

EXHIBIT E
PARTICIPATION
AGREEMENT

Participating Group Name: _____

Participating Group Address: _____

Contact Person: _____

This Participation Agreement (the "**Participation Agreement**"), dated as of [date] (the "**Effective Date**"), supplements the MASTER PHARMACY BENEFIT ADMINISTRATOR SERVICES AGREEMENT ("Master Agreement") between MaxorPlus, Ltd., a Texas limited partnership ("**PBA**"), with its corporate headquarters located at 320 South Polk, Suite 200, Amarillo, TX 79101 and Nevada Health Partners ("**Coalition**"), dated as of January 1, 2020.

Participating Group represents that it's Plan(s) (please check appropriate response):

_____ is governed by ERISA.

_____ is not governed by ERISA.

1. The undersigned Participating Group ("Participating Group") is a member of the coalition established by Coalition. Participating Group has reviewed the Master Agreement and desires that PBA provide to it the products and services described in the Master Agreement on the terms and conditions set forth in the Master Agreement, as amended from time to time, and this Addendum. By signing this Addendum, Participating Group agrees to the terms and conditions of the Master Agreement, including the Exhibits attached thereto, and this Addendum.
2. Pricing adjustments in future Contract Years under the Master Agreement, if any, will be negotiated on behalf of all participating groups by Coalition. PBA will notify Participating Group in writing of any updated pricing terms in advance of the effective date of such updated pricing.
3. This Addendum, together with the Master Agreement constitutes the entire agreement between the parties with respect to the subject matter herein and supersedes all prior understandings, agreements, contracts or arrangements between the parties, whether oral or written.

IN WITNESS WHEREOF, the parties hereto have caused this Participation Agreement to be executed by their respective duly authorized officers or agents as of the date first above written.

MaxorPlus, Ltd.

[Participating Group Name]

By: _____

By: _____

Name: _____

Name: _____

Title: _____

Title: _____

Nevada Health Partners

By: _____

Name: _____

Title: _____