduciary Standard; Conflicts. With respect to all Plan funds it handles, all discretion it exercises, and all compensation it receives under this Agreement, PBM owes contractual duties of loyalty and care solely to the Plan and its Members, shall act in the Plan's economic interest whenever exercising delegated discretion, shall disclose all direct and indirect compensation received in connection with the Plan and every economic conflict of interest (including PBM Related Entity ownership of, or economic interest in, any pharmacy, GPO, wholesaler, or manufacturer relationship touching Plan Claims), shall not place its own or any PBM Related Entity's interest ahead of the Plan's, and shall disgorge to the Plan any compensation retained in breach of this Section, without any requirement that the Plan prove resulting damages. These obligations exist and are enforceable as independent contractual covenants regardless of any statutory or common-law fiduciary status. In addition, PBM acts as a fiduciary of the Plan [cite [STATE PBM FIDUCIARY STATUTE] where enacted]; if that fiduciary designation is held unenforceable or is stricken, the covenants of this Section survive in full. Where Plan and individual Member interests differ, PBM shall follow the Plan Sponsor's lawful direction, subject to the express Member protections of this Agreement, applicable clinical standards, and applicable law. PBM shall also disclose all compensation paid by PBM or any PBM Related Entity to any procurement consultant, benefit consultant, broker, analytics firm, or subcontractor in connection with this Plan or this procurement. The Plan is a governmental plan not subject to ERISA; PBM waives any preemption defense to enforcement of this Section.

2.5 Economic Architecture (Six Buckets). Every dollar of economic value arising in connection with the Plan shall be attributable to exactly one of: (1) the drug's true acquisition economics; (2) Pharmacy Reimbursement, fully disclosed; (3) Member payments, never exceeding the Cheapest Lawful Option; (4) Plan Claim Cost, the lowest contractually permissible amount; (5) manufacturer, GPO, wholesaler, and PBM Related Entity value attributable to Plan utilization, flowing 100% to the Plan; or (6) the Administrative Fee. Any economic value in connection with the Plan not attributable to one of these six buckets is retained in breach and subject to disgorgement under Section 2.4. This Section governs the interpretation of every economic provision of this Agreement.

2.6 Officer Certifications. Quarterly and annually, a named PBM officer with authority over the relevant business shall certify in writing — based on reasonable inquiry, including review of the control reports specified in Exhibit B, certifications obtained from each Affiliate and Economically Related Entity, the Exhibit I ledger reconciliations, and inquiry of the responsible personnel identified in Exhibit B — that: all Manufacturer Revenue has been disclosed and remitted; all GPO and purchasing economics have been disclosed with their compensation drivers per Section 5.4; no prohibited spread exists; all Affiliates and Economically Related Entities are identified and current; no Alternative Drug Source retaliation, economic or operational, has occurred; all pricing under Section 3.2(a) reflects Net Acquisition Cost; and the Exhibit I feeds and ledger are complete. A knowingly or recklessly false certification is a material breach and cause for immediate termination, subject to the Section 14.3 indemnity and all remedies available under applicable state law, including state false-claims remedies where legally applicable. An innocently erroneous certification shall be corrected promptly upon discovery, with restitution of any affected amounts; innocent technical error does not itself trigger fraud-level consequences.

SECTION 3 — CLAIM PRICING

3.1 Non-Affiliate pharmacies (benchmark construction). For each Claim at a pharmacy priced under this Section per Sections 1.16 and 3.2(b), Plan Claim Cost equals the lowest applicable of: (a) the Benchmark Rate; (b) the pharmacy's U&C; (c) submitted cost (each per the Exhibit I field definitions); or (d) the Section 3.3 ceiling where applicable. Pharmacy Reimbursement is determined under this Section and Section 7.2. PBM shall retain no positive spread; any amount by which Pharmacy Reimbursement exceeds Plan Claim Cost is a PBM Price Guarantee Differential under Section 1.7. A Claim adjudicating at the pharmacy's own U&C or submitted charge reflects the pharmacy's voluntary pricing and does not violate the Section 7.2 floor, which applies only to PBM-determined rates (the Benchmark Rate). The unavailability of any single pricing benchmark shall never suspend or excuse this Section; pricing falls to the next component of the Benchmark Rate definition.

3.2 Related-entity pharmacies; non-affiliated mail and specialty. (a) Each Claim dispensed by any Affiliate pharmacy, or by any pharmacy that is an Economically Related Entity, in any channel, shall be invoiced at Net Acquisition Cost plus the applicable stated dispensing fee in Exhibit D; PBM shall retain no margin of any kind on such Claims, and the documentation default in (c) applies to every such Claim. (b) Each Claim at a Mail Order or specialty pharmacy that is not priced under (a) is priced under the Section 3.1 construction using the applicable Exhibit D channel dispensing fee. (c) Documentation default: if PBM fails to produce the records substantiating Net Acquisition Cost for any Claim priced under (a) — including transfer-price and supplier purchase records — within ten (10) business days of the Plan Sponsor's or its auditor's request, Plan Claim Cost for each affected Claim is provisionally reset to the lower of (i) the amount originally invoiced and (ii) the lowest of NADAC plus the Exhibit D fee, WAC plus that fee, or the Published Benchmark Cost plus that fee where the product is listed, with any excess refunded immediately with Late Remittance Damages from the original payment date. PBM has one cure period of ten (10) additional business days to produce the records; if produced and they establish actual Net Acquisition Cost, correction applies prospectively only, any true-up of the provisional reset requires Plan Sponsor approval, and in no event may late production establish a price higher than the amount originally invoiced. Absent timely cure the reset is final and not subject to dispute. Repeated late production is a material breach. (d) The drug-level rates in Exhibit A-3 apply as a per-drug ceiling for every Specialty Drug in every channel and at every pharmacy type; no specialty guarantee or ceiling may ever increase any price above Net Acquisition Cost plus the applicable fee where that rule applies.

3.3 Benchmark Ceiling. Notwithstanding any other provision, for any Generic Drug or Biosimilar listed on a Benchmark Site — and for any other covered Drug, including any Brand Drug, for which a directly comparable publicly transactable benchmark exists (Brand Drugs matched on identical NDC) — the ingredient cost component of Plan Claim Cost shall not exceed the Published Benchmark Cost, with the applicable Exhibit D dispensing fee payable in addition. Where a Benchmark Site offers an actual all-in delivered price for the identical product and quantity, the Plan Sponsor may elect the lower of the contract formula and that actual all-in transactable cost. For Brand Drugs, a benchmark price qualifies only if the product is in stock or reasonably orderable in the claimed quantity and the price is generally available: prices conditioned on coupons, personal or income eligibility, patient-specific manufacturer assistance, or one-time promotions do not qualify. The ceiling operates solely as a ceiling and may never increase Plan Claim Cost. If Pharmacy Reimbursement required under this Agreement exceeds the ceiling, the excess is a PBM Price Guarantee Differential funded solely by PBM per Section

1.7; PBM may cure the differential by sourcing the product at the Benchmark Site's published prices. Pharmacies priced under Section 3.2(a) shall be reimbursed at no more than the ceiling. Member Cost Share never exceeds the ceiling. PBM shall capture Benchmark Site prices on a daily or event-driven basis with date/time stamps, quantity, package configuration, and NDC where available, per the Exhibit I normalization rules, retained for the full Section 9.2 audit period.

