DELEGATION AGREEMENT ADDENDUM
TO
PRESCRIPTION BENEFIT SERVICES AGREEMENT

This Delegation Agreement Addendum to Prescription Benefit Services Agreement (the "Addendum"), is entered into as of September 1, 2016 (the "Effective Date"), between CaremarkPCS Health, L.L.C., a Delaware limited liability company ("CVS/caremark") Evolent Health LLC, a Delaware limited liability company ("Client") and University Health Plan, Inc. d/b/a Passport Health Plan, a Kentucky not-for-profit corporation ("Participating Customer").

WHEREAS, CVS/caremark, Participating Customer, and Client are parties to that certain Prescription Benefit Services Agreement, dated 9/1/2016, as amended (the "Agreement"); and

WHEREAS, CVS/caremark or Client has agreed to perform certain services for Participating Customer in the Agreement ("Services"); and

WHEREAS, Participating Customer now desires to delegate authority to CVS/caremark or Client to perform certain activities related to Contracted Services that Participating Customer would otherwise perform to meet specific requirements in the National Committee for Quality Assurance ("NCQA") standards and guidelines; and

WHEREAS, Participating Customer, Client and CVS/caremark, desire to enter into this Addendum to memorialize such delegation in compliance with NCQA standards and guidelines,

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

The Agreement is hereby amended by adding this Addendum as Exhibit H. Such Addendum is expressly incorporated into the Agreement and as so incorporated constitutes the entire understanding and agreement of Participating Customer, Client, and CVS/Caremark with respect to the subject matter of the Addendum and supersedes all prior and contemporaneous agreements or understandings, inducements or conditions, express or implied, written or oral, between the parties with respect hereto.

1. Delegated Activities

1.1 Delegated Activities.

1.1.1 Participating Customer shall delegate to CVS/caremark responsibility for performing the following activities related to Services ("Delegated Activities"):

1.1.2 Utilization Management Activities as indicated in Schedule 1 below

1.1.3 Member Connection Activities as indicated in Schedule 1 below

1.1.4 Participating Customer shall delegate to Client responsibility for performing the following activities related to Services ("Delegated Activities"):

1.1.5 Utilization Management Activities as indicated in Schedule 1 below
1.1.6 Member Connection Activities as indicated in Schedule 1 below

1.2 Responsibilities for Delegated Activities. The responsibilities of each party for NCQA Health Plan Accreditation Standards applicable to Delegated Activities are outlined in Schedule 1 of this Addendum. Responsibilities will be performed in accordance to the current NCQA Health Plan Accreditation Standards. Participating Customer shall retain responsibility for any Delegated Activity or NCQA Health Plan Accreditation Standard not explicitly delegated to CVS/caremark or Client. As applicable standards are modified by NCQA, Schedule 1 shall be deemed amended without further need for amendment or modification of this Addendum.

2. CVS/caremark Responsibilities

2.1. Protected Health Information. CVS/caremark agrees to comply with all applicable laws and regulations to protect the member's protected health information ("PHI"), as set forth in the Business Associate Agreement between Client and CVS/caremark.

2.2. Client Reports. CVS/caremark shall provide Client with periodic reporting related to Services and Delegated Activities, as specified in the Agreement. Such reporting shall be provided at least semiannually.

2.3. Sub-Delegation. If CVS/caremark sub-delegates any Delegated Activities to a third party provider or vendor, those responsibilities shall be performed in accordance with the terms of the Agreement, current NCQA Health Plan Accreditation Standards, and this Addendum. CVS/caremark shall provide appropriate oversight of its providers and vendors.

3. Client Responsibilities

3.1 Protected Health Information. Client agrees to comply with all applicable laws and regulations to protect the member's protected health information ("PHI"), as set forth in the Business Associate Agreement between Participating Customer and Client.

3.2 Participating Customer Reports. Client shall provide Participating Customer with periodic reporting related to Services and Delegated Activities, as specified in the Agreement. Such reporting shall be provided at least semiannually.

