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State of New Hampshire

DEPARTMENT OF ADMINISTRATIVE SERVICES
25 Capitol Street – Room 100
Concord, New Hampshire 03301
(603) 271-3201 | Office@das.nh.gov

Charles M. Arlinghaus
Commissioner

Catherine A. Keane
Deputy Commissioner

Sheri L. Rockburn
Assistant Commissioner

September 7, 2022

His Excellency, Governor Christopher T. Sununu
and the Honorable Council
State House
Concord, NH 03301

REQUESTED ACTION

Authorize the Department of Administrative Services (DAS), Division of Risk and Benefits to enter into an Agreement with Anthem Health Plans of New Hampshire, Inc., d/b/a Anthem Blue Cross and Blue Shield (Anthem) (VC# 177335), 1155 Elm Street, Suite 200 Manchester, NH 03101-2000. The term of the Agreement is for a period of three years, from January 1, 2023 through December 31, 2025, with an option to extend for up to an additional two years with approval from the Governor and Executive Council. Administrative charges are estimated to be $17,500,000 during the initial term of the Agreement. Approximately 42% General funds, 23% Federal Funds, 3% Enterprise funds, 13% Highway funds, 1% Turnpike funds and 18% Other.

Funding is available in the Employee Benefit Risk Management Fund contingent upon availability and continued appropriations for all fiscal years with the authority to adjust encumbrances in each of the State fiscal years through the Budget Office if needed and justified:

Administration Costs	**SFY2023** (1/1/2023 – 6/30/2024)	**SFY2024** (7/1/2024 – 6/30/2025)	**SFY2025** (7/1/2025 – 6/30/2026)	**SFY2026** (7/1/2026 – 12/31/2026)
01-14-14-140560-66000000 102-500634 Med Admin Fee - Actives	$2,492,000	$4,977,000	$4,977,000	$2,492,000
01-14-14-140560-66600000 102-500634 Med Admin Fee - Troopers	$69,000	$138,000	$138,000	$69,000
01-14-14-140560-66500000 102-500634 Med Admin Fee – Non-Medicare	$363,000	$718,000	$711,000	$356,000
FISCAL YEAR TOTALS	$2,924,000	$5,833,000	$5,826,000	$2,917,000
GRAND TOTAL				$17,500,000

EXPLANATION

The DAS Commissioner is authorized, pursuant to RSA 21-1:28, to enter into contracts with "any organization necessary to administer and provide a health plan." DAS contracts with a third party administrator (TPA) to administer the Employee and Retiree Health Benefit Plan's (HBP) medical claims. This contract provides self-funded medical benefits coverage for state employees, non-Medicare eligible retirees, spouses and eligible dependents in accordance with the provisions of RSA 21-1:30 and the state collective bargaining agreements. The State's current medical TPA contract is with Anthem and expires on December 31, 2022.

DAS, with the assistance of its health benefits consultant, the Segal Company (Segal), issued a Request for Proposal (RFP) for the administration of medical benefits on April 7, 2022. In addition, DAS published notice of this RFP on the DAS Division of Procurement and Support Services website. All major TPAs with networks in NH were contacted including, Anthem, Cigna, Harvard, United Health Plans, and Aetna. On May 17, 2022, DAS received proposals from Anthem and Health Plans, Inc. (HPI), Harvard Pilgrim Health Care's third party administrator. DAS evaluated and scored both proposals.

The scoring of the proposals was based upon the areas of: Total Projected Costs (40%), Required Medical Trend Guarantee Administrative Withhold (5%), Provider Contracting Financial Impact (5%), Performance Guarantees (10%), Value-Based Purchasing (10%), Administrative Services, Reporting, Appeals, and Federal Compliance (10%), Health Management Programs (5%), Wellness Services (5%), Tiered-Networks/Site of Service (5%) and Client References (5%). Based on the foregoing, Anthem's proposal received the highest ranking score and was unanimously recommended by evaluation team. The evaluation team members included: Joyce Pitman (DAS, Director of Risk and Benefits), Margaret Blacker (DAS, Deputy Director of Risk and Benefits), Michael Loomis (DAS, Wellness Program Administrator), Kirstin Barber (DAS, Health Benefits Program Manager), Peter Demas (DAS, Manager of Employee Relations, Division of Personnel), Aliza Druzba (Health Benefits Committee, State Employees Association of New Hampshire), The scoring summary is attached.

