

Exhibit F

Public Creditor Trust Distribution Procedures

PUBLIC CREDITOR TRUST DISTRIBUTION PROCEDURES¹

| Issue | Description |
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| <p>1. APPLICABILITY OF AGREEMENT</p> | <p>These terms shall apply to the allocation of value received by NOAT and the Tribe Trust² (including both the Tribal Abatement Fund Trust and Tribal Abatement Fund II, LLC) under the plan of reorganization (the “Chapter 11 Plan” or the “Plan”) in the chapter 11 cases of Purdue Pharma L.P. and its affiliates (collectively, “Purdue”) pending in the U.S. Bankruptcy Court for the Southern District of New York (the “Bankruptcy Court”) in respect of the Public Creditor Trust Distributions (including the Initial Public Creditor Trust Distribution and all amounts distributed in respect of the TopCo Interests and the MDT Interests), which shall be distributed among (i) the states, territories and the District of Columbia (each a “State” as defined in the Plan), (ii) each county, city, town, parish, village, and municipality that is a Domestic Governmental Entity³ or other holder of a Non-Federal Domestic Governmental Claim that is otherwise not a “State” as defined in the Plan (collectively, the “Local Governments”), and (iii) each federally recognized Native American, Native Alaskan or American Indian Tribe or other tribal organization (each a “Tribe” as defined in the Plan), in the case of (i) and (ii) whose Claims in Class 4 (Non-Federal Domestic Governmental Claims) are channeled to the National Opioid Abatement Trust under the Plan and in the case of (iii) whose Claims in Class 5 (Tribe Claims) are channeled to the Tribe Trust under the Plan. To the extent not explicitly reflected in the Chapter 11 Plan, the terms set forth herein will be deemed incorporated into the Chapter 11 Plan, the trust agreement for the National Opioid Abatement Trust (the “NOAT Agreement”), the NOAT Documents and/or the Tribe Trust Documents, as applicable.</p> <p>These terms set forth the manner in which NOAT and the Tribe Trust shall make Abatement Distributions to States, Local Governments and Tribes</p> |

¹ [Oklahoma and Kentucky Local Governments will receive funds from the Estate for their claims. Kentucky has filed a timely proof of claim in the Purdue bankruptcy. The amount of the allocations to Oklahoma and Kentucky Local Governments and the mechanism by which the distributions will be provided to those Local Governments is an open issue in this proceeding that must be negotiated and reasonably resolved prior to solicitation; *provided* that (1) any distributions to Local Governments must be made pursuant to the provisions of the Public Creditor Trust Distribution Procedures, and (2) any such resolution will include an accounting of any funds earmarked for Local Governments in any prior settlement, including whether such funds remain available to those Local Governments. If a mutual agreement cannot be reached, the parties will consider the use of a third-party to help facilitate discussions among the parties.]

² NOAT and the Tribe Trust will be operated and governed independently. These trust distribution procedures set forth the distribution procedures for both NOAT and the Tribe Trust, and may be amended in the form of separate trust distribution procedures for each of NOAT and the Tribe Trust.

³ Capitalized terms used but not otherwise defined herein shall have the meanings ascribed to them in the Chapter 11 Plan or NOAT Agreement, as applicable.

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| | (such entities, “ Authorized Recipients ”), which may be used exclusively on the parameters set forth herein. ⁴ |
| <p>2. PURPOSE</p> | <p>Virtually all creditors and the Court itself in the Purdue Chapter 11 cases recognize the need for and value in developing a comprehensive abatement strategy to address the opioid crisis as the most effective use of the funds that can be derived from the Purdue estate (including without limitation insurance proceeds and, if included in the Chapter 11 Plan, payments by third-parties seeking releases). Because of the unique impact the crisis has had throughout all regions of the United States, and as repeatedly recognized by Judge Drain, distribution of a substantial portion of the estates should occur through an established governmental structure, with the use of such funds strictly limited to abatement purposes as provided herein.⁵ This approach recognizes that funding abatement efforts – which would benefit most creditors and the public by reducing future effects of the crisis through treatment and other programs – is a much more efficient use of limited funds than dividing thin slices among all creditors with no obligation to use it to abate the opioid crisis. Because maximizing abatement of the opioid crisis requires coordination of efforts by all levels of government, particularly when the abatement needs far exceed the available funds, this structure requires a collaborative process between each State and its Local Governments.</p> <p>These distribution procedures (these “Public Creditor Trust Distribution Procedures”) are intended to establish the mechanisms for the distribution and allocation of funds (1) distributed by the National Opioid Abatement Trust (“NOAT”) to the States and Local Governments and (2) distributed by the Tribe Trust to the Tribes. All funds described in clauses (1) and (2)</p> |

⁴ Subject to the approved settlement between the United States Department of Justice and the Debtors, resolution of States’ and Local Governments’ claims under this model presumes reaching satisfactory agreement regarding all claims asserted by the federal government in the Chapter 11 Cases.

⁵ See, e.g., Hrg. Tr at 149:22-150:5 (Oct. 11, 2019) (“I would hope that those public health steps, once the difficult allocation issues that the parties have addressed here, can be largely left up to the states and municipalities so that they can use their own unique knowledge about their own citizens and how to address them. It may be that some states think it’s more of a law enforcement issue, i.e. interdicting illegal opioids at this point. Others may think education is more important. Others may think treatment is more important.”); *id.* At 175:24-176:6 (“I also think, and again, I didn’t say this lightly, that my hope in the allocation process is that there would be an understanding between the states and the municipalities and localities throughout the whole process that[,] subject to general guidelines on how the money should be used, specific ways to use it would be left up to the states and the municipalities, with guidance from the states primarily.”); Hr’g Tr. At 165:3-165:14 (Nov. 19, 2019) (“I continue to believe that the states play a major role in [the allocation] process. The role I’m envisioning for them is not one where they say we get everything. I think that should be clear and I think it is clear to them. But, rather, where they act – in the best principles of federalism, for their state, the coordinator for the victims in their state.”); Hr’g Tr. at 75:19-76:1 (Jan. 24, 2020) (“Even if there ultimately is an allocation here – and there’s not a deal now, obviously, at this point on a plan. But if there is an allocation that leaves a substantial amount of the Debtors’ value to the states and territories, one of the primary benefits of a bankruptcy case is that the plan can lock in, perhaps only in general ways, but perhaps more in specific ways, how the states use that money . . .”).