3.3 Sub-Delegation. If Client sub-delegates any Delegated Activities to a third party provider or vendor, those responsibilities shall be performed in accordance with the terms of the Agreement and this Addendum. Client shall provide appropriate oversight of its providers and vendors.

4. Participating Customer Responsibilities

4.1 Payment for Activities Outside Scope of Services. To the extent that compliance with NCQA Health Plan Accreditation Standards, as amended, would require CVS/caremark to conduct activities outside the scope of Services (a "Scope Change"), Participating Customer shall pay CVS/caremark a mutually negotiated fee for such activities. The parties acknowledge and agree that in the event of such a Scope Change, CVS/caremark shall have no obligation to provide such activities until such time as mutual agreement as to the applicable fees is reached. Participating Customer acknowledges and agrees that any request for a Scope Change must be in writing and shall not be effective until approved by CVS/caremark.

4.2 Oversight and Evaluation of CVS/caremark's Performance. Participating Customer shall provide ongoing oversight and evaluation of CVS/caremark's and Client's performance of Delegated Activities. Such oversight and evaluation may include: (a) evaluation of periodic reports provided by CVS/caremark or Client, (b) annual, review of CVS/caremark's and Client's then current policies, procedures and program description related to Delegated Activities, (c) annual, evaluation of CVS/caremark's and Client's performance of Delegated Activities against NCQA Health Plan reditation Standards, and (d) annual audit of records and documents related to Delegated Activities on a date mutually agreeable to both parties. In the event routine monitoring identifies a performance concern, Participating Customer shall have the right to evaluate performance as necessary to confirm appropriate action has been taken.

4.3 Remedies for Non-Performance. If CVS/caremark or Client fails to perform its responsibilities under this Addendum, Participating Customer shall provide notice of any material deficiencies to the party responsible for the non-performance and give CVS/caremark or Client as applicable a reasonable opportunity to cure. If a material deficiency remains uncured after a reasonable, mutually agreed-upon time period for remediation, Participating Customer may revoke the delegation of any or all Delegated Activities and terminate this Addendum. Revocation of delegation or termination of this Addendum shall have no automatic effect on the term of the Agreement.

5. Except as otherwise provided in this Addendum, all terms and conditions in the Agreement remain unchanged. To the extent any provision in this Addendum conflicts with any provision in the Agreement, the terms of the Agreement shall control.

6. This Addendum may be executed in counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

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

CAREMARKPCS HEALTH, L.L.C.:

By: _____
Its: Group Head, Health Plans
Date Signed: September 14, 2016

PASSPORT HEALTH PLAN:

By: _____
Its: CEO
Date Signed: 9/8/16

EVOLENT HEALTH, LLC

By: _____
Its: President
Date Signed: 9/9/16

SCHEDULE 1

DESCRIPTION OF RESPONSIBILITIES FOR DELEGATED ACTIVITIES

NCQA Standard*	Utilization Management	CVS/caremark responsibility (please check)	Client responsibility Evolent (please check)	Participating Customer responsibility (Health Plan (please check)
UM 1	**Utilization Management Structure** The organization clearly defines the structures and processes within its UM program and assigns responsibility to appropriate individuals			
	Element A: Written Program Description ➤ The organization's UM program description includes the following: (1) A written description of the program structure. (2) The behavioral healthcare aspects of the program. (3) Involvement of a designated senior –level physician in UM program implementation. (4) Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. (5) The program scope and process used to determine benefit coverage and medical necessity. (6) Information sources used to determine benefit coverage and medical necessity.	X		
	Element B: Physician Involvement ➤ A senior-level physician is actively involved in implementing the organization's UM program.	X		
	Element C: Behavioral Healthcare Practitioner Involvement ➤ A behavioral healthcare practitioner is actively involved in implementing the behavioral healthcare aspects of the UM program.	X		
	Element D: Annual Evaluation ➤ The organization annually evaluates and updates the UM program, as necessary.	X		
UM 2	**Clinical Criteria for UM Decisions** To make utilization decisions, The organization uses written criteria based on sound clinical evidence and specifies procedures for appropriately applying the criteria.			
	Element A: UM Criteria ➤ The organization: (1) Has written UM decision-making criteria	x		