Anthem received a technical score of 41.4 points out of a total possible 50 points, surpassing HPI's technical score of 37.4. Anthem's financial score of 48.0 out of a possible 50 points is a result of their proposal offering approximately 3.8% lower total projected costs over the three-year contract. The differential between the two bidders' costs is primarily due to Anthem's greater HMO and POS/PPO Plan estimated network discounts. The State projects an average $8.2 million annual cost differential between medical claims paid with Anthem as compared to medical claims paid with HPI, totaling approximately $24.6 million over the contract period. The total cost of the contract represents the fixed fee of $29.75 per employee per month (PEPM) for administrative services, $2.60 PEPM for the shopping incentive program, an average of $1.62 PEPM for wellness programs, plus fees for usage-based wellness and other services that represent projected costs based on prior utilization under the Health Benefit Plan.

This contract continues the State's objective to partner with its medical TPA to enhance the quality of healthcare services received by plan members and the cost-effectiveness of the health care purchased by the State through a comprehensive valued-based health care purchasing

strategy. Value-based purchasing incentivizes quality care and outcomes for individuals. Under this contract, Anthem will continue to be held accountable to performance guarantees specific to plan operations, clinical outcomes and medical trend management. Operational performance guarantees include program and plan design implementation, customer/member services, claims processing and payment accuracy, and timeliness of reporting. Clinical performance guarantees put up to 7.5% of the base administrative services fees at risk each year if Anthem is not able to hit certain state specific clinical targets. Anthem also guarantees a medical trend of less than 5% and agrees to place up to 10% of its base administrative fee at risk each year. If the actual trend is less than 4%, the State will return the 10% withhold plus an additional amount up to 2%.

In summary, this contract reinforces Anthem's commitment to work with the State to achieve mutually beneficial financial and quality goals. Included in these goals is Anthem's commitment to meet performance guarantees with respect to its service of the State's account. Based on the foregoing, I recommend the approval of this contract.

Respectfully submitted,

Charles M. Arlinghaus
Commissioner
Administrative Services

Scoring Summary

Category	Avail. Points	State Score	
		Anthem	HPI/Harvard
Performance Guarantees, Technical Questionnaire & References			
Performance Guarantees	10	7.0	8.0
Value-Based Purchasing	10	7.5	6.0
Administrative, Reporting, Appeals, Federal Compliance	10	9.0	9.0
Health Management Programs	5	4.0	4.0
Wellness Services	5	4.1	4.4
Tiered-Networks / Site-of-Service	5	4.8	1.0
References	5	5.0	5.0
Sub-Total	**50**	**41.4**	**37.4**
Financial			
Total Projected Costs	40	40.0	36.2
Medical Trend Guarantee Admin Withhold	5	5.0	3.0
Provider Contracting Financial Impact	5	3.0	2.1
Sub-Total	**50**	**48.0**	**41.3**
Total Points	**100**	**89.4**	**78.7**
Rank		1	2

State of New Hampshire

Projected Self-Funded Medical Costs

Effective January 1, 2023 through December 31, 2025

Projected Costs	Anthem	Health Plans, Inc.
Year 1 - Calendar Year 2023		
Medical Claims	$197,831,000	$206,228,000
Administrative Expenses	$5,205,000	$4,449,000
Total Medical Plan Costs	**$203,036,000**	**$210,677,000**
Year 2 - Calendar Year 2024		
Medical Claims	$210,606,000	$219,633,000
Administrative Expenses	$5,233,000	$4,353,000
Total Medical Plan Costs	**$215,839,000**	**$223,986,000**
Year 3 - Calendar Year 2025		
Medical Claims	$224,211,000	$233,909,000
Administrative Expenses	$5,260,000	$4,353,000
Total Medical Plan Costs	**$229,471,000**	**$238,262,000**
Total Three-Year Costs	**$648,346,000**	**$672,925,000**
Difference From Lowest Cost Proposal - $	**$0**	**$24,579,000**
Difference From Lowest Cost Proposal - %	**0.0%**	**3.8%**
Financial Score *	40.0	36.2

*The lowest cost proposal will receive 100% of the 40 points allocated to the "Total Projected Costs" Financial Score.

All other financial proposals will be scored on a sliding scale where the bidder's score will be reduced by 1 point for every percentage point it is higher than the lowest cost proposal.

STATE EVALUATION TEAM BIOS

JOYCE PITMAN

Current Position: Director, Division of Risk and Benefits, Department of Administrative Services

Background: Joyce Pitman joined DAS in the Division of Risk and Benefits in 2013 and began serving as the Director in May 2018. As Director, Joyce oversees all Health Benefit Plan initiatives, including procurements and contract management. Joyce has a BS in Health Management and Policy from the University of New Hampshire and an MBA in Business Administration/HR Management from Southern NH University. Previously, Joyce worked for 15 years in Health Benefits Administration and Human Resources. She has a wealth of knowledge in vendor relations and the contract management process as well as with employee communications concerning benefits.