3.4 Member pricing and accumulator credit. (a) Member Cost Share for any Claim shall equal the least of: (i) the plan design copay, or the plan design coinsurance percentage applied to Plan Claim Cost; (ii) Plan Claim Cost; (iii) the Section 3.3 ceiling where applicable; or (iv) the pharmacy's cash price — and shall never exceed the Cheapest Lawful Option. Coinsurance shall never be computed on any amount greater than Plan Claim Cost. (b) Cash and alternative-source accumulator credit. If a Member purchases a covered drug outside the Plan — at any pharmacy, Benchmark Site, or Alternative Drug Source — for less than the amount payable through the Plan, the documented amount the Member paid shall be credited in full toward all applicable deductible and out-of-pocket accumulators to the same extent as a conventionally processed Claim, and PBM shall transmit the purchase to the Plan's claims and accumulator records. Acceptable documentation includes an electronic receipt, pharmacy receipt, transaction record, Benchmark Site invoice, or manufacturer-direct invoice; PBM shall not impose documentation requirements more burdensome than necessary to establish member, drug, quantity, date, and amount. PBM shall provide automated electronic crediting wherever practicable and a simple submission process (mobile, web, and paper) at no charge where it is not; each submission is processed and credited within ten (10) business days, no credit may be denied for immaterial defects of form, and PBM shall report credit volumes quarterly. (c) Assistance counts. All manufacturer copay assistance, coupons, and charitable foundation support applied to a Member's cost share shall count in full toward the Member's deductible and out-of-pocket maximum, except that (i) for any Member enrolled in an HSA-qualified high-deductible health plan, third-party assistance is credited only to the extent consistent with maintaining HSA qualification and eligibility under the Internal Revenue Code and IRS guidance, and (ii) for EGWP or other Medicare Part D coverage, cost-share and TrOOP accumulation follow applicable CMS requirements. No accumulator, maximizer, or similar program that excludes such amounts may be applied absent the Plan Sponsor's express written direction, and PBM shall receive no compensation of any kind related to any such program.

3.5 MAC governance. A single MAC List shall apply wherever MAC is an applicable pricing input under this Agreement, to both Plan Claim Cost and Pharmacy Reimbursement; the MAC List does not supersede Section 3.2(a)'s Net Acquisition Cost requirement. (a) Methodology control. The Plan Sponsor approves the MAC methodology and all material changes to it. PBM may make individual MAC adjustments without advance approval only pursuant to the approved methodology, which shall incorporate the shortage protocol in (c). The Plan Sponsor may override any MAC price prospectively at any time. (b) Ceiling, no floor. No MAC may exceed [___]% of NADAC where NADAC exists — this percentage is fixed by the Plan Sponsor in the solicitation and is not proposed by PBM — absent documented evidence that commercially reasonable acquisition at or below that amount is unavailable; no minimum relative to NADAC applies, and nothing in this Section requires the Plan to pay more than prevailing market acquisition cost. Where NADAC is unpublished for a product or is stale beyond [30] days, the ceiling reference falls to the next component of the Benchmark Rate; single-source generics price under the Benchmark Rate; documented market-wide acquisition above NADAC is handled exclusively through the shortage protocol in (c). (c) Shortage protocol. For any product on the FDA or ASHP drug shortage list, or with documented market-wide acquisition above the

(b) ceiling, PBM may reprice immediately with same-day notice and supporting documentation; each such reprice is subject to retroactive review and shall be rolled back, with restitution, when the condition ends. (d) Completeness. Every Multi-Source Generic shall be added to the MAC List no later than ten (10) business days after commercially meaningful availability from a second A-rated supplier, and in all cases within thirty (30) calendar days, absent written exception; any generic not on the MAC List shall be priced at NADAC plus the Exhibit D fee, never at Brand Drug or AWP-discount rates. (e) Pharmacy appeal. A non-Affiliate pharmacy may appeal any MAC price below its actual invoiced acquisition cost with wholesaler invoice documentation; PBM decides within seven (7) business days. A sustained appeal is paid to the appealing pharmacy retroactively to the fill date at documented acquisition cost plus the Exhibit D fee; any excess over Plan Claim Cost is a PBM Price Guarantee Differential. The network-wide MAC changes only if the corrected price remains within the (b) ceiling; a single pharmacy's invoice never raises Plan Claim Cost for other pharmacies' Claims [conform to [STATE MAC APPEAL STATUTE] if stricter]. (f) Reporting. Machine-readable MAC change file by the next business day (old price, new price, effective date, reason, applicable NADAC, shortage flags), plus dated full-list snapshots monthly.

3.6 Guarantees. The discount, dispensing fee, and rebate guarantees in Exhibit A-3 are secondary to Sections 3.1–3.5. Brand discount guarantees are stated in both AWP and WAC terms. No Generic Drug guarantee shall be expressed as an AWP discount. Guarantees reconcile per component with no offsetting across channels, drug types, guarantee categories, or between pricing and fees; shortfalls are paid dollar-for-dollar within ninety (90) days with Late Remittance Damages thereafter; zero-balance Claims count; no rounding; all measurement uses Plan-specific data. PBM shall deliver quarterly, without request, a claim-level reconciliation file and a distribution report showing: the percentage and dollar value of Claims priced at or below NADAC and above 1.2×, 2×, 5×, and 10× NADAC; total excess dollars over NADAC and over the Section 3.3 benchmark; the utilization-weighted average multiple of NADAC; the 95th and 99th percentile markup over NADAC; and the top 100 NDCs by excess dollars over NADAC — each split by Section 3.2(a) versus other pharmacies and by Generic, Brand, and Specialty Drug.

3.7 Alternative Drug Sources. The Plan Sponsor may designate, contract with, or make available to Members any pharmacy, direct-purchase source, manufacturer program, public pharmacy, mail-order pharmacy, specialty pharmacy, cash-pay source, or other lawful dispensing arrangement — including any Benchmark Site or its affiliated pharmacy — whenever the Plan Sponsor determines it is clinically and economically advantageous, without PBM consent. PBM shall integrate each such source into eligibility, formulary, claims, prior authorization, reporting, and accumulator systems at no charge beyond the Exhibit E fee, with production implementation no later than thirty (30) calendar days after the Plan Sponsor provides the implementation specifications conforming to the completeness checklist in Exhibit I — a submission is deemed complete unless PBM identifies specific deficiencies in writing within five (5) business days — including API/SFTP support, eligibility and accumulator integration, prior-authorization integration, reporting, and claim-equivalent record creation, with automatic Exhibit F service credits for each day of delay. Go-live acceptance follows the Exhibit I procedure: Plan-supplied test file, test adjudications, accumulator and prior-authorization testing, defined error thresholds, and production certification; PBM may not refuse or delay go-live for defects that do not exceed the defined thresholds. PBM shall not require any Alternative Drug Source to adopt proprietary PBM technology, proprietary switching arrangements, or commercially unreasonable data requirements where the same objective can be achieved through reasonable industry-standard interfaces. PBM shall not impose or assert

any penalty, minimum volume requirement, lost-rebate charge, network fee, reconciliation charge, guarantee adjustment, fee increase, or any other economic consequence because the Plan uses an Alternative Drug Source; every guarantee and economic term remains in full force measured on the utilization that continues to flow through PBM. PBM shall likewise not alter formulary status, prior-authorization or step-therapy requirements, network status, member communications, data feeds, eligibility rules, or any other clinical or administrative condition where the purpose or effect is to disadvantage an Alternative Drug Source or the Members using it.