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| | <p>of the foregoing sentence are referred to herein as “Abatement Funds”, and Abatement Funds net of the portion allocated to the Tribe Trust under clause (2) of the foregoing sentence are referred to herein as “Public Funds.” 100% of the Public Funds distributed under the Chapter 11 Plan (and not otherwise dedicated to the attorneys’ fee fund set forth in Section 4 herein) shall be used to abate the opioid crisis in accordance with the terms hereof. Specifically, (i) no less than ninety five percent (95%) of the Public Funds distributed under the Chapter 11 Plan shall be used for abatement of the opioid crisis by funding opioid or substance use disorder-related projects or programs that fall within the list of uses in <u>Schedule B</u> (the “Approved Opioid Abatement Uses”); (ii) priority should be given to the core abatement strategies (“Core Strategies”) as identified on <u>Schedule A</u>; and (iii) no more than five percent (5%) of the Public Funds may be used to fund expenses incurred in administering the distributions for the Approved Opioid Abatement Uses, including the process of selecting programs to receive distributions of Public Funds for implementing those programs and in connection with the Government Participation Mechanism⁶ (“Approved Administrative Expenses”) and together with the other Authorized Abatement Purposes set forth in (i) and (ii), “Approved Uses”.</p> <p>Notwithstanding anything in these Public Creditor Trust Distribution Procedures that might imply to the contrary, projects or programs that constitute Approved Opioid Abatement Uses may be provided by States, State agencies, Local Governments, Local Government agencies or nongovernmental parties and funded from Public Funds.</p> |
| <p>3. DISBURSEMENT OF FUNDS</p> | <p>The Chapter 11 Plan shall provide for the establishment of the NOAT and the appointment of NOAT Trustees. The NOAT Trustees shall distribute the Public Funds consistent with the allocation agreement attached as <u>Schedule C</u> and in accordance with the NOAT Agreement.</p> <p>The Chapter 11 Plan shall also provide for the establishment of the Tribe Trust and appointment of Tribe Trustees. The Tribe Trustees shall distribute the Abatement Funds allocated to the Tribes pursuant to section 5 hereof and the Tribe Trust Documents.</p> |
| <p>4. ATTORNEYS’ FEES AND COSTS FUND</p> | <p>A separate fund will be established with Abatement Funds from NOAT or the Tribe Trust, as applicable, for the payment of attorneys’ fees and costs of the States, counties, municipalities and Tribes (including members of the Ad Hoc Committee of Governmental and Other Contingent Litigation</p> |

⁶ Capitalized terms not defined where first used shall have the meanings later ascribed to them in these Public Creditor Trust Distribution Procedures.

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| | Claimants, the Non-Consenting States Group, and the MSGE Group) on terms as provided for in the Chapter 11 Plan. | | | | | | | | | | |
| <p>5. TRIBAL ABATEMENT FUNDING</p> | <p>1. Public Creditor Trust Distributions (as defined in the Plan) will be allocated to the Tribe Trust in accordance with the Chapter 11 Plan, and these funds will not be a part of the structure involving abatement programs funded by state and local governments, as follows:</p> <ul style="list-style-type: none"> • \$50 million from the first \$1 billion in available Public Creditor Trust Distributions • 2.935% of the next \$2 billion in available Public Creditor Trust Distributions • 2.8125% of the next \$2 billion in available Public Creditor Trust Distributions • 3% of all additional available Public Creditor Trust Distributions <p>The following chart summarizes the foregoing:</p> <table border="1" data-bbox="527 1037 1461 1121"> <thead> <tr> <th>Threshold</th> <th>\$0 to \$1.0B</th> <th>\$1.0B+ to \$3.0B</th> <th>\$3.0B+ to \$5.0B</th> <th>\$5.0B+</th> </tr> </thead> <tbody> <tr> <td>%</td> <td>\$50M</td> <td>2.935%</td> <td>2.8125%</td> <td>3.0%</td> </tr> </tbody> </table> <p>2. The allocation of distributions among Tribes will be included as part of the Tribe Trust Documents.</p> <p>3. The Tribes will use the tribal allocation of Abatement Funds for programs on the approved list of abatement strategies (see Schedule B) and also for culturally appropriate activities, practices, teachings or ceremonies that are, in the judgment of a tribe or tribal health organization, aimed at or supportive of remediation and abatement of the opioid crisis within a tribal community. A list of representative examples of such culturally appropriate abatement strategies, practices, and programs is attached hereto as Schedule D (the “Tribal Abatement Strategies”). The separate allocation of abatement funding and illustrative list of Tribal Abatement Strategies recognizes that American Indian and Alaska Native Tribes and the communities they serve possess unique cultural histories, practices, wisdom, and needs that are highly relevant to the health and well-being of American Indian and Alaska Native people and that may play an important role in both individual and public health efforts and responses in Native communities.</p> | Threshold | \$0 to \$1.0B | \$1.0B+ to \$3.0B | \$3.0B+ to \$5.0B | \$5.0B+ | % | \$50M | 2.935% | 2.8125% | 3.0% |
| Threshold | \$0 to \$1.0B | \$1.0B+ to \$3.0B | \$3.0B+ to \$5.0B | \$5.0B+ | | | | | | | |
| % | \$50M | 2.935% | 2.8125% | 3.0% | | | | | | | |