MARGARET BLACKER

Current Position: Deputy Director, Division of Risk and Benefits, Department of Administrative Services

Background: Margaret Blacker started her State service in the Division of Risk and Benefits in February 2016. As the Deputy Director, Margaret provides oversight of the State's Employee and Retiree Health Benefit Program to ensure compliance with current state and federal laws, rules and guidelines and collective bargaining agreements; property and casualty insurance programs, including workers' compensation, fleet, cybersecurity liability, and other liability insurance policies. Also ensures periodic financial and management reports are available that serve the various needs of state agencies as well as the executive and legislative branches in their decision making processes. Prior to becoming employed by the State of New Hampshire, Margaret was employed by Elliot Health System in Manchester, NH, most recently as the Director of Employee Benefits. Margaret earned a Bachelor's degree in Business Administration from the University of Southern New Hampshire.

ALIZA DRUZBA

Current Position: Administrator, Rural Health and Primary Care, Division of Public Health Services, Department of Health and Human Services, and Representative for the State Employees Association of NH, SEIU Local 1984

Background: Alisa Druzba joined Rural Health and Primary Care in the Division of Public Health Services in 2004 and began serving as the Administrator in May 2006. As the Administrator, Alisa oversees the State Office of Rural Health, the New Hampshire Primary Care Office, the Medicare Rural Hospital Flexibility Program, State Loan Repayment and J1 Visa Waiver Programs, the Health Professions Data Center and associated staff and contractors. Alisa has a BA in Political Science from Centenary College of Louisiana and a MA in Community and Social Psychology from University of Massachusetts – Lowell. She has a background in information technology, clinical mental health care of adolescents, family therapy, youth development and community dynamics.

PETER DEMAS

Current Position: Manager of Employee Relations, Division of Personnel, Department of Administrative Services

Background: Peter Demas joined DAS in 2019 and began serving as the Manager or Employee Relations, in the Division of Personnel in March of 2021. Peter is responsible for negotiating, interpreting, and implementing collective bargaining agreements as well as representing the State's interests in response to union grievances. Peter has BA in Political Science from Boston University and JD from Widener University School of Law. Prior to joining DAS, Peter worked for 12 years in the Legal Unit at the Department of Environmental Services

KIRSTIN BARBER

Current Position: Health Benefit Program Manager, Division of Risk and Benefits, Department of Administrative Services

Background:
Kirstin Barber joined DAS in the Division of Risk and Benefits in 2021. As Health Benefit Program Manager, Kirstin oversees the daily operations of the Health Benefit Plan and works with the vendors of the Plan to ensure that the benefits are administered in accordance with contractual requirements and collective bargaining agreements. Kirstin has a BS in Business Administration from the University of New Hampshire and a Masters in Organizational Leadership from Southern NH University and currently maintains designations as a Certified Employee Benefit Specialist and Professional in Human Resources. Prior to joining the State, Kirstin spent over a decade assisting in the administration of two separate self-funded risk pools for New Hampshire local governments.

MICHAEL LOOMIS

Current Position: Wellness Program Administrator, Division of Risk and Benefits, Department of Administrative Services

Background: As the Wellness Administrator, Michael analyzes demographics, health benefit utilization, and risk analysis to create innovative solutions to health improvement objectives in collaboration with State Agencies, Employee Union Groups, and Health Benefit Program Administrators. Michael holds a Master of Public Health Degree from A.T. Still University of Health Sciences, School of Health Management and a Bachelor of Science Degree from the University of New England.

ADMINISTRATION OF MEDICAL BENEFITS

AGREEMENT BETWEEN THE STATE OF NEW HAMPSHIRE AND

ANTHEM BLUE CROSS AND BLUE SHIELD OF NH

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Date 09/07/22

Subject: **ADMINISTRATION OF MEDICAL BENEFITS**

Notice: This agreement and all of its attachments shall become public upon submission to Governor and Executive Council for approval. Any information that is private, confidential or proprietary must be clearly identified to the agency and agreed to in writing prior to signing the contract.