3.8 Benefit-Assignment Integrity; medical-benefit pricing. (a) No drug's benefit assignment (pharmacy versus medical), billing pathway, or site of dispensing or administration — including any move to or from white-bagging, brown-bagging, buy-and-bill, or a Related Entity infusion or home-administration channel — may be changed, recommended into effect, or implemented through utilization-management design without the Plan Sponsor's prior written approval, supported by a net-cost and clinical-impact analysis across both benefits. (b) Neither PBM nor any PBM Related Entity may receive compensation that varies with a drug's benefit assignment or site of care, and no such change may reduce, remove, or re-bucket any drug from the pricing rules, ceilings, guarantees, or Manufacturer Revenue obligations of this Agreement: a drug moved out of the pharmacy benefit is deemed to remain within Sections 3, 4, and 5 for all economics PBM or any PBM Related Entity touches. (c) Medical-benefit pricing rule. Where PBM or any PBM Related Entity purchases or supplies a covered drug billed under the medical benefit, the drug acquisition component shall equal Net Acquisition Cost plus an expressly stated distribution or dispensing fee. Where a PBM Related Entity only administers a drug it did not purchase or supply, the acquisition rule applies to the actual supplier if that supplier is itself a PBM Related Entity, and the administration fee shall be separately stated and disclosed. An entity that merely bills on behalf of an unrelated provider does not thereby assume acquisition-pricing responsibility, but all such claims shall separately itemize drug, administration, and facility components and carry an NDC-to-HCPCS crosswalk where available. (d) The Plan Sponsor intends to mirror this Agreement's Specialty Drug pricing, attribution, and data terms in its medical-benefit administrator's agreement; PBM shall cooperate, including supplying Exhibit I specifications and cross-benefit linkage keys; Related Entity medical-benefit transactions flow into the Exhibit I feed and economic-event ledger with the same linkage, pricing documentation, and attribution presumption as pharmacy-benefit Claims. (e) Quarterly reporting of every drug whose benefit assignment or site-of-care pattern shifted materially, with volumes and cost per unit in each pathway.

SECTION 4 — MANUFACTURER REVENUE

4.1 One hundred percent (100%) of Manufacturer Revenue shall be paid to the Plan. The Plan Sponsor shall elect annually to receive the greater of actual Manufacturer Revenue or the guaranteed minimums in Exhibit C, which expressly include New-to-Market, Exclusive Distribution, and Limited Distribution drugs. No rebate management, aggregation, collection, or data fee may be charged or netted.

4.2 Guaranteed amounts are payable quarterly within thirty (30) days after quarter-end regardless of when collected, with per-channel detail reports delivered without request; annual true-up of actuals within one hundred twenty (120) days. Amounts unpaid after the due date accrue Late Remittance Damages until paid. All amounts survive expiration or termination in full.

4.3 The only Claims excludable from Exhibit C guarantees are those in the closed list in Exhibit

C-1; open-ended formulations such as "unable to collect" or "etc." shall not exclude any Claim. Each C-1 exclusion shall specify the exact claim category, the exact reason, its duration, and its treatment in guarantee measurement. Exclusion of a Claim from a guarantee never excludes it from actual pass-through: one hundred percent of Manufacturer Revenue actually attributable to excluded Claims is still payable to the Plan under Section 4.1.

4.4 **Economic Substance Controls; list-price reductions.** The characterization, timing, recipient, contractual label, or accounting treatment of economic value shall not affect the Plan's entitlement to that value. Any economic value attributable directly or indirectly to Plan utilization shall either (a) reduce Net Acquisition Cost, (b) constitute Manufacturer Revenue payable 100% to the Plan, or (c) otherwise reduce Plan cost dollar-for-dollar. PBM may not avoid any payment obligation through reclassification of any form of consideration. If any manufacturer reduces a list price or converts rebate value into purchase-price value, the full economic value previously flowing to the Plan shall continue to flow to the Plan as lower prices, continued payments, or both, measured against a defined baseline: for each affected NDC, pre-change Net Plan Cost equals Plan Claim Cost minus Manufacturer Revenue attributable to the NDC minus purchasing/GPO value minus other attributable economic value — normalized per unit, per standardized 30-day equivalent, or per other clinical unit specified in Exhibit C, so that changes in strength mix, quantity, or dosing do not distort the comparison — and post-change Net Plan Cost may not exceed that baseline except for expressly enumerated, objectively measurable adjustments stated in Exhibit C. Exclusive safe harbor: a rebate credit against the Exhibit C minimums may apply only for (i) a Biosimilar launched after pricing was set with a WAC reduction of forty-five percent (45%) or more versus its reference product, or carrying a dedicated discount guarantee delivering at least ten percent (10%) net cost savings versus the reference product — with the reference AWP, reference WAC, and discount guarantee used for purposes of the applicable guarantee calculation remaining fixed during eligibility — or such other product-specific threshold as the Plan Sponsor approves in writing after independent analysis, with no unilateral PBM adjustment; or (ii) a statutory price-cap event, by mutual agreement not unreasonably withheld — in each case on sixty (60) days' notice with detailed financial modeling, and automatically expiring at the next market check, renewal, or re-procurement. No other paper credit shall satisfy any cash obligation. No economic term may be repriced except by bilateral written amendment supported by Claim-level evidence; unilateral equitable adjustments, mix-consistency conditions, and market-event triggers are void.

SECTION 5 — PURCHASING ENTITIES AND RELATED ENTITIES

5.1 All purchase discounts, volume credits, and supplier payments received by PBM or any PBM Related Entity shall be allocated per Section 5.4 and passed through per Section 1.5. 5.2 PBM identifies its rebate aggregation and purchasing entities as [LIST] and warrants full flow-through from each. PBM shall structure all Related Entity and purchasing arrangements so that all Plan-required records are legally available for production under Section 9.2, and shall terminate its use of any entity that refuses that access. If PBM asserts that disclosure of any record is legally prohibited: PBM bears the burden of proof and shall provide a written legal opinion with citation; the auditor shall receive the maximum lawfully producible evidence; all uncertainty is construed against PBM; inability to substantiate economics triggers the Section 3.2(c) documentation default for affected Claims; and repeated inability is cause for termination. The Plan contracts with PBM and shall never be required to pursue any Related Entity to obtain

records. 5.3 PBM shall disclose any new PBM Related Entity or purchasing arrangement affecting Plan economics within thirty (30) days of its creation.
5.4 Driver-based allocation. Enterprise-level, cross-client, or book-of-business value — volume credits, purchase discounts, supplier payments, GPO distributions, and analogous consideration — shall be allocated to the Plan according to the objectively identifiable economic driver of the payment under the underlying third-party agreement, with no PBM discretion: value computed as a percentage of purchases allocates by the Plan's share of the qualifying dollars; per-unit value allocates by the Plan's qualifying units; rebate-percentage value tracks the utilization generating the rebate; market-share value tracks the share-generating utilization. Where no driver is objectively identifiable, value allocates by the closest objectively correlated economic measure, applied in this order: the Plan's share of qualifying spend; the Plan's share of rebate-generating utilization; and only then the Plan's share of qualifying units — with the selected fallback subject to the auditor's approval. For every allocation, PBM shall produce the actual third-party compensation formula and the driver data — payment basis, measurement period, products, volume, spend, rebate, market share, or other driver — and the Plan Sponsor's auditor independently calculates the Plan's allocation from that data; PBM may never satisfy this Section by supplying only a final allocation number. Allocations are computed quarterly, reported with the Section 4.2 detail, and reconciled at the annual true-up. Attribution disputes are resolved under the Section 1.6 presumption. Formulations such as "reasonable share," "equitable allocation," or any methodology proposed or modified by PBM are void. Exhibit C-2 contains worked examples only and creates no discretion.