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| | <p>4. The Tribes agree that 100% of the Abatement Funds distributed under the Chapter 11 Plan (and not otherwise dedicated to the attorneys’ fee fund(s) set forth in Section 4 herein or to reasonable administrative costs) shall be used to abate the opioid crisis in accordance with the terms hereof.</p> |
| <p>6. DIVISION OF PUBLIC FUNDS</p> | <p>Public Funds shall be allocated among the States, the District of Columbia, and Territories in the percentages set forth on Schedule C.</p> <p>Except as set forth below in section 6(C) for the District of Columbia and Territories, each State’s Schedule C share shall then be allocated within the State in accordance with the following:</p> <ol style="list-style-type: none"> 1. Default Allocation Mechanism (excluding Territories and DC addressed below). The Public Funds allocable to a State that is not party to a Statewide Abatement Agreement as defined in 7(2) above (each a “Non-SAA State”) shall be allocated as between the State and its Local Governments to be used only for Approved Uses, in accordance with this Section (2) (the “Default Allocation Mechanism”). <ol style="list-style-type: none"> i. Regions. Except as provided in the final sentence of this paragraph, each Non-SAA State shall be divided into “Regions” as follows: (a) each Qualifying Block Grantee (as defined below) shall constitute a Region; and (b) the balance of the State shall be divided into Regions (such Regions to be designated by the State agency with primary responsibility (the “Lead Agency”) ⁷ for opioid use disorder services employing, to the maximum extent practical, existing regions established in that State for opioid use disorder treatment or similar public health purposes); such non-Qualifying Block Grantee Regions are referred to herein as “Standard Regions”. The Non-SAA States which have populations under four (4) million and do not have existing regions described in the foregoing clause (b) shall not be required to establish Regions; ⁸ such a State that does not establish Regions but which does contain one or more Qualifying Block Grantees shall be deemed to consist of one Region for each Qualifying Block Grantee and one Standard Region for the balance of the State. |

⁷ A list of Lead Agencies will be made available on the NOAT website.

⁸ To the extent they are not parties to a Statewide Abatement Agreement, the following States will qualify as a Non-SAA State that does not have to establish Regions: Connecticut, Delaware, Hawai’i, Iowa, Maine, Nevada, New Hampshire, New Mexico, Rhode Island, Vermont.

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| | <p>ii. Regional Apportionment. Public Funds shall be allocated to each Non-SAA State, as defined in 7(1) above, as (a) a Regional Apportionment or (b) a Non-Regional Apportionment based on the amount of Public Funds dispersed under a confirmed Chapter 11 Plan as follows:</p> <p>A. First \$1 billion – 70% Regional Apportionment/30% Non-Regional Apportionment</p> <p>B. \$1-\$2.5 billion – 64% Regional Apportionment /36% Non-Regional Apportionment</p> <p>C. \$2.5-\$3.5 billion – 60% Regional Apportionment /40% Non-Regional Apportionment</p> <p>D. Above \$3.5 billion – 50% Regional Apportionment /50% Non-Regional Apportionment</p> <p>iii. Qualifying Block Grantee. A “Qualifying Local Government” means a county or parish (or in the cases of States that do not have counties or parishes that function as political subdivisions, a city), that (a) either (i) has a population of 400,000 or more or (ii) in the case of California has a population of 750,000 or more and (b) has funded or otherwise manages an established, health care and/or treatment infrastructure (e.g., health department or similar agency) to evaluate, award, manage and administer a Local Government Block Grant.⁹ A Qualifying Local Government that is eligible and wishes to receive Public Funds through Local Government Block Grants shall elect to receive funds in such manner no later than (90) ninety days following the Agreement Date. A Qualifying Local Government that elects to receive Public Funds through Local Government Block Grants is referred to herein as a Qualifying Block Grantee.</p> <p>iv. Proportionate Shares of Regional Apportionment. As used herein, the “Proportionate Share” of each Region in each Non-SAA State shall be (a) for States in which counties or parishes function as Local Governments, the aggregate shares of the counties or parishes located in such Region under the allocation model employed in connection with the Purdue</p> |

⁹ As noted in footnote 11, the population for each State shall refer to published U. S. Census Bureau population estimates as of [July 1, 2019], released March 2020, and shall remain unchanged during the term of this agreement. These estimates can currently be found at <https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html>.

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| | <p>Bankruptcy (the “Allocation Model”),¹⁰ divided by the aggregate shares for all counties or parishes in the State under the Allocation Model; and (b) for all other States, the aggregate shares of the cities and towns in that Region under the Allocation Model’s intra-county allocation formula, divided by the aggregate shares for all cities and towns in the State under the Allocation Model.</p> <p>v. Expenditure or Disbursement of Regional Apportionment. Subject to 6(2)(i) below regarding Approved Administrative Expenses, all Regional Apportionments shall be disbursed or expended in the form of Local Government Block Grants or otherwise for Approved Opioid Abatement Uses in the Standard Regions of each Non-SAA State.</p> <p>vi. Qualifying Block Grantees. Each Qualifying Block Grantee shall receive its Regional Apportionment as a block grant (a “Local Government Block Grant”).</p> <p>Local Government Block Grants shall be used only for Approved Opioid Abatement Uses by the Qualifying Block Grantee or for grants to organizations within its jurisdiction for Approved Opioid Abatement Uses and for Approved Administrative Expenses in accordance with 7(2)(i) below. Where a municipality located wholly within a Qualifying Block Grantee would independently qualify as a block grant recipient (“Independently Qualifying Municipality”), the Qualifying Block Grantee and Independently Qualifying Municipality must make a substantial and good faith effort to reach agreement on use of Abatement Funds as between the qualifying jurisdictions. If the Independently Qualifying Municipality and the Qualifying Block Grantee cannot reach such an agreement on or before the Effective Date of the Chapter 11 Plan, the Qualifying Block Grantee will receive the Local Government Block Grant for its full Proportionate Share and commit programming expenditures to the benefit of the Independently Qualifying Municipality in general proportion to Proportionate Shares (determined as provided in 6(2)(iv) above) of the municipalities within the Qualifying Block Grantee. Notwithstanding the allocation of the Proportionate Share of each Regional Apportionment to the Qualifying Block Grantee, a Qualifying Block Grantee may</p> |

¹⁰ [Such Allocation Model is available at www.opioidnegotiationclass.info and is described in further detail in the Disclosure Statement.]