	that are objcctivc and based on medical evidence (2) Has written policies for applying the criteria based on individual needs. (3) Has written policies for applying the criteria based on an assessment of the local delivery system (4) Involvcs appropriate practitioners in developing, adopting and reviewing criteria. (5) Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate			
	Element B: Availability of Criteria ➤ The organization: (1) States in writing how practitioners can obtain UM criteria (2) Makes the criteria available to its practitioners upon request.	X		
	Element C: Consistency in Appling Criteria ➤ At least annually, the organization: (1) Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. (2) Acts on opportunities to improve consistency, if applicable.	X		
UM 3	**Communication Services** The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.			
	Element A: Access to Staff ➤ The organization provides the following communication services for practitioners and members: (1) Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. (2) Staff can receive inbound communication regarding UM issues after normal business hours. (3) Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. (4) TDD/TTY services for members who need them. (5) Language assistance for members to discuss UM issues.	X (providers)		X (members)
UM 4	**Appropriate Profcssionals** Qualified licensed health professionals assess the clinical information used to support UM			

	decisions.			
	Element A: Licensed Health Professionals ➤ The organization has written procedures: (1) Requiring appropriately licensed professionals to supervise all medical necessity decisions. (2) Specifying the type of personnel responsible for each level of UM decision making.	x		
	Element B: Use of Practitioners for UM Decisions ➤ The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: (1) Education, training or professional experience in medical or clinical practice. (2) A current clinical license to practice or an administrative license to review UM cases.	X		
	Element E: Practitioner Review of Pharmacy Denials ➤ The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity.	X		
	Element F: Use of Board-Certified Consultants ➤ The organization:. (1) Has written procedures for using board-certified consultants to assist in making medical necessity determinations. (2) Provides evidence that it uses board-certified consultants for medical necessity determinations	x		
	Element G: Affirmative Statement About Incentives ➤ The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions affirming that: (1) UM decision making is based only on appropriateness of care and service and existence of coverage (2) The organization does not specifically reward practitioners or other individuals for issuing denials of coverage (3) Financial incentives for UM decision makers do not encourage decisions that result in underutilization	X (UM employees/practitioners)		X (Distribution to members & practitioners)
	Element H: Element H: Appropriate Classification of Denials ➤ The organization demonstrates that it classifies denials appropriately.	X		
UM 5	**Timeliness of UM Decisions**			

	The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of the situation.			
	Element E: Timeliness of Pharmacy UM Decision Making ➤ The organization adheres to the following time frames when making pharmacy UM decisions: (1) For urgent concurrent review, within 24 hours of receiving the request. (2) For urgent preservice decisions, within 72 hours of receiving the request. (3) For nonurgent preservice decisions, within 15 calendar days of receiving the request. (4) For postservice decisions, within 30 calendar days of receiving the request. (5)	X		
	Element F: Notification of Pharmacy Decisions ➤ The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: (1) For urgent concurrent decisions, electronic or written notification of the decision to members and practitioners within 24 hours of the request. (2) For urgent preservice decisions, electronic or written notification of the decision to members and practitioners within 72 hours of the request. (3) For nonurgent preservice decisions, electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. (4) For postservice decisions, electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. (5)	X		
	Element G: UM Timeliness Report The organization monitors and submits a report for timeliness of: (5) Pharmacy UM decision making. (6) Notification of pharmacy UM decisions.	-x		
UM 6	**Clinical Information** When determining coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner.			
	Element C: Relevant Information for Pharmacy Decisions ➤ The organization documents that it consistently gathers relevant information to	x		