AGREEMENT

The State of New Hampshire and the Contractor hereby mutually agree as follows:

GENERAL PROVISIONS

1. IDENTIFICATION.

1.1 State Agency Name Department of Administrative Services (DAS), Division of Risk and Benefits		1.2 State Agency Address 25 Capitol Street, Room 412 Concord, NH 03301	
1.3 Contractor Name Anthem Health Plans of NH, Inc. d/b/a Anthem Blue Cross and Blue Shield of NH		1.4 Contractor Address 1155 Elm Street, Suite 200 Manchester, NH 03101-2000	
1.5 Contractor Phone Number 603-541-2000	1.6 Account Number 01-14-14-140560-66000000 01-14-14-140560-66600000 01-14-14-140560-66500000	1.7 Completion Date December 31, 2025	1.8 Price Limitation $17,500,000
1.9 Contracting Officer for State Agency Joyce I. Pitman, Director, Risk and Benefits		1.10 State Agency Telephone Number 603-271-3180	
1.11 Contractor Signature Maria M. Proulx Date: 09/07/22		1.12 Name and Title of Contractor Signatory Maria M. Proulx, President & GM	
1.13 State Agency Signature Date: 9/9/22		1.14 Name and Title of State Agency Signatory Charles M. Arlinghaus, DAS Commissioner	
1.15 Approval by the N.H. Department of Administration, Division of Personnel *(if applicable)* By:		Director, On:	
1.16 Approval by the Attorney General (Form, Substance and Execution) *(if applicable)* By: /s/Christen Lavers		On: 9/9/22	
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number:		G&C Meeting Date:	

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2. SERVICES TO BE PERFORMED. The State of New Hampshire, acting through the agency identified in block 1.1 ("State"), engages contractor identified in block 1.3 ("Contractor") to perform, and the Contractor shall perform, the work or sale of goods, or both, identified and more particularly described in the attached EXHIBIT B which is incorporated herein by reference ("Services").

3. EFFECTIVE DATE/COMPLETION OF SERVICES.

3.1 Notwithstanding any provision of this Agreement to the contrary, and subject to the approval of the Governor and Executive Council of the State of New Hampshire, if applicable, this Agreement, and all obligations of the parties hereunder, shall become effective on the date the Governor and Executive Council approve this Agreement as indicated in block 1.17, unless no such approval is required, in which case the Agreement shall become effective on the date the Agreement is signed by the State Agency as shown in block 1.13 ("Effective Date").

3.2 If the Contractor commences the Services prior to the Effective Date, all Services performed by the Contractor prior to the Effective Date shall be performed at the sole risk of the Contractor, and in the event that this Agreement does not become effective, the State shall have no liability to the Contractor, including without limitation, any obligation to pay the Contractor for any costs incurred or Services performed. Contractor must complete all Services by the Completion Date specified in block 1.7.

4. CONDITIONAL NATURE OF AGREEMENT.

Notwithstanding any provision of this Agreement to the contrary, all obligations of the State hereunder, including, without limitation, the continuance of payments hereunder, are contingent upon the availability and continued appropriation of funds affected by any state or federal legislative or executive action that reduces, eliminates or otherwise modifies the appropriation or availability of funding for this Agreement and the Scope for Services provided in EXHIBIT B, in whole or in part. In no event shall the State be liable for any payments hereunder in excess of such available appropriated funds. In the event of a reduction or termination of appropriated funds, the State shall have the right to withhold payment until such funds become available, if ever, and shall have the right to reduce or terminate the Services under this Agreement immediately upon giving the Contractor notice of such reduction or termination. The State shall not be required to transfer funds from any other account or source to the Account identified in block 1.6 in the event funds in that Account are reduced or unavailable.

5. CONTRACT PRICE/PRICE LIMITATION/ PAYMENT.

5.1 The contract price, method of payment, and terms of payment are identified and more particularly described in EXHIBIT C which is incorporated herein by reference.

5.2 The payment by the State of the contract price shall be the only and the complete reimbursement to the Contractor for all expenses, of whatever nature incurred by the Contractor in the performance hereof, and shall be the only and the complete compensation to the Contractor for the Services. The State shall have no liability to the Contractor other than the contract price.

5.3 The State reserves the right to offset from any amounts otherwise payable to the Contractor under this Agreement those liquidated amounts required or permitted by N.H. RSA 80:7 through RSA 80:7-c or any other provision of law.

5.4 Notwithstanding any provision in this Agreement to the contrary, and notwithstanding unexpected circumstances, in no event shall the total of all payments authorized, or actually made hereunder, exceed the Price Limitation set forth in block 1.8.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/ EQUAL EMPLOYMENT OPPORTUNITY.