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| | <p>choose to contribute a portion of its Proportionate Share towards a Statewide program.</p> <p>vii. Standard Regions. The portions of each Regional Apportionment not disbursed in the form of Local Government Block Grants shall be expended throughout the Standard Regions of each Non-SAA State in accordance with 95%-105% of the respective Proportionate Shares of such Standard Regions. Such expenditures will be in a manner that will best address Opioid abatement within the State as determined by the State with the input, advice and recommendations of the Government Participation Mechanism described in Section 8 below. This regional spending requirement may be met by delivering Approved Opioid Abatement Use services or programs to a Standard Region or its residents. Delivery of such services or programs can be accomplished directly or indirectly through many different infrastructures and approaches, including without limitation the following:</p> <ul style="list-style-type: none"> A. State agencies, including local offices; B. Local governments, including local government health departments; C. State public hospital or health systems; D. Health care delivery districts; E. Contracting with abatement service providers, including nonprofit and commercial entities; or F. Awarding grants to local programs. <p>viii. Expenditure or Disbursement of Public Funds Other Than Regional Apportionment. All Public Funds allocable to a Non-SAA State that are not included in the State’s Regional Apportionment shall be expended only on Approved Uses. The expenditure of such funds shall be at the direction of the State’s lead agency (or other point of contact designated by the State) and may be expended on a statewide and/or localized manner, including in the manners described in herein. Qualifying Block Grantees will be eligible to participate in or receive the benefits of any such expenditures on the same basis as other Regions.</p> |

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| | <p>ix. Approved Administrative Expenses. Qualifying Block Grantees and States may use up to 5% of their Non-Regional Apportionments plus 5% of the Regional Apportionment not used to fund Local Government Block Grants, for Approved Administrative Expenses. Qualifying Block Grantees may use up to 5% of their Local Government Block Grants to fund their Approved Administrative Expenses.</p> <p>2. Statewide Abatement Agreement. Each State and its Local Governments will have until (14) fourteen days after the Effective Date of the Chapter 11 Plan (the “Agreement Date”) to file with the Bankruptcy Court an agreed-upon allocation or method for allocating the Public Funds for that State dedicated only to Approved Uses (each a “Statewide Abatement Agreement” or “SAA”). Any State and its Local Governments that have reached agreement before the Effective Date of the Chapter 11 Plan that satisfies the metric for approval as described in the immediately following paragraph shall file a notice with the Bankruptcy Court that it has adopted a binding SAA and either include the SAA with its filing or indicate where the SAA is publicly available for the SAA to be effective for the Purdue Bankruptcy. Any dispute regarding allocation within a State will be resolved as provided by the Statewide Abatement Agreement; <i>provided</i> that no Statewide Abatement Agreement may remove or otherwise limit the reporting requirements set forth in any of the NOAT Trust Documents, including without limitation in the NOAT Trust Agreement and Sections 6(3) and 8 hereof.</p> <p>A Statewide Abatement Agreement shall be agreed when it has been approved by the State and either (a) representatives¹¹ of its Local Governments whose aggregate Population Percentages, determined as set forth below, total more than Sixty Percent (60%), or (b) representatives of its Local Governments whose aggregate Population Percentages total more than fifty percent (50%) provided that these Local Governments also represent 15% or more of the State’s counties or parishes (or, in the case of States whose counties and parishes that do not function as Local Governments, 15% of or more of the State’s incorporated cities or towns), by number.¹²</p> |

¹¹ An authorized “representative” of local, or even State, government can differ in these Public Creditor Trust Distribution Procedures depending on the context.

¹² All references to population in these Public Creditor Trust Distribution Procedures shall refer to published U. S. Census Bureau population estimates as of [July 1, 2019], released March 2020, and shall remain unchanged during

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| | <p>Population Percentages shall be determined as follows:</p> <p>For States with counties or parishes that function as Local Governments,¹³ the Population Percentage of each county or parish shall be deemed to be equal to (a) (1) 200% of the population of such county or parish, minus (2) the aggregate population of all Primary Incorporated Municipalities located in such county or parish, divided by (b) 200% of the State’s population. A “Primary Incorporated Municipality” means a city, town, village or other municipality incorporated under applicable state law with a population of at least 25,000 that is not located within another incorporated municipality. The Population Percentage of each primary incorporated municipality shall be equal to its population (including the population of any incorporated or unincorporated municipality located therein) divided by 200% of the State’s population; provided that the Population Percentage of a primary incorporated municipality that is not located within a county shall be equal to 200% of its population (including the population of any incorporated or unincorporated municipality located therein) divided by 200% of the State’s population. For all States that do not have counties or parishes that function as Local Governments, the Population Percentage of each incorporated municipality (including any incorporated or unincorporated municipality located therein), shall be equal to its population divided by the State’s population.</p> <p>The Statewide Abatement Agreement will become effective within fourteen (14) days of filing, unless otherwise ordered by the Bankruptcy Court.</p> <p>A State and its Local Governments may revise, supplement, or refine a Statewide Abatement Agreement by filing an amended Statewide Abatement Agreement that has been approved by the State and sufficient Local Governments to satisfy the approval standards set forth above with the Bankruptcy Court, which shall become effective within fourteen (14) days of filing, unless otherwise ordered by the Bankruptcy Court</p> <p>3. Records. The States shall maintain records of abatement expenditures and their required reporting as set forth in further</p> |

the term of this agreement. These estimates can currently be found at <https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html>.

¹³ Certain states do not have counties or parishes that function as Local Governments, including: Alaska, Connecticut, Massachusetts, Rhode Island, and Vermont. All other States have counties or parishes that function as Local Governments.