SECTION 6 — FORMULARY AND CLINICAL

6.1 The Plan Sponsor approves the formulary and all changes; final formulary decisions belong exclusively to the Plan Sponsor. PBM shall recommend the clinically appropriate option expected to produce the lowest total net Plan cost among therapeutically acceptable alternatives, including Biosimilars and low-list-price products — where "total net Plan cost" includes pharmacy spend, medical spend, administration, site-of-care costs, Member cost, Manufacturer Revenue, acquisition concessions, and objectively measurable adherence and disruption effects, and shall not be narrowed to pharmacy economics — and the Plan Sponsor makes the final decision considering clinical outcomes, disruption, Member impact, medical-benefit effects, net cost, and other Plan objectives; PBM implements the Plan Sponsor's direction. Every formulary recommendation shall disclose, for each clinically reasonable alternative: gross ingredient cost; expected Manufacturer Revenue; expected acquisition discounts; Member cost; total expected net cost to the Plan; and all direct or indirect economic benefits to PBM and its Related Entities. 6.2 Clinical program savings belong 100% to the Plan; no clinical fee may be contingent on drug spend or "shared savings." 6.3 PBM shall not restrict any provider's or pharmacist's communication with any Member about treatment options or prices. **6.4 No pay-for-placement authority.** PBM shall have no authority to select, exclude, prefer, tier, disadvantage, or otherwise position any drug based upon Manufacturer Revenue or any payment or economic benefit received by PBM or any PBM Related Entity, except where the Plan Sponsor affirmatively selects a placement after receiving the complete Section 6.1 economics.
6.5 Utilization-Management Outcomes. (a) Quarterly, by drug and in aggregate, through Exhibit I: prior-authorization and step-therapy volumes; approval and denial rates by reason code; appeal rates, overturn rates, and median, 90th-percentile, and 95th-percentile time to

decision at each level; and abandonment rates — separately for Related Entity and non-Related-Entity dispensing channels. Exhibit I shall define the methodology: minimum case count of [20] before any percentage triggers review; what constitutes initiation and abandonment; treatment of incomplete provider submissions, Member and provider withdrawals, resubmissions (counted once per episode), and duplicate PAs. Reporting cohorts shall not combine unrelated drugs to dilute a result, nor split a single drug across channels or PA types to avoid a threshold; the Plan Sponsor may require aggregation or disaggregation where clinically or economically appropriate. (b) No PBM or Related Entity compensation, guarantee credit, or performance metric may improve with denial volume, denial rate, or abandonment; savings attributable to overturned denials or to abandonment following utilization-management friction are separately identified and excluded from clinical-program savings. (c) An overturn rate above [25]% or abandonment above [__]% for any drug in any quarter (at or above the minimum case count) triggers Plan Sponsor criteria review, implemented within [30] days. (d) No utilization-management program may be designed or operated where the purpose or effect is savings through non-treatment rather than appropriate lower-cost treatment. (e) Clinical independence. Utilization-management criteria may not differ based on the economic interest of PBM or any PBM Related Entity — including criteria favoring Related Entity pharmacy use, higher-rebate products, products with better GPO economics, or medical-benefit migration — unless the Plan Sponsor expressly approves after full disclosure of the economics. (f) Criteria versioning. PBM shall archive, for the full Section 9.2 period: each utilization-management criteria version; effective dates; changes; rationale; approver; and the economic impacts disclosed at approval.

SECTION 7 — PHARMACY NETWORK PROTECTIONS

7.1 Finality. Plan Claims are final when adjudicated. Neither PBM nor any PBM Related Entity shall impose any post-adjudication recoupment, offset, reduction, fee, penalty, or chargeback of any kind, however styled, against any pharmacy with respect to Plan Claims, except for the following closed set of corrections, each resolved through the appeal process in Exhibit B: documented fraud, waste, or abuse; documented clerical error; duplicate claims; claims reversed by the dispensing pharmacy; verified incorrect quantity, days-supply, or NDC; retroactive Member eligibility corrections; coordination-of-benefits corrections; and recoveries expressly required by law. Except for fraud, no correction may be initiated more than one hundred eighty (180) days after adjudication. Network performance fees, DIR-like fees, effective-rate reconciliations, generic- or brand-effective-rate adjustments, participation fees, and volume reconciliations are not permissible corrections under any label. Corrections under the Section 3.5(e) MAC appeal operate in the pharmacy's favor and are not recoupments.

7.2 No volume conditioning; floors. PBM shall not condition any pharmacy's network participation, reimbursement, or fees on any minimum volume dispensed through PBM or its Related Entities, and shall not assess any volume-shortfall penalty against any pharmacy serving Plan Members. PBM-determined Pharmacy Reimbursement to non-Affiliate pharmacies — any Claim priced at the Benchmark Rate rather than limited by the pharmacy's own U&C or submitted charge — shall not be less than the Benchmark Rate [or the floor required by [STATE STATUTE], if higher], subject to the Section 3.5(e) appeal. Claims adjudicating at the pharmacy's own U&C or submitted charge do not violate this floor.

7.3 Steering; any willing provider. PBM shall not steer Claims into Related Entity channels to capture margin, nor away from them solely to enhance PBM's profits. Any exclusive or preferred

channel accepts all Claims within its scope, profitable or not, except Claims it cannot lawfully or objectively dispense under an exception approved pursuant to this Section. No mandatory mail order; any willing provider meeting network terms shall be admitted, and network terms shall be objective, uniformly applied, clinically relevant, economically reasonable, and not designed or applied to disadvantage pharmacies that are not PBM Related Entities; Members shall never pay more than the pharmacy's cash price. Exceptions are permitted only where dispensing through a pharmacy is objectively impossible because of a manufacturer-imposed limited-distribution restriction, an FDA REMS requirement, applicable law, cold-chain or controlled-substance handling the pharmacy cannot satisfy, or the pharmacy's inability to satisfy objective clinical or operational standards established by the Plan Sponsor — each approved in writing drug-by-drug, reported quarterly, re-certified annually, and lapsing when the restriction ends. PBM economic arrangements, Related Entity ownership, rebates, purchasing contracts, and profitability are never permissible grounds for exclusion.