6.1 In connection with the performance of the Services, the Contractor shall comply with all applicable statutes, laws, regulations, and orders of federal, state, county or municipal authorities which impose any obligation or duty upon the Contractor, including, but not limited to, civil rights and equal employment opportunity laws. In addition, if this Agreement is funded in any part by monies of the United States, the Contractor shall comply with all federal executive orders, rules, regulations and statutes, and with any rules, regulations and guidelines as the State or the United States issue to implement these regulations. The Contractor shall also comply with all applicable intellectual property laws.

6.2 During the term of this Agreement, the Contractor shall not discriminate against employees or applicants for employment because of race, color, religion, creed, age, sex, handicap, sexual orientation, or national origin and will take affirmative action to prevent such discrimination.

6.3. The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts for the purpose of ascertaining compliance with all rules, regulations and orders, and the covenants, terms and conditions of this Agreement.

7. PERSONNEL.

7.1 The Contractor shall at its own expense provide all personnel necessary to perform the Services. The Contractor warrants that all personnel engaged in the Services shall be qualified to perform the Services, and shall be properly licensed and otherwise authorized to do so under all applicable laws.

7.2 Unless otherwise authorized in writing, during the term of this Agreement, and for a period of six (6) months after the Completion Date in block 1.7, the Contractor shall not hire, and shall not permit any subcontractor or other person, firm or corporation with whom it is engaged in a combined effort to perform the Services to hire, any person who is a State employee or official, who is materially involved in the procurement, administration or performance of this Agreement. This provision shall survive termination of this Agreement.

7.3 The Contracting Officer specified in block 1.9, or his or her successor, shall be the State's representative. In the event of any dispute concerning the interpretation of this Agreement, the Contracting Officer's decision shall be final for the State.

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Date 09/07/22

8. EVENT OF DEFAULT/REMEDIES.

8.1 Any one or more of the following acts or omissions of the Contractor shall constitute an event of default hereunder ("Event of Default"):

8.1.1 failure to perform the Services satisfactorily or on schedule;

8.1.2 failure to submit any report required hereunder; and/or

8.1.3 failure to perform any other covenant, term or condition of this Agreement.

8.2 Upon the occurrence of any Event of Default, the State may take any one, or more, or all, of the following actions:

8.2.1 give the Contractor a written notice specifying the Event of Default and requiring it to be remedied within, in the absence of a greater or lesser specification of time, thirty (30) days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) days after giving the Contractor notice of termination;

8.2.2 give the Contractor a written notice specifying the Event of Default and suspending all payments to be made under this Agreement and ordering that the portion of the contract price which would otherwise accrue to the Contractor during the period from the date of such notice until such time as the State determines that the Contractor has cured the Event of Default shall never be paid to the Contractor;

8.2.3 give the Contractor a written notice specifying the Event of Default and set off against any other obligations the State may owe to the Contractor any damages the State suffers by reason of any Event of Default; and/or

8.2.4 give the Contractor a written notice specifying the Event of Default, treat the Agreement as breached, terminate the Agreement and pursue any of its remedies at law or in equity, or both.

8.3. No failure by the State to enforce any provisions hereof after any Event of Default shall be deemed a waiver of its rights with regard to that Event of Default, or any subsequent Event of Default. No express failure to enforce any Event of Default shall be deemed a waiver of the right of the State to enforce each and all of the provisions hereof upon any further or other Event of Default on the part of the Contractor.

9. TERMINATION.

9.1 Notwithstanding paragraph 8, the State may, at its sole discretion, terminate the Agreement for any reason, in whole or in part, by thirty (30) days written notice to the Contractor that the State is exercising its option to terminate the Agreement.

9.2 In the event of an early termination of this Agreement for any reason other than the completion of the Services, the Contractor shall, at the State's discretion, deliver to the Contracting Officer, not later than fifteen (15) days after the date of termination, a report ("Termination Report") describing in detail all Services performed, and the contract price earned, to and including the date of termination. The form, subject matter, content, and number of copies of the Termination Report shall be identical to those of any Final Report described in the attached EXHIBIT B. In addition, at the State's discretion, the Contractor shall, within 15 days of notice of early termination, develop and submit to the State a Transition Plan for services under the Agreement.

10. DATA/ACCESS/CONFIDENTIALITY/ PRESERVATION.

10.1 As used in this Agreement, the word "data" shall mean all information and things developed or obtained during the performance of, or acquired or developed by reason of, this Agreement, including, but not limited to, all studies, reports, files, formulae, surveys, maps, charts, sound recordings, video recordings, pictorial reproductions, drawings, analyses, graphic representations, computer programs, computer printouts, notes, letters, memoranda, papers, and documents, all whether finished or unfinished.