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| | <p>detail in Section 8 will include data on regional expenditures so it can be verified that the Regional Distribution mechanism guarantees are being met. Qualifying Block Grantees shall maintain records of abatement expenditures and shall provide those records periodically to their State for inclusion in their State’s required periodic reporting.</p> <p>(C) Allocation for Territories and the District of Columbia Only The allocation of Public Funds within a Territory or the District of Columbia will be determined by its local legislative body within one year of the Effective Date, unless that legislative body is not in session, in which case, the allocation of Public Funds shall be distributed pursuant to the direction of the Territory’s or District of Columbia’s executive, in consultation – to the extent applicable – with its Government Participation Mechanism.</p> |
| <p>7. GOVERNMENT PARTICIPATION MECHANISM</p> | <p>In each Non-SAA State, as defined in 6(1) above, there shall be a process, preferably pre-existing, whereby the State shall allocate funds under the Regional Distribution mechanism only after meaningfully consulting with its respective Local Governments. Each such State shall identify its mechanism (whether be it a council, board, committee, commission, taskforce, or other efficient and transparent structure) for consulting with its respective Local Governments (the “Government Participation Mechanism” or “GPM”) in a notice filed with the Bankruptcy Court identifying what GPM has been formed and describing the participation of its Local Governments in connection therewith. States may combine these notices into one or more notices for filing with the Bankruptcy Court. These notices are reviewable by the Bankruptcy Court upon the motion of any Local Government in that State asserting that no GPM has been formed.</p> <p>Government Participation Mechanisms shall conform to the following:</p> <ol style="list-style-type: none"> 1. Composition. For each State, <ol style="list-style-type: none"> 1. the State, on the one hand, and State’s Local Governments, on the other hand, shall have equal representation on a GPM; 2. Local Government representation on a GPM shall be weighted in favor of the Standard Regions but can include representation from the State’s Qualifying Block Grantees; 3. the GPM will be chaired by a non-voting Chairperson appointed by the State; |

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| | <p>4. Groups formed by the States’ executive or legislature may be used as a GPM, provided that the group has equal representation by the State and the State’s Local Governments.</p> <p>A GPM should have appointees such that as a group they possess experience, expertise and education with respect to one or more of the following: public health, substance abuse, healthcare equity and other related topics as is necessary to assure the effective functioning of the GPM.</p> <p>2. Consensus. Members of the GPMs should attempt to reach consensus with respect to GPM Recommendations and other actions of the GPM. Consensus is defined in this process as a general agreement achieved by the members that reflects, from as many members as possible, their active support, support with reservations, or willingness to abide by the decision of the other members. Consensus does not require unanimity or other set threshold and may include objectors. In all events, however, actions of a GPM shall be effective if supported by at least a majority of its Members. GPM Recommendations and other action shall note the existence and summarize the substance of objections where requested by the objector(s).</p> <p>3. Proceedings. Each GPM shall hold no fewer than four public meetings annually, to be publicized and located in a manner reasonably designed to facilitate attendance by residents throughout the State. Each GPM shall function in a manner consistent with its State’s open meeting, open government or similar laws, and with the Americans with Disabilities Act. GPM members shall be subject to State conflict of interest and similar ethics in government laws.</p> <p>4. Consultation and Discretion. The GPM shall be a mechanism by which the State consults with community stakeholders, including Local Governments (including those not a part of the GPM), state and local public health officials and public health advocates, in connection with opioid abatement priorities and expenditure decisions for the use of Public Funds on Approved Opioid Abatement Uses.</p> <p>The GPM is authorized to identify and recommend that non-Qualifying Local Government(s) (individually or in combination) should be considered for a block grant to be funded from an applicable Regional Apportionment. “Non-Qualifying Local Government(s)” individually or in combination are Local Governments that are not Qualifying Local Government but they fund or otherwise manage an established, health care and/or treatment infrastructure (e.g., health department or similar agency) to evaluate, award, manage and administer a block grant for programs constituting Approved Uses.</p> |

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| | <p>5. Recommendations. A GPM shall make recommendations regarding specific opioid abatement priorities and expenditures for the use of Public Funds on Approved Opioid Abatement Uses to the State or the agency designated by a State for this purpose (“GPM Recommendations”). In carrying out its obligations to provide GPM Recommendations, a GPM may consider local, state and federal initiatives and activities related to education, prevention, treatment and services for individuals and families experiencing and affected by opioid use disorder; recommend priorities to address the State’s opioid epidemic, which recommendations may be Statewide or specific to Regions; recommend Statewide or Regional funding with respect to specific programs or initiatives; recommend measurable outcomes to determine the effectiveness of funds expended for Approved Opioid Abatement Uses; and monitor the level of Approved Administrative Expenses expended from Public Funds.</p> <p>The goal is for a process that produces GPM Recommendations that are recognized as being an efficient, evidence-based approach to abatement that addresses the State’s greatest needs while also including programs reflecting particularized needs in local communities. It is anticipated that such a process, particularly given the active participation of state representatives, will inform and assist the state in making decisions about the spending of the Public Funds. To the extent a State chooses not to follow a GPM Recommendation, it will make publicly available within 14 days after the decision is made a written explanation of the reasons for its decision, and allow 7 days for the GPM to respond.</p> <p>6. Non-SAA States Review. In Non-SAA States, Local Governments and States may object to any apportionment, allocation, use or expenditure of Public Funds (an “Allocation”) solely on the basis that: the Allocation at issue (i) is inconsistent with the provisions of Section 7(1) hereof with respect to the levels of Regional Apportionments and Non-Regional Apportionments, (ii) is inconsistent with the provisions of Section 7(1) hereof with respect to the amounts of Local Government Block Grants or Regional Apportionment expenditures, (iii) is not for an Approved Use or (iv) violates the limitations set forth herein with respect to Approved Administrative Fees. The objector shall have the right to bring that objection to either (a) a state court with jurisdiction within the applicable State (“State Court”) or (b) the Bankruptcy Court if the Purdue chapter 11 case has not been closed (each an “Objection”). If an Objection is filed within fourteen (14) days of approval of an Allocation, then no funds shall be distributed on account of the aspect of the Allocation that is the subject of the Objection until the Objection is resolved or decided by the</p> |