	support pharmacy UM decision making			
UM 7	**Denial Notices** The organization clearly documents and communicates the reasons for each denial.			
	Element G: Discussing a Pharmacy Denial With a Reviewer ➤ The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist.	X		
	Element H: Written Notification of Pharmacy Denials ➤ The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: (1) The specific reasons for the denial, in language that is easy to understand. (2) A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based. (3) A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request.	X		
	Element I: Pharmacy Notice of Appeals Rights/Process ➤ The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: (1) A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal. (2) An explanation of the appeal process, including the appeal time frames and the member's right to representation. (3) A description of the expedited appeal process for urgent preservice or urgent concurrent denials. (4) Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.	X		
UM 8	**Policies for Appeals** The organization has written policies and procedures for thorough, appropriate and timely resolution of member appeals.			
	Element A: Internal Appeals ➤ The organization's written policies and	x		

	procedures for registering and responding to written internal appeals include the following: (1) allowing at least 30days after notification of the denial for the member to file an appeal (This requirement changes to 60 days effective 1/1/2017.) (2) documenting the substance of the appeal and any actions taken (3) full investigation of the substance of the appeal, including any aspects of clinical care involved (4) the opportunity for the member to submit written comments, documents or other information relating to the appeal (5) the appointment of a new person to review an appeal who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination (6) the appointment of at least one person to review an appeal who is a practitioner in the same or similar specialty (7) the decision for a preservice appeal and notification to the member within 30 calendar days of receipt of the request (8) the decision for a postservice appeal and notification to the member within 30 calendar days of receipt of the request (9) the decision for an expedited appeal and notification to the member within 72 hours of receipt of the request (10) notification to the member about further appeal rights (11) referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based (12) providing members access to and copies of all documents relevant to their appeal, free of charge, upon request (13) including a list of titles and qualifications, including specialties, of individuals participating in the appeal (14) allowing an authorized representative to act on behalf of the member (15) providing notices of the appeals process to members in a culturally and linguistically appropriate manner (16) continued coverage pending the outcome of an appeal			
	Element B: Notice of External Review Rights ➤ The organization provides annual written notification to members of the availability of	X		

	independent, external review of final internal UM determinations.			
UM 9	**Appropriate Handling of Appeals** The organization adjudicates member appeals in a thorough, appropriate and timely manner.			
	Element A: Preservice and Postservice Appeals ➤ An NCQA review of The organization's appeal files indicates that they contain the following information (1) Documentation of the substance of appeals. (2) Investigation of appeals. (3) Appropriate response to the substance of the appeal.	X		
	Element B: Timeliness of the Appeal Process ➤ Timeliness of the organization's preservice, postservice and expedited appeal processes is within the specified time frames: (1) Resolution of preservice appeals within 30 calendar days of receipt of the request. (2) Resolution of postservice appeals within 30 calendar days of receipt of the request. (3) Resolution of expedited appeals within 72 hours of receipt of the request.	X		
	Element C: Appeal Reviewers ➤ The organization provides nonsubordinate reviewers who were not involved in the previous determination and same-or-similar-specialist review, as appropriate.	X		
	Element D: Notification of Appeal Decision/Rights ➤ An NCQA review of the organization's internal appeal files indicates notification to members of the following: (1) Specific reasons for the appeal decision, in easily understandable language. (2) A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based. (3) Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request. (4) Notification that the member is entitled to receive reasonable access to and copies of all documents, upon request. (5) A list of titles and qualifications, including specialties, of individuals participating in the appeal review.	X		

	(6) A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures.			
	Element E: Final Internal and External Appeal Files ➤ In an NCQA review of denials overturned by the IRO or of the organization's final internal denials, the files contained the following: (1) Member notification of independent appeal rights. (2) Member notification about obtaining more information regarding independent appeal rights. (3) A statement that members are not required to bear costs of the IRO, including any filing fees.	X		
	Element F: Appeals Overturned by the IRO ➤ In an NCQA review of the organization's files of appeals overturned by the IRO, there is evidence that the organization implemented the IRO's decision in all cases reviewed.	X		
UM 10	**Evaluation of New Technology** The organization evaluates the inclusion of new technology and the new application of existing technology in its benefits plan, including medical and behavioral healthcare procedures, pharmaceuticals and devices.			
	Element A: Written Process ➤ The organization's written process for evaluating new technology and the new application of existing technology for inclusion in its benefits plan includes an evaluation of the following: (3) Pharmaceuticals			x
	Element B: Description of the Evaluation Process ➤ The organization's written evaluation process includes the following: (1) The process and decision variables the organization uses to make determinations. (2) A review of information from appropriate government regulatory bodies. (3) A review of information from published scientific evidence (4) A process for seeking input from relevant specialists and professionals who have expertise in the technology.			X
UM 12	**Procedures for Pharmaceutical Management**			