10.2 All data and any property which has been received from the State or purchased with funds provided for that purpose under this Agreement, shall be the property of the State, and shall be returned to the State upon demand or upon termination of this Agreement for any reason.

10.3 Confidentiality of data shall be governed by N.H. RSA chapter 91-A or other existing law. Disclosure of data requires prior written approval of the State.

11. CONTRACTOR'S RELATION TO THE STATE. In the performance of this Agreement the Contractor is in all respects an independent contractor, and is neither an agent nor an employee of the State. Neither the Contractor nor any of its officers, employees, agents or members shall have authority to bind the State or receive any benefits, workers' compensation or other emoluments provided by the State to its employees.

12. ASSIGNMENT/DELEGATION/SUBCONTRACTS.

12.1 The Contractor shall not assign, or otherwise transfer any interest in this Agreement without the prior written notice, which shall be provided to the State at least fifteen (15) days prior to the assignment, and a written consent of the State. For purposes of this paragraph, a Change of Control shall constitute assignment. "Change of Control" means (a) merger, consolidation, or a transaction or series of related transactions in which a third party, together with its affiliates, becomes the direct or indirect owner of fifty percent (50%) or more of the voting shares or similar equity interests, or combined voting power of the Contractor, or (b) the sale of all or substantially all of the assets of the Contractor.

12.2 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State. The State is entitled to copies of all subcontracts and assignment agreements and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

13. INDEMNIFICATION. Unless otherwise exempted by law, the Contractor shall indemnify and hold harmless the State, its officers and employees, from and against any and all claims, liabilities and costs for any personal injury or property damages, patent or copyright infringement, or other claims asserted against the State, its officers or employees, which arise out of (or which may be claimed to arise out of) the acts or omission of the

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Contractor, or subcontractors, including but not limited to the negligence, reckless or intentional conduct. The State shall not be liable for any costs incurred by the Contractor arising under this paragraph 13. Notwithstanding the foregoing, nothing herein contained shall be deemed to constitute a waiver of the sovereign immunity of the State, which immunity is hereby reserved to the State. This covenant in paragraph 13 shall survive the termination of this Agreement.

14. INSURANCE.

14.1 The Contractor shall, at its sole expense, obtain and continuously maintain in force, and shall require any subcontractor or assignee to obtain and maintain in force, the following insurance:

14.1.1 commercial general liability insurance against all claims of bodily injury, death or property damage, in amounts of not less than $1,000,000 per occurrence and $2,000,000 aggregate or excess; and

14.1.2 special cause of loss coverage form covering all property subject to subparagraph 10.2 herein, in an amount not less than 80% of the whole replacement value of the property.

14.2 The policies described in subparagraph 14.1 herein shall be on policy forms and endorsements approved for use in the State of New Hampshire by the N.H. Department of Insurance, and issued by insurers licensed in the State of New Hampshire.

14.3 The Contractor shall furnish to the Contracting Officer identified in block 1.9, or his or her successor, a certificate(s) of insurance for all insurance required under this Agreement. Contractor shall also furnish to the Contracting Officer identified in block 1.9, or his or her successor, certificate(s) of insurance for all renewal(s) of insurance required under this Agreement no later than ten (10) days prior to the expiration date of each insurance policy. The certificate(s) of insurance and any renewals thereof shall be attached and are incorporated herein by reference.

15. WORKERS' COMPENSATION.

15.1 By signing this agreement, the Contractor agrees, certifies and warrants that the Contractor is in compliance with or exempt from, the requirements of N.H. RSA chapter 281-A *("Workers' Compensation")*.

15.2 To the extent the Contractor is subject to the requirements of N.H. RSA chapter 281-A, Contractor shall maintain, and require any subcontractor or assignee to secure and maintain, payment of Workers' Compensation in connection with activities which the person proposes to undertake pursuant to this Agreement. The Contractor shall furnish the Contracting Officer identified in block 1.9, or his or her successor, proof of Workers' Compensation in the manner described in N.H. RSA chapter 281-A and any applicable renewal(s) thereof, which shall be attached and are incorporated herein by reference. The State shall not be responsible for payment of any Workers' Compensation premiums or for any other claim or benefit for Contractor, or any subcontractor or employee of Contractor, which might arise under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. NOTICE. Any notice by a party hereto to the other party shall be deemed to have been duly delivered or given at the time of mailing by certified mail, postage prepaid, in a United States Post Office addressed to the parties at the addresses given in blocks 1.2 and 1.4, herein.