7.4 Remedies. For each breach of this Section 7: (i) restitution of every amount improperly charged, withheld, or recouped; (ii) Late Remittance Damages on that amount from the date taken; (iii) liquidated damages of $[500] per affected Claim, increased to $[1,500] per affected Claim for repeated or systemic violations — "repeated or systemic" meaning the same violation type affecting [100] or more Claims, recurring in two or more reporting periods, or resulting from a common configuration, policy, contract term, or coding logic — which the parties agree is a reasonable pre-estimate of harm difficult to fix precisely, including pharmacy attrition, network degradation, and enforcement cost, and not a penalty [confirm under [STATE] liquidated-damages doctrine]; and (iv) cause for termination. **7.5 Anti-circumvention.** PBM shall not apply, enforce, or permit any pharmacy-network contract term with respect to Plan Claims that would produce an outcome prohibited by this Section 7, and PBM is responsible for ensuring that all downstream network arrangements, including those of Related Entities and subcontractors, comply.

SECTION 8 — MOST FAVORED PRICING; MARKET CHECK; TRANSPARENCY

8.1 Most favored pricing — two tiers. (a) States (automatic, auditor-administered). PBM warrants that no state client receives more favorable net effective pricing than the Plan on any financial component — discounts, dispensing fees, rebate guarantees, or administrative fees — measured per unit and per component. "State client" means any plan sponsored by a state or state instrumentality, including employee, retiree, university, and public-authority plans, and excluding Medicaid fee-for-service and Medicaid managed-care PBM arrangements. PBM shall deliver quarterly to the Plan Sponsor's independent auditor the unmasked pricing terms provided to each state client; the auditor certifies to the Plan Sponsor whether a superior term exists, the component, the amount, and the effective date, with the comparator anonymized; the Plan Sponsor retains the right to receive unmasked terms where applicable law or enforcement requires. Any more favorable term applies to the Plan automatically as of the date the other state received it, without reduction, deterioration, or offset in any other component. (b) Comparable commercial clients (auditor-verified). PBM shall provide the auditor, under NDA, the economic terms of its commercial clients meeting the fixed criteria in Exhibit A-4 — a closed list addressing covered lives [±50%], channel mix, formulary restrictiveness, specialty mix, Medicare/EGWP inclusion, geographic footprint, mail penetration, network design, rebate eligibility, average script volume, and service scope, which PBM may not supplement — with

claim-level data sufficient to test them. The auditor compares net effective economics per unit and per component, normalizing across pricing structures from the claim-level data, so structure differences never exclude a client from comparison. Any more favorable per-unit, per-component net term certified by the auditor applies automatically as of certification, retroactive to the start of the then-current contract year, without offset. PBM bears the burden of demonstrating non-comparability under the Exhibit A-4 criteria only; no other comparability argument is permitted.

8.2 Market check (meet, credit, or release). The Plan Sponsor may conduct an annual market check through a third party of its choosing. "Available value" is measured by repricing the Plan's actual utilization at the claim level across total Plan economics — administrative fees, ingredient cost, network reimbursement, Manufacturer Revenue, specialty economics, all other fees, and implementation costs — comparing guaranteed and reasonably modeled terms available in the market, supported by qualifying evidence: executed comparator contracts, binding proposals, recent bid results, validated pricing submissions, or market data supported by claim-level repricing; consultant estimates unsupported by such evidence do not qualify. No term may worsen for the Plan as a result. If the market check identifies improvement of one-half percent (0.5%) or more in available value, PBM shall negotiate conforming terms. Absent executed conforming terms within sixty (60) days, the Plan Sponsor may elect either: (i) termination without penalty on thirty (30) days' notice; or (ii) continuation, in which case the independent auditor's quantification of the identified improvement applies as a credit against amounts owed to PBM, retroactive to the start of the then-current contract year and continuing until conforming terms are executed — unless PBM demonstrates with verifiable evidence that the identified terms are not genuinely available to a plan of the Plan's size, utilization, and profile, in which case the auditor determines the portion that is available and that portion applies as the credit. The credit shall not exceed the verified economic improvement available to this Plan. PBM bears the burden on availability. Conforming terms, when executed, apply retroactively to the start of the then-current contract year, with an editable amendment within ten (10) business days.

8.3 PBM acknowledges that pricing, guarantees, administrative fees, dispensing fees, rebate guarantees, and other economic terms were material elements of a public procurement and shall not be designated by PBM as confidential, proprietary, or trade secret. Nothing herein requires disclosure where disclosure is affirmatively prohibited by applicable law. Interest earned on Plan funds — claims funding, advances, and Manufacturer Revenue pending remittance — belongs to the Plan, remitted or credited quarterly.

SECTION 9 — REPORTING, AUDIT, AND RECORDS

9.1 PBM shall deliver the reports in Exhibit B on schedule and without request, including the Section 3.6 reconciliation and distribution files. PBM shall provide the Plan Sponsor and its designated auditor access to Claim submission and adjudication data in the same processing cycle as adjudication — including rejected, reversed, modified, and paid Claims — with per-Claim ingredient cost, dispensing fee, Pharmacy Reimbursement, Member payment, applicable benchmark values (NADAC, MAC, AWP, WAC, Published Benchmark Cost), pharmacy Related Entity status, channel code with dispensing facts, rebate eligibility, and reversals, in machine-readable form, all conforming to Exhibit I per Section 9.4. The Plan Sponsor may establish prospective or concurrent automated edits to identify duplicate billing, impossible quantities, suspect prescribers, inappropriate NDCs, pricing anomalies, eligibility

issues, or potential fraud, waste, or abuse before Plan funds are remitted, and PBM shall not disable or circumvent any Plan-approved edit. 9.2 The Plan Sponsor and any auditor it selects (no PBM approval, no audit fee, no Claim-count limits) may audit all records bearing on this Agreement for ten (10) years, with remote data access, including unredacted manufacturer, GPO, supplier, wholesaler, and purchase agreements; Related Entity acquisition and transfer-price records; pharmacy network agreements; and all recoupment and chargeback ledgers. The auditor may employ sampling, full-population testing, and statistical extrapolation where legally permitted, and where systemic error is identified may require full-population identification and remediation. The independent auditor receives every document complete and unredacted; the Plan Sponsor may receive copies redacted only where the redaction relates solely to unrelated customers, cannot affect any allocation or Plan economics, and the auditor certifies both facts. Documents shall be produced within ten (10) business days. Where an audit, investigation, dispute, claim, or litigation is pending, all relevant records shall be preserved beyond the ten-year period until final resolution. All undisputed audit findings are due and payable within twenty (20) days of delivery of the audit report, without any requirement of PBM agreement. PBM may dispute a specific finding only by written notice within thirty (30) days identifying the finding, the amount, and the specific factual and contractual basis, accompanied by a claim-level written explanation and all supporting evidence; any finding not so disputed is waived and payable. Disputes unresolved after thirty (30) days are submitted to an independent accounting or pharmacy-benefit expert selected under [STATE DISPUTE PROCESS, conforming to procurement and sovereign-immunity law], whose determination binds PBM; the non-prevailing party bears its cost. Disputed amounts, if not sustained, are payable immediately with Late Remittance Damages from the original due date, and PBM bears the burden of demonstrating any finding is incorrect. PBM bears its own cooperation costs and funds the audit allowance in Exhibit E. 9.3 All Claims data, the MAC List, the Specialty Drug List, and formulary files are the Plan's property; PBM shall not sell, license, or monetize Plan data in any form; this subsection survives termination.