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| | <p>Bankruptcy Court or State Court, as applicable. There shall be no other basis for bringing an Objection to the approval of an Allocation.</p> |
| <p>8. COMPLIANCE, REPORTING, AUDIT AND ACCOUNTABILITY</p> | <ol style="list-style-type: none"> 1. At least annually, each State shall publish on its Lead Agency’s website and/or on its Attorney General’s website and deliver to the NOAT, a report detailing for the preceding time period, respectively (i) the amount of Public Funds received, (ii) the allocation awards approved (indicating the recipient, the amount of the allocation, the program to be funded and disbursement terms), and (iii) the amounts disbursed on approved allocations, to Qualifying Local Governments for Local Government Block Grants and Approved Administrative Expenses. 2. At least annually, each Qualifying Block Grantee which has elected to take a Local Government Block Grant shall publish on its Lead Agency’s or Local Government’s website, and deliver to the NOAT, a report detailing for the preceding time period, respectively (i) the amount of Local Government Block Grants received, (ii) the allocation awards approved (indicating the recipient, the amount of the grant, the program to be funded and disbursement terms), and (iii) the amounts disbursed on approved allocations. 3. As applicable, each State or Local Government shall impose reporting requirements on each recipient to ensure that Public Funds are only being used for Approved Uses, in accordance with the terms of the allocation. 4. NOAT shall prepare an Annual Report that shall be audited by independent auditors as provided in the NOAT Agreement, which audited Annual Report shall be filed annually with the Bankruptcy Court, and the States and Qualifying Block Grantees shall provide NOAT with any information reasonably required regarding the expenditure and disbursement of Public Funds to satisfy the requirements of such an audited Annual Report of NOAT. 5. (a) A state court with jurisdiction within the applicable State (“State Court”) or (b) the Bankruptcy Court if the Purdue chapter 11 case has not been closed shall have jurisdiction to enforce the terms of this agreement, and as applicable, a Statewide Abatement Agreement or Default Mechanism; provided that nothing herein is intended to expand the scope of the Bankruptcy Court’s post-confirmation jurisdiction. For the avoidance of doubt, the Bankruptcy Court shall have continuing jurisdiction over NOAT, <i>provided</i> however, the courts of the State of Delaware, including any federal court located therein, shall also have jurisdiction over |

| Issue | Description |
|--------------|--|
| | NOAT, <i>provided further</i> , that the foregoing shall not preclude State Court jurisdiction in any State with respect to any matter arising under the Public Creditor Trust Distribution Procedures involving that State and one or more of its political subdivisions or agencies. |

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies (“**Core Strategies**”).¹

A. NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES

1. Expand training for first responders, schools, community support groups and families; and
2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. MEDICATION-ASSISTED TREATMENT (“MAT”) DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;
2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;
3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and
4. Treatment and Recovery Support Services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

C. PREGNANT & POSTPARTUM WOMEN

1. Expand Screening, Brief Intervention, and Referral to Treatment (“SBIRT”) services to non-Medicaid eligible or uninsured pregnant women;
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder (“OUD”) and other Substance Use Disorder (“SUD”)/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and
3. Provide comprehensive wrap-around services to individuals with Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare.

¹ As used in this Schedule A, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Public Creditor Trust Distribution Procedures.

D. EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME

1. Expand comprehensive evidence-based and recovery support for NAS babies;
2. Expand services for better continuum of care with infant-need dyad; and
3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;
2. Expand warm hand-off services to transition to recovery services;
3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;
4. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and
5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. TREATMENT FOR INCARCERATED POPULATION

1. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and
2. Increase funding for jails to provide treatment to inmates with OUD.

G. PREVENTION PROGRAMS

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);
2. Funding for evidence-based prevention programs in schools.;
3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);
4. Funding for community drug disposal programs; and
5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. EXPANDING SYRINGE SERVICE PROGRAMS

1. Provide comprehensive syringe services programs with more wrap-around services including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE.

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

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|---------------------|
| PART ONE: TREATMENT |
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A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following¹:

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.
2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions
3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.
7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

¹ As used in this Schedule B, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Public Creditor Trust Distribution Procedures.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.
12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.
13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.
14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.
2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.
3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.
4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance

programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.
6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.
7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.
8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.
9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.
11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.
12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.
13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.
14. Create and/or support recovery high schools.
15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have – or at risk of developing – OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.
3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.
4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.
7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.
8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.
9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.
10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.
11. Expand warm hand-off services to transition to recovery services.
12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.
13. Develop and support best practices on addressing OUD in the workplace.
14. Support assistance programs for health care providers with OUD.
15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:
 1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);
 2. Active outreach strategies such as the Drug Abuse Response Team (DART) model;
 3. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
 4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;
 5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
 6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.
2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.
3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.
4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.
5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison have recently left jail

or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.
7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.
3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.
4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.
5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.
6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.
8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.
9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.
10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

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| PART TWO: PREVENTION |
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F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).
2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:
 1. Increase the number of prescribers using PDMPs;
 2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
 3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.
7. Increase electronic prescribing to prevent diversion or forgery.
8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund media campaigns to prevent opioid misuse.
2. Corrective advertising or affirmative public education campaigns based on evidence.
3. Public education relating to drug disposal.
4. Drug take-back disposal or destruction programs.
5. Fund community anti-drug coalitions that engage in drug prevention efforts.
6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).
7. Engage non-profits and faith-based communities as systems to support prevention.
8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
10. Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.
11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.
2. Public health entities providing free naloxone to anyone in the community.
3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.
4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.
6. Public education relating to emergency responses to overdoses.
7. Public education relating to immunity and Good Samaritan laws.
8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.
9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.
12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide

care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.
3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.
2. Research non-opioid treatment of chronic pain.
3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.
4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).
7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.
8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.
9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