17. AMENDMENT. This Agreement may be amended, waived or discharged only by an instrument in writing signed by the parties hereto and only after approval of such amendment, waiver or discharge by the Governor and Executive Council of the State of New Hampshire unless no such approval is required under the circumstances pursuant to State law, rule or policy.

18. CHOICE OF LAW AND FORUM. This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire, and is binding upon and inures to the benefit of the parties and their respective successors and assigns. The wording used in this Agreement is the wording chosen by the parties to express their mutual intent, and no rule of construction shall be applied against or in favor of any party. Any actions arising out of this Agreement shall be brought and maintained in New Hampshire Superior Court which shall have exclusive jurisdiction thereof.

19. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and/or attachments and amendment thereof, the terms of the P-37 (as modified in EXHIBIT A) shall control.

20. THIRD PARTIES. The parties hereto do not intend to benefit any third parties and this Agreement shall not be construed to confer any such benefit.

21. HEADINGS. The headings throughout the Agreement are for reference purposes only, and the words contained therein shall in no way be held to explain, modify, amplify or aid in the interpretation, construction or meaning of the provisions of this Agreement.

22. SPECIAL PROVISIONS. Additional or modifying provisions set forth in the attached EXHIBIT A are incorporated herein by reference.

23. SEVERABILITY. In the event any of the provisions of this Agreement are held by a court of competent jurisdiction to be contrary to any state or federal law, the remaining provisions of this Agreement will remain in full force and effect.

24. ENTIRE AGREEMENT. This Agreement, which may be executed in a number of counterparts, each of which shall be deemed an original, constitutes the entire agreement and understanding between the parties, and supersedes all prior agreements and understandings with respect to the subject matter hereof.

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EXHIBIT A: SPECIAL PROVISIONS

Section 12.2 of the General Provisions P-37 is hereby deleted in its entirety and replaced as follows:

Contractor may perform certain services hereunder through one or more of its subsidiaries, affiliates or subcontractors. However, performance of such services by subcontractors or affiliates shall require prior written notice to and consent of the State, which shall not be unreasonably withheld. A list of current subcontractors and affiliates performing such services is attached hereto as Appendix B and constitutes such written notice and consent of the State of those subcontractors or affiliates. Contractor may, without prior written notice or consent, contract with third-party vendors for ancillary services which are not direct third party administration services but that support Contractor's conduct of its general business operations, including but not limited to information technology support services, photocopying, shredding, actuarial, legal, or accounting services. Contractor shall be accountable for the performance of all subsidiaries, affiliates, partner networks and subcontractors and shall be responsible for all performance guarantee penalties that may result from underperformance of the subsidiary, affiliate and/or subcontractor.

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Date 09/07/22

EXHIBIT B: SERVICES TO BE PERFORMED

This EXHIBIT B is made a part of the Agreement between the State of New Hampshire ("State") and Anthem Health Plans of New Hampshire, Inc. dba Anthem Blue Cross and Blue Shield of NH (hereinafter referred to as "Anthem" or "Contractor") and sets forth the services and obligations to be performed by Anthem.

ARTICLE 1 - DEFINITIONS

For purposes of this EXHIBIT B and any addenda, attachments, appendices or schedules to the Agreement, the following words and terms have the following meanings unless the context or use clearly indicates another meaning or intent.

A. **ADMINISTRATIVE SERVICES FEE.** The amount payable to the Contractor in consideration of its administrative services and operating expenses as specified in EXHIBIT C to this Agreement, excluding any cost for administration of external review, if applicable. Administrative Services Fee does not include any expenses associated with subrogation or any other recovery activities by the Contractor referred to under this Agreement. Administrative Services Fee may include network access charges, if applicable. All additional charges not included in the Administrative Services Fee are specified elsewhere in this Agreement.

B. **ANTHEM AFFILIATE.** An entity controlling, under common control with, or controlled by Anthem.

C. **AGREEMENT or CONTRACT.** The Agreement or Contract includes the following documents: General Provisions Form P-37, Exhibits A, B, and C, Attachments 1, 2, 3, and 4, and any Appendices attached hereto, including Contractor's RFP response which is incorporated herein by reference.