9.4 Data & Integration Specification. (a) All data, feed, integration, accumulator, audit-access, Alternative Drug Source, benefit-assignment, channel-classification, and utilization-management reporting obligations — including Sections 1.16, 3.4(b), 3.5(f), 3.6, 3.7, 3.8, 6.5, 9.1, 9.2, and 12.4 — conform to Exhibit I, fixed by the Plan Sponsor at execution: the single canonical definition of every data interface. Exhibit I is organized in two parts with distinct cadences: Part I-A (adjudication-cycle interfaces — claims, eligibility, accumulator, MAC changes, exception queue) delivered in the same processing cycle as the underlying events; and Part I-B (periodic economic interfaces — the economic-event ledger, Section 5.4 allocations and driver data, reconciliations, Manufacturer Revenue detail, Section 3.8 and 6.5 reports) delivered on the schedule each Section states. (b) Required contents: (1) Schema and dictionary: NCPDP/X12-anchored layouts with a field dictionary for every Agreement-defined economic element and pricing input (per Section 1.15) — every defined term a populated field, not a narrative. (2) Delivery: continuous machine-readable API or SFTP as the Plan Sponsor elects; PDF, portal-view-only, and manually extracted formats never satisfy any data obligation. (3) Validation and reconciliation controls: completeness/conformance thresholds; control totals every cycle tying, without unexplained variance, to invoices, Section 3.6 reconciliations, and Section 4.2 reports. The feed is the canonical operational record for reconciliation, but underlying source documents control where they demonstrate the feed is incomplete or inaccurate; any feed-versus-source discrepancy is construed against PBM as record-keeper, and PBM may never invoke its own feed error to reduce any amount owed to the Plan. (4) Latency: defined in hours per interface per Part. (5) Lineage and cross-domain linkage:

persistent unique transaction identifiers linking each Claim to its Pharmacy Reimbursement, Member payment, every item of Manufacturer Revenue and purchasing-entity value attributable to it, its Section 5.4 allocation entry, and any Section 3.8 medical-benefit counterpart — the Section 2.5 six-bucket attribution computable from data alone; corrections as new linked records, never silent restatement. (6) Economic-event ledger (Part I-B): every payment or credit received by PBM or any PBM Related Entity from any drug-channel counterparty, as a coded entry (date, payer, amount, characterization, driver per Section 5.4, NDC linkage, bucket, allocation treatment). An event absent from the ledger is rebuttably presumed Plan-attributable, with the burden entirely on PBM; PBM may rebut only within ten (10) business days of discovery or notice, with contemporaneous third-party records, extendable once by up to ten (10) additional business days upon proof that the records are third-party controlled, the request to that party was timely initiated, and interim evidence has been supplied; failure to rebut within the applicable period makes the attribution final. (7) Exception handling and continuous exception reporting: Plan-visible exception queue with [5]-business-day cure; standing automated reports at least [weekly] — above-benchmark Claims, Related Entity outliers, allocation anomalies, guarantee drift, unlinked ledger events, channel-misclassification flags, material benefit-assignment shifts, and Section 6.5 outliers. (8) Data-quality SLAs: completeness ≥[99.5]% and accuracy ≥[99.9]% per interface per cycle, with Exhibit F dollars at risk. (9) Change control: Plan approval, versioned releases, [90] days' notice, backward compatibility; emergency changes documented in [5] business days. (10) Retention: all underlying data necessary to reconstruct every feed and economic event — raw source data, corrections, versions, pricing files, ledger events, MAC files, Related Entity acquisition records — retained for the full Section 9.2 period (including its litigation-hold extension), with no silent overwrites. (c) Automated analytics and independent verification: the Plan Sponsor and its auditor may run any software, including AI-based analytics, against every feed, ledger, and extract, continuously and without notice; no prohibition, rate-limiting, degradation, or manual-only condition. Independent-source verification applies to all PBM-reported values using the external reference classes defined in Exhibit I (including NADAC, Benchmark Sites, and wholesaler acquisition files); a material variance unexplained by contemporaneous third-party records within [15] business days establishes presumptive noncompliance, and the auditor determines the correct amount using the best available evidence, payable as a Section 9.2 finding. (d) Certification: pre-go-live certification of every interface against Plan-supplied test claims; monthly conformance measurement; Exhibit F feed-conformance and data-quality guarantees with dollars at risk. (e) Teeth (proportionate). Only the specific Claim lines and amounts unsupported by conforming Exhibit I data are not payable until conformed; conforming portions of every invoice remain payable on schedule, and no data non-conformance ever interrupts, delays, or reduces Pharmacy Reimbursement or any payment to any pharmacy. Sub-threshold SLA misses are remedied through Exhibit F dollars at risk. Amounts owed to the Plan are never suspended by PBM non-conformance; [3] consecutive or [5]-of-12 months of non-conformance is a material breach; deadlines and Late Remittance Damages run from original due dates.

SECTION 10 — PERFORMANCE GUARANTEES

10.1 The guarantees in Exhibit F are measured quarterly on Plan-specific data, reconciled within thirty (30) days of each period, and penalties are paid automatically within forty-five (45) days without request; payment shall not be delayed because a reconciliation, amendment, corrective-action plan, or other document remains unsigned or pending. The Plan Sponsor may

reallocate amounts at risk annually on thirty (30) days' notice. No metric may be rounded. Except as expressly stated in this Agreement, no document other than Exhibit F may modify a performance guarantee, and no term may be incorporated by reference.

SECTION 11 — AMENDMENTS; CHANGE IN LAW

11.1 No amendment is effective unless in writing and signed by both parties. Any amendment affecting Administrative Fees, Manufacturer Revenue, pharmacy reimbursement methodology, pricing guarantees, Specialty Drug pricing, Related Entity economics, audit rights, termination rights, or total expected Plan cost by more than [0.10% / $___ annually] requires: (a) an independent fiscal impact analysis delivered to the Plan Sponsor and published; (b) a component-level statement of each changed number; and (c) the approval required for a material contract amendment under applicable procurement law. Related amendments and economic changes shall be aggregated over a rolling twelve-month period and shall not be divided, sequenced, characterized, or implemented separately to avoid this Section. Routine operational amendments below the threshold may be approved by the designated contracting authority after written fiscal analysis, summarized in the next quarterly report. A certification that cost "will remain the same" has no effect as to any economic change. Amendments apply prospectively only, except adjustments expressly required under Sections 3, 4, 8.1, 8.2, 9, or 10 — including reconciliations, audit recoveries, guarantee true-ups, and market-check conforming terms and credits — which apply as those Sections provide.
11.2 **Change in law.** If a change in applicable law requires modification of this Agreement, PBM shall identify the exact new legal requirement with citation, the required operational change, and the claim-level economic impact; any resulting amendment is limited to the minimum change legally necessary, is subject to Section 11.1, and effects no unilateral repricing. If the change materially affects Plan economics, the Plan Sponsor may terminate without penalty on sixty (60) days' notice.