	The organization ensures that it procedures for pharmaceutical management, if any, promote the clinically appropriate use of pharmaceuticals.			
	Element A: Pharmaceutical Management Procedures ➢ The organization's policies and procedures for pharmaceutical management include: (1) the criteria used to adopt pharmaceutical management procedures (2) a process that uses clinical evidence from appropriate external organizations (3) a process to include pharmacists and appropriate practitioners in the development of procedures. (4) a process to provide procedures to practitioners annually and when it makes changes.			X
	Element B: Pharmaceutical Restrictions/Preferences ➢ The organization communicates to members and prescribing practitioners, annually and after updates: (1) a list of pharmaceuticals, including restrictions and preferences. (2) how to use the pharmaceutical management procedures (3) an explanation of any limits or quotas (4) an explanation of how prescribing practitioners must provide information to support an exception request (5) The organization's process for generic substitution, therapeutic interchange and step-therapy protocols			x
	Element C: Pharmaceutical Patient Safety Issues ➢ The organization's pharmaceutical procedures include: (1) identifying and notifying members and prescribing practitioners affected by a Class II recall or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification (2) an expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall.		X	x
	Element D: Review & Update of Procedures ➢ The organization, with the participation of physicians and pharmacists, annually: (1) reviews the procedures. (2) reviews its list of pharmaceuticals. (3) updates the procedures as appropriate. (4) updates the list of pharmaceuticals as			X

	appropriate.			
	Element E: Considering Exceptions ➤ The organization has exceptions policies and procedures that describe the process for: (1) making an exceptions request based on medical necessity (2) obtaining medical necessity information from prescribing practitioners (3) using appropriate pharmacists and practitioners to consider exception requests (4) timely request handling (5) communicating the reason for the denial and an explanation of the appeals process when it does not approve an exception request.	X		
MEM 4	**Pharmacy Benefit** The organization provides members with the information they need to understand and use their pharmacy benefit.			
	Element A: Pharmacy Benefit Information – Web Site ➤ In one attempt or contact, members can complete the following actions : (1) determine their financial responsibility for a drug based on the pharmacy benefit (2) initiate the exception process (3) order a refill for an existing, non-expired mail-order prescription (4) find the location of an in-network pharmacy (5) conduct a pharmacy proximity search based on zip code (6) determine potential drug-drug interactions (7) determine a drug's common side effects (8) determine the availability of generic substitutes.	x		
	Element B: Pharmacy Benefit Information – Telephone ➤ In one attempt or contact, members can complete the following actions via telephone: (1) determine their financial responsibility for a drug based on the pharmacy benefit (2) initiate the exception process (3) order a refill for an existing, non-expired mail-order prescription (4) find the location of an in-network pharmacy (5) conduct a proximity search based on zip code (6) determine potential drug-drug interactions	X (clinical)		X (benefit)

	(7) determine common side effects of a drug (8) determine the availability of generic substitutes.			
	Element C: QI Process on Accuracy of Information ➢ The organization has a quality improvement process for pharmacy benefit information that: (1) collects data on quality and accuracy of pharmacy benefit information (2) analyzes data results (3) takes action on identified deficiencies.	x		x
	Element D: Pharmacy Benefit Updates The organization updates members information on www.CVS Caremark.com and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	x		x
MEM 6	Member Support The organization is an innovator in member services, using technology to improve convenience and appropriate use of health benefits.			
	Element A: Supportive Technology ➢ The organization uses, supports, or facilitates the following technology- supported processes: (1) Electronic refill reminders for people on medications for chronic conditions (4) E-prescribing	x		

***NCQA Standards and Guidelines for the Accreditation of Health Plans, effective July 1, 2016**