D. **AGREEMENT PERIOD.** The period commencing at 12:00 a.m. on January 1, 2023 and ending at 11:59 p.m. on December 31, 2025, unless otherwise terminated in accordance with the terms of the Agreement. The Agreement Period shall be comprised of three one-year terms (each a "Term"). Each Term shall commence at 12:00 a.m. on January 1st and end at 11:59 p.m. on December 31st of the applicable calendar year. Agreement Period shall also include any extension of the Agreement for a period of up to two (2) additional years upon terms and conditions as the parties may mutually agree and upon the approval of the Governor and Executive Council.

E. **BEHAVIORAL HEALTH.** Services related to both mental health and substance use disorder.

F. **BENEFIT BOOKLET or BOOKLET.** A description of the portion of the health care benefits provided under the Program that is administered by the Contractor. A copy of said Benefit Booklet is available on the State's Human Resources website.

G. **BILLED CHARGES.** The amount which appears on an Enrollee's Claim form (or other written notification acceptable to the Contractor that Covered Services have been provided) as the Provider's charge for the services rendered to a Enrollee, without any adjustment or reduction and irrespective of any separate reimbursement contract between the Provider and the Contractor.

H. **INTER-PLAN PROGRAMS.** Blue Cross and Blue Shield Association programs, including the BlueCard Program, where Anthem can process certain Claims for Covered Services received by Members, which

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may include accessing the reimbursement arrangement of a Provider that has contracted with another Blue Cross and/or Blue Shield plan.

I. **CLAIM.** Written or electronic notice of a request for reimbursement of any hospital, medical, pharmacy, dental, vision or other health related service in a format acceptable to the Contractor.

J. **CLAIM INCURRED DATE.** The date of hospital admission if the Claim is for in-patient hospital services or the date that the service is provided to an Enrollee if the Claim is for any other services.

K. **CLAIMS RUNOUT SERVICES.** Processing and payment of Claims which are incurred but unreported and/or unpaid as of the completion date or termination date of the Agreement.

L. **CLINICAL PATHWAYS.** Standardized tools designed for a particular chronic condition or procedure provides clear care guidelines based on scientific evidence and organizational consensus regarding the best way to manage the condition or procedure.

M. **COLLABORATIVE CARE MODEL.** The treatment of common mental health conditions such as depression and anxiety by trained primary care providers and embedded mental health professionals. See https://aims.uw.edu/collaborative-care.

N. **COMPARATIVE EFFECTIVENESS RESEARCH (CER).** Direct comparison of existing health care interventions to determine which work best for which patients and which pose the greatest benefits and harms.

O. **CONTRACTOR.** The entity responsible for providing third-party plan administration services on behalf of the State and contracting with a provider organization(s) representing a defined network for purposes of providing benefits to Enrollees. For the purposes of this Agreement the Contractor is Anthem.

P. **COVERED SERVICE.** Any hospital, medical, pharmacy, dental, vision or other health related service rendered to Enrollees for which benefits are eligible for reimbursement pursuant to the terms of the Benefit Booklet.

Q. **ENROLLEE.** The individuals, including the State of New Hampshire employees and retirees and their spouse and dependents as defined in the Benefit Booklet, who have satisfied the eligibility requirements of the employee and/or retiree health benefit program of the State, applied for coverage, and been enrolled for benefits. Enrollee may also be referred to herein as Member or Program Member.

R. **EPISODE-BASED PAYMENT.** Setting a single price for all services to providers and/or health care facilities for all services related to a specific procedure (e.g., hip replacement) or condition (maternity care). The payment is designed to improve value and outcomes by using quality metrics for provider accountability. Providers may assume financial risk for the cost of services for a particular procedure/condition and related services for a specified time period, as well as costs associated with preventable complications.

S. **GROUP HEALTH PROGRAM.** See the definition of Program and Group Health Program.

T. **GROUP IDENTIFICATION NUMBER (GID).** The identifying number assigned to the State or subgroups of the State.

U. **HOSPITAL.** A facility which provides medical or surgical care to patients for a continuous period longer than twenty-four (24) hours and which is not primarily providing psychiatric, rehabilitative, drug or alcoholism treatment.

V. **IMPROVEMENT GOALS.** The defined objectives to improve the value generated to the State and Enrollees, including to satisfy the requirements of the Contract. Such Improvement Goals are developed collaboratively by the State's and the Contractor's identification of opportunities for

improvement in the Contractor's management of health services to successfully meet the Purchasing Specifications (contained in **Appendix A**).

W. **LINES OF COVERAGE**. The benefit plans, such as HMO, POS, or PPO, available to Enrollees under this Agreement, as determined by the Benefit Booklet.

X. **MEASURE**. The means by which the State determines the Contractor's compliance with the Purchasing Specifications and achievement of the Contractor's annual Improvement