SECTION 12 — TERM AND TERMINATION

12.1 Initial term: [___] years from [___], with [___] one-year renewals at the Plan Sponsor's sole option. 12.2 The Plan Sponsor may terminate for convenience on sixty (60) days' notice, and for Cause. **"Cause"** includes: loss or suspension of any required PBM license; debarment or exclusion from any government program; fraud or intentional misrepresentation; undisclosed compensation or prohibited spread; failure to remit Manufacturer Revenue when due; material audit obstruction or repeated inability to produce Section 9.2 records; persistent Exhibit I non-conformance (Section 9.4(e)); repeated pricing violations or channel misclassification; unauthorized formulary conduct; Alternative Drug Source retaliation; a knowingly or recklessly false Section 2.6 certification; material cybersecurity failure; insolvency; Material Adverse Regulatory Action; and failure to maintain the Exhibit H security. Cure periods: failure to remit money when due — five (5) business days; data-feed failures — the applicable Exhibit I SLA cure; failure to maintain the Exhibit H security or a material security control — immediate reinstatement required; network or member-access failures — immediate remediation with a written plan in five (5) business days; other operational failures — thirty (30) days after written notice. No cure period applies to fraud, intentional diversion, knowing concealment, or a knowingly or recklessly false certification. "Material Adverse Regulatory Action" means a license restriction, consent decree affecting performance, governmental finding of fraud, program

exclusion, or enforcement action reasonably threatening PBM's ability to perform; a subpoena or pending investigation alone does not constitute Cause. 12.3 No termination penalty, forfeiture, or reduction of any earned amount applies; all guarantees, Manufacturer Revenue, credits, and interest survive and pay through final reconciliation. 12.4 PBM shall provide transition services for [___] days, during which the only permitted charge is [the Exhibit E per-claim run-out administrative fee of $[___]] [no charge], covering claims run-out and reversals, continued rebate collection and remittance for all pre-termination Claims, and data transfer — with no data-extraction, programming, project-management, or other transition surcharge of any kind. Within thirty (30) days PBM shall transfer in standard machine-readable formats: complete claim history; accumulator balances; eligibility; open prior authorizations and specialty authorizations (continuing for the longer of their stated duration or ninety (90) days); formulary files; MAC history; pharmacy network files; pending appeals; pending rebates and Manufacturer Revenue; reversals and run-out; all audit history; and all member communications necessary for transition. PBM shall not condition delivery of any Plan data on payment of any fee, and shall maintain systems, records, and personnel sufficient to satisfy its post-termination audit, reconciliation, and remittance obligations throughout the Section 9.2 period.

SECTION 13 — MEDICARE / EGWP (if elected)

13.1 One hundred percent (100%) of CMS subsidies, direct subsidies, reinsurance, low-income subsidies, and manufacturer discounts shall pass to the Plan within ten (10) business days of receipt, with full CMS revenue-stack disclosure in each quarterly report. 13.2 Any insured product option shall carry rate guarantees for the full term and the same audit rights as this Agreement. 13.3 Where any provision conflicts with applicable CMS requirements for EGWP coverage, CMS requirements control for that coverage, and the parties implement the closest lawful equivalent.

SECTION 14 — GENERAL PROVISIONS

14.1 **Compliance.** PBM shall comply with all applicable law, including [STATE PBM ACT], HIPAA (per the BAA at Exhibit G), and, as applicable, Medicare Part D requirements; the Plan is a governmental plan not subject to ERISA, and PBM waives any ERISA-preemption defense to enforcement of this Agreement, including Section 2.4 (whose covenants exist independently of any fiduciary status). 14.2 **Force majeure** excuses performance only for events beyond a party's reasonable control such as natural disaster, war, or governmental order; market fluctuations, drug pricing changes, and pricing available to PBM are expressly not force majeure. 14.3 **Indemnification; insurance.** The State does not and cannot indemnify PBM or any other party; nothing in this Agreement or any incorporated document shall be construed as an indemnity by the Plan Sponsor or the State. PBM shall indemnify, defend, and hold harmless the Plan Sponsor, the State, and the Plan against claims and losses arising from: PBM's or any PBM Related Entity's or subcontractor's breach, acts, or omissions; violation of law; privacy or security breach or data loss; intellectual-property infringement; taxes attributable to PBM; fraudulent billing; wrongful denial or utilization-management conduct where liability results from PBM's breach; and unauthorized pharmacy recoupments — subject to limitations imposed by state law — and shall maintain the insurance in Exhibit B and [STATE STANDARD TERMS]. Defense mechanics: the indemnified party gives prompt notice (delay excuses only actual prejudice); PBM controls the defense with counsel reasonably acceptable to the Plan Sponsor;

the Plan Sponsor may engage separate counsel at PBM's expense where a conflict exists; no settlement may impose any liability, admission, or operational obligation on the State or the Plan without written consent; PBM reimburses reasonable defense costs as incurred; this Section survives termination. 14.4 **Assignment; subcontracting.** Assignment only with the Plan Sponsor's written consent; a change of control is an assignment. Material subcontracting of claims adjudication, rebate services, GPO services, mail, specialty, formulary, clinical programs, data hosting, or member services requires prior notice and Plan Sponsor approval; PBM remains fully responsible for all subcontractor and Related Entity performance. 14.5 **Governing law:** the State of [STATE]; venue in [___]. 14.6 **Notices** to the addresses on the signature page. 14.7 **Order of precedence:** this Agreement; then Exhibits A–I; then the solicitation; then the proposal — every amendment states its place in this order. 14.8 **Severability; survival; entire agreement** — standard clauses per [STATE STANDARD TERMS], provided Sections 1.5, 1.7, 1.16, 2.4, 2.5, 2.6, 3, 4, 5, 6.5, 7, 8.3, 9, 12.3, 12.4, 14.11, 14.12, 14.13, and 14.14 survive as stated. 14.9 **Financial security.** PBM shall maintain throughout the Term the performance security in Exhibit H, sized at not less than the sum of: trailing [two] quarters of Manufacturer Revenue guarantees and other amounts payable to the Plan; the actuary's estimate of one year of PBM Price Guarantee Differential exposure; outstanding audit recoveries; accrued unpaid claims-related obligations; and estimated transition exposure — recalculated annually. Preferred form: an unconditional guarantee from the ultimate creditworthy parent; absent a sufficiently creditworthy parent, a performance bond or letter of credit; a net-worth covenant alone does not satisfy this Section. Failure to maintain the security is Cause. **14.10 Completion condition.** No award shall be made and execution is prohibited while any material economic term or Exhibit A–I remains blank or incomplete; any such term is ineffective until completed by written agreement with required procurement approval. Minor non-economic blanks are filled by the objective fallbacks stated in Exhibit A-1. **14.11 Cumulative remedies; no double recovery.** All rights and remedies are cumulative, and the exercise of one does not waive another; provided that the Plan shall not recover the same dollar of loss more than once, and liquidated damages and Late Remittance Damages may both apply to an event only to the extent they compensate different obligations. **14.12 Cybersecurity and continuity.** PBM shall maintain, and evidence annually: SOC 2 Type II attestation; encryption in transit and at rest; multi-factor authentication and privileged-access management; vendor security management; incident notification to the Plan Sponsor within [72] hours; annual penetration testing with remediation timelines; disaster recovery with stated RTO/RPO and claim-adjudication continuity; business continuity planning; and cyber insurance of $[___] — with detail in Exhibits B and G. Material cybersecurity failure is Cause. **14.13 No limitation of liability for core obligations.** No limitation of liability, damages cap, or waiver of consequential damages — whether in this Agreement, any Exhibit, any proposal, any incorporated or referenced document, or any subsequent writing — shall apply to: Manufacturer Revenue and other amounts payable to the Plan; overcharges and refunds; audit recoveries; prohibited spread and disgorgement; confidentiality, privacy, or data-breach obligations; indemnification; fraud or willful misconduct; intellectual-property infringement; liquidated damages under this Agreement; unpaid guarantees; and transition obligations. Any provision purporting to do so is void as to these categories. Any waiver of consequential damages, if otherwise agreed, shall in all events carve out data breach, transition failure, fraud, intentional misconduct, confidentiality breach, indemnified third-party claims, and Member harm where recovery is legally permitted. **14.14 Taxes.** No tax, assessment, provider tax, regulatory fee, or governmental charge may be passed through to the Plan unless it is specifically identified, legally applicable to the Plan transaction, actually paid by PBM, and not already included in the Administrative Fee or dispensing fees; PBM bears all taxes on its own income

and operations.