Schedule C
State Allocation Percentages

| State | Final Percentage Division of Funds |
|----------------------|---|
| Alabama | 1.6579015983% |
| Alaska | 0.2681241169% |
| American Samoa* | 0.0175102976% |
| Arizona | 2.3755949882% |
| Arkansas | 0.9779907816% |
| California | 9.9213830698% |
| Colorado | 1.6616291219% |
| Connecticut | 1.3490069542% |
| Delaware | 0.5061239962% |
| District of Columbia | 0.2129072934% |
| Florida | 7.0259134409% |
| Georgia | 2.7882080114% |
| Guam* | 0.0518835714% |
| Hawaii | 0.3476670198% |
| Idaho | 0.5364838684% |
| Illinois | 3.3263363702% |
| Indiana | 2.2168933059% |
| Iowa | 0.7639415424% |
| Kansas | 0.8114241462% |
| Kentucky | 1.5963344879% |
| Louisiana | 1.5326855153% |
| Maine | 0.5725492304% |
| Maryland | 2.1106090494% |
| Massachusetts | 2.3035761083% |
| Michigan | 3.4020234989% |
| Minnesota | 1.2972597706% |
| Mississippi | 0.8994318052% |
| Missouri | 2.0056475170% |
| Montana | 0.3517745904% |
| N. Mariana Islands* | 0.0191942445% |
| Nebraska | 0.4335719578% |
| Nevada | 1.2651495115% |
| New Hampshire | 0.6419355371% |
| New Jersey | 2.7551354545% |
| New Mexico | 0.8749406830% |
| New York | 5.3903813405% |
| North Carolina | 3.2502525994% |
| North Dakota | 0.1910712849% |
| Ohio | 4.3567051408% |
| Oklahoma | 0.6073894708% |
| Oregon | 1.4405383452% |
| Pennsylvania | 4.5882419559% |

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|-----------------|---------------|
| Puerto Rico** | 0.7324076274% |
| Rhode Island | 0.5040770915% |
| South Carolina | 1.5989037696% |
| South Dakota | 0.2231552882% |
| Tennessee | 2.6881474977% |
| Texas | 6.2932157196% |
| Utah | 1.2039654451% |
| Vermont | 0.2945952769% |
| Virgin Islands* | 0.0348486384% |
| Virginia | 2.2801150757% |
| Washington | 2.3189040182% |
| West Virginia | 1.1614558107% |
| Wisconsin | 1.7582560561% |
| Wyoming | 0.2046300910% |

* Allocations for American Samoa, Guam, N. Mariana Islands, and Virgin Islands are 100% based on population because of lack of available information for the other metrics.

** Allocations for Puerto Rico are 25% based on MMEs and 75% based on population because of lack of available information for the other metrics.

The metrics noted above are calculated as follows:

A. Amount of Prescription Opioids Sold as Measured by MME

The MME metric reflects the intensity of prescription opioid sales by state over a nine-year period from 2006 to 2014. This measure accounts for the flow of prescription opioids from manufacturers to distributors to pharmacies. The MME metric uses sales data for 12 categories of prescription opioids and was collected in a standardized manner by the Drug Enforcement Administration (DEA) in its Automation of Reports and Consolidated Orders System (ARCOS) database. As part of the National Prescription Opiate Litigation Multi-District Litigation, Case No. 1:17-MD-2804 (N.D. Ohio) (Opioid MDL), the DEA agreed to produce the nine years of data from 2006-2014, which encompassed the peak years of opioid sales in most states. The ARCOS data is standardized by converting data from varying products and prescription strengths into uniform MME totals to accurately reflect higher doses and stronger drugs in the data.

B. Pain Reliever Use Disorder

This metric consists of the number of people in each state with pain reliever use disorder, as identified by the annual National Survey on Drug Use and Health conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The SAMHSA survey is widely used by federal and other agencies. This metric included all three prior years in which pain reliever use disorder was broken down by state, 2015-2017, and included both people receiving treatment and those who are not.

C. Overdose Deaths

The overdose death metric includes two measures: (1) overdose deaths caused by opioids and (2) overdose deaths caused by all drugs. The overdose death figures used for the metric are from the years 2007-2017, with data drawn from a database compiled by the Centers for Disease Control and Prevention (“CDC”). The CDC database does not adjust for local reporting problems

that differ from state to state and over time. To mitigate this data collection issue, figures for all drug overdose deaths, which captures some unidentified opioid overdoses as well as overdoses unrelated to opioids.

D. Population

Population is measured by the 2018 U.S. Census estimate.

E. Negotiation Class Metrics

The Opioid MDL Plaintiffs' proposed "negotiation class" metrics weighting factor consists of the Allocation Model (defined below) applied at the state level.

ii. Intrastate Allocation of NOAT Abatement Funds

Each State and its Local Governments will have until (14) fourteen days after the Effective Date of the Plan (the "**Agreement Date**") to file with the Bankruptcy Court an agreed-upon allocation or method for allocating the Public Funds for that State dedicated only to Approved Uses (each a "**Statewide Abatement Agreement**" or "**SAA**"). Any State and its Local Governments that have reached agreement before the Effective Date of the Plan that satisfies the metric for approval as described in the immediately following paragraph shall file a notice with the Bankruptcy Court that it has adopted a binding SAA and either include the SAA with its filing or indicate where the SAA is publicly available for the SAA to be effective for the Purdue Bankruptcy. Any dispute regarding allocation within a State will be resolved as provided by the Statewide Abatement Agreement; *provided* that no Statewide Abatement Agreement may remove or otherwise limit the reporting requirements set forth in any of the NOAT Trust Documents, including without limitation in the NOAT Trust Agreement.

A Statewide Abatement Agreement shall be agreed when it has been approved by the State and either (a) representatives of its Local Governments whose aggregate Population Percentages, determined as set forth below, total more than [Sixty Percent (60%), or (b) representatives of its Local Governments whose aggregate Population Percentages total more than fifty percent (50%) provided that these Local Governments also represent 15%] or more of the State's counties or parishes (or, in the case of States whose counties and parishes that do not function as Local Governments, 15% of or more of the State's incorporated cities or towns), by number.

Population Percentages shall be determined as follows: For States with counties or parishes that function as Local Governments,¹ the Population Percentage of each county or parish shall be deemed to be equal to (a) (1) 200% of the population of such county or parish, minus (2) the aggregate population of all Primary Incorporated Municipalities located in such county or parish, divided by (b) 200% of the State's population. A "**Primary Incorporated Municipality**" means a city, town, village or other municipality incorporated under applicable state law with a population of at least 25,000 that is not located within another incorporated municipality. The

¹ Certain states do not have counties or parishes that function as Local Governments, including: Alaska, Connecticut, Massachusetts, Rhode Island, and Vermont. All other States have counties or parishes that function as Local Governments.

Population Percentage of each primary incorporated municipality shall be equal to its population (including the population of any incorporated or unincorporated municipality located therein) divided by 200% of the State's population; provided that the Population Percentage of a primary incorporated municipality that is not located within a county shall be equal to 200% of its population (including the population of any incorporated or unincorporated municipality located therein) divided by 200% of the State's population. For all States that do not have counties or parishes that function as Local Governments, the Population Percentage of each incorporated municipality (including any incorporated or unincorporated municipality located therein), shall be equal to its population divided by the State's population.

The Statewide Abatement Agreement will become effective within fourteen (14) days of filing, unless otherwise ordered by the Bankruptcy Court.

A State and its Local Governments may revise, supplement, or refine a Statewide Abatement Agreement by filing an amended Statewide Abatement Agreement that has been approved by the State and sufficient Local Governments to satisfy the approval standards set forth above with the Bankruptcy Court, which shall become effective within fourteen (14) days of filing, unless otherwise ordered by the Bankruptcy Court

Under the Plan, Public Funds allocated to each Non-SAA State are allocated between a "**Regional Apportionment**" and a "**Non-Regional Apportionment.**" The Proportionate Share of the Regional Apportionment for each Region in a Non-SAA State is determined by reference to the aggregate shares of counties (as used herein, the term county includes parishes), and cities or towns in the cases of a Non-SAA States in which counties do not function as Local Governments, in the Region under an allocation mode (the "**Allocation Model**") available at www.opioidnegotiationclass.info that was developed as part of the establishment of a negotiation class procedure implemented in *In re: National Prescription Opiates Litigation*, MDL No. 2804 (N.D. Ohio).

The Allocation Model employs a three-factor analysis to allocate potential opioids settlement proceeds among counties. The three factors are:

- A. Opioid Use Disorder ("**ODU**"). Under this factor, each county is assigned a percentage derived by dividing the number of people in the county with OUD by the total number of people nationwide with OUD. The Model uses data reported in the National Survey on Drug Use and Health ("**NSDUH**") for 2017. The data is accessible at <https://bit.ly/2HqF554>.
- B. Overdose Deaths. This factor assigns to each county a percentage of the nation's opioid overdose deaths. The percentage is based on Multiple Causes of Death ("**MCD**") data reported by the National Center for Health Statistics ("**NCHS**"), the Centers for Disease Control ("**CDC**") and the Department of Health and Human Services ("**DHHS**"). The data so reported is adjusted using a standard, accepted method (the "**Ruhm Adjustment**")

designed to address the well-established under-reporting of deaths by opioids overdose.

- C. Amount of Opioids. This factor assigns to each county a percentage of the national opioids shipments during 2006-2016 (expressed as morphine molecule equivalents, or MMEs) that produced a negative outcome. This percentage is based on data reported by the U.S. Drug Enforcement Agency (“DEA”) in its ARCOS (Automation of Reports and Consolidated Orders System) database. Each county’s share of national shipments is multiplied by the higher of two ratios: (1) the ratio of the percentage of people in the county with OUD to the percentage of people nationwide with OUD; or (2) the ratio of the percentage of people in the county who died of an opioids overdose between 2006-2016 to the national percentages of opioids overdose deaths during that time.

The Allocation Model gives equal weight to each of these factors. Thus, a hypothetical county with an OUD percentage of .3%, and overdose deaths percentage of .2% and an amounts of opioids percentage of .16% would receive an overall allocation of .22%.

Where a county and its cities and towns are unable to reach agreement regarding the sharing of the county’s overall allocation, the Allocation Model provides for such sharing based on how the county and its cities and towns have historically split funding for opioids abatement. This historical analysis employs data reported by the U.S. Census Bureau on local government spending by certain functions. The Allocation Model assigns to each incorporated city and town a portion of the county’s overall allocation based on this historical data.

Under the Plan, the Allocation Model shares of each county in a Region are aggregated. Those aggregate Allocation Model shares are then divided by the total Allocation Model shares for all Regions in the State to determine the subject Region’s Proportionate Share. For Non-SAA States in which counties do not function as Local Governments, the Allocation Model shares for each city and town in a Region are aggregated, and the aggregate is divided by the total Allocation Model shares for all cities and towns in the State to determine the Region’s Proportionate Share.

On September 30, 2020, the Bankruptcy Court entered the *Order Expanding Scope of Mediation* [D.I. 1756] (the “**Supplemental Mediation Order**”), which authorized the Mediators to continue the Mediation to resolve certain open issues referenced in the Mediators’ Report, as well as to mediate the estate causes of action and any potential claims or causes of action held by any of the Non-Federal Public Claimants against, or that otherwise may become the subject of releases for, members of the Sackler Families in Phase 2 of Mediation.