SIGNATURES.

[STATE AGENCY / PLAN SPONSOR] — By: _____ Name/Title: _____ Date: _____

[PBM LEGAL NAME] — By: _____ Name/Title: _____ Date: _____

EXHIBITS (all must be complete before execution per Section 14.10): A-1 Definitions, Drug Classification Codes, order-of-operations pricing schedule, and objective fallbacks for minor blanks; A-2 Specialty Criteria & Specialty Drug List; A-3 Pricing & Discount Guarantees (drug-level specialty grid applying in every channel; AWP and WAC statements); A-4 Commercial Comparability Criteria (closed list fixed by the Plan Sponsor at execution, not proposed by PBM); B Statement of Work, Service Standards, Appeal Processes, control reports and responsible personnel for §2.6, Security & Continuity Requirements; C Manufacturer Revenue Guarantees (including §4.4 baseline adjustments and normalization units); C-1 Closed Exclusion List (per §4.3 specificity rules); C-2 Allocation Worked Examples (illustrative only; the operative rule is Section 5.4); D Dispensing Fees & Network Reimbursement Floors by channel (including the WAC-minus no-benchmark rate — never AWP-based); E Administrative Fee & Allowances (separately stating the Differential-risk component; run-out fee if any); F Performance Guarantees & Amounts at Risk (including §9.4 conformance and §3.7 integration credits); G Business Associate Agreement & security detail; H Performance Security (form and sizing per §14.9); I Data & Integration Specification (fixed by the Plan Sponsor at execution; Parts I-A adjudication-cycle and I-B periodic economic; layouts and field dictionary incl. §1.15 pricing-input field definitions; validation and control totals; latency; identifier and linkage rules incl. cross-benefit keys; ledger and driver/bucket/allocation coding; benchmark normalization and daily capture; approved external reference classes for §9.4(c); §3.7 specification completeness checklist and go-live acceptance procedure; §6.5 UM methodology; exception and cure procedures; SLA measurement; change control; retention; certification test plan).

v3.4 CONSOLIDATED changelog (2026-08-28, forty-one-item round-10 counsel review absorbed; 35 adopted, 6 adopted as modified, 0 rejected): (1) HEADLINE — §1.1 rebuilt as three tiers (Affiliate / Economically Related Entity / ordinary arm's-length providers excluded), and §3.2(a) NAC pricing EXTENDED to every pharmacy that is an Economically Related Entity (material equity, profit participation, revenue participation, management rights, purchasing control, or material economic benefit from dispensing Plan Claims), closing the 49%-JV specialty pharmacy gap; passive sub-[5]% holdings carved out; §5.2 record-availability duty expressly tied to the extension. (2) §1.6 presumption re-scoped from temporal coincidence to economic nexus (products, manufacturers, markets, utilization, formulary access, purchasing activity, data, services including Plan utilization); every-dollar burden retained inside the nexus. (3) §1.7 clarified: six-bucket/ledger reconciliation is the operative pass-through test; claim-level no-spread lives in §§3.1–3.2. (4) §2.3 Administrative Fee defined as the only residual retained value, expressly excluding all third-party receipts. (5) §2.6 certifications given a defined reasonable-inquiry standard; knowing/reckless falsity = immediate-termination cause; innocent error = correction + restitution. (6) §3.2(c) converted to provisional reset + one 10-business-day cure; late-proven NAC corrects prospectively only, never above the amount originally invoiced; repeated lateness = material breach. (7) §3.3 all-in delivered-price election added; brand benchmark availability conditions (in stock, quantity purchasable, no coupon/eligibility/promotional/patient-assistance prices). (8) §3.4(b) documentation classes defined + least-burdensome rule. (9) §3.5: MAC/NADAC ceiling percentage fixed by the state in the solicitation; NADAC-missing/stale, single-source, and above-NADAC-market rules added; generic-add trigger accelerated to 10 business days after commercially meaningful

second-supplier availability (30-day outer bound). (10) §3.6 distribution report expanded: excess dollars over NADAC and benchmark, weighted-average NADAC multiple, 95th/99th percentile markup. (11) §3.7: Exhibit I completeness checklist with 5-business-day deemed-complete rule; formal go-live acceptance procedure with error thresholds; no refusal for immaterial defects. (12) §3.8(c) split by role: purchase/supply → NAC; administer-only → supplier rule + disclosed administration fee; billing alone ≠ acquisition responsibility, itemization still required. (13) §4.4 baseline normalized per unit/30-day equivalent; biosimilar safe harbor gains sponsor-approved product-specific threshold option, no unilateral PBM adjustment. (14) §5.4 no-driver fallback rebuilt: qualifying spend → rebate-generating utilization → units, auditor-approved. (15) §6.1 total net Plan cost defined at whole-plan level. (16) §6.5 denominator anti-gaming + criteria versioning archive. (17) §7.3 objective/uniform/clinically-relevant network terms; channel accepts-all tied to the exception list; cold-chain/controlled-substance exceptions enumerated. (18) §7.4 repeated/systemic defined. (19) §8.1(a) auditor-administered state MFN (unmasked terms to auditor, certified findings to sponsor, sponsor retains unmasked rights where law/enforcement requires; automaticity intact); "state client" defined, Medicaid FFS/MCO excluded. (20) §8.1(b)/A-4 expanded closed comparability list. (21) §8.2 qualifying-evidence rules; credit capped at verified available economics. (22) §9.4(b)(3) feed = canonical operational record, source documents control where feed wrong, discrepancies construed against PBM, no self-benefit from feed error. (23) §9.4(b)(6) one narrowly conditioned rebuttal extension. (24) §9.4(c) external reference classes defined in Exhibit I. (25) §9.2 sampling/full-population/extrapolation/remediation rights; litigation hold beyond ten years. (26) §12.2 differentiated cure periods; Material Adverse Regulatory Action defined (subpoena/investigation alone ≠ Cause). (27) §12.4 post-termination systems-and-personnel duty. (28) §14.3 defense-control mechanics. (29) NEW §14.13 limitation-of-liability and consequential-damages carve-outs — any cap in any document void as to core economic obligations. (30) NEW §14.14 tax pass-through restrictions. Modifications from reviewer text: NAC extension paired with §5.2/§3.2(c) enforcement path; §3.2(c) cure keeps prospective-only and never-above-invoiced asymmetries; §1.6 keeps every-dollar burden; MFN auditor channel preserves sponsor's legal right to unmasked terms; feed-of-record fix adds construed-against-PBM direction rule. Provenance: v3.3 and prior changelogs; eleven review rounds plus internal-consistency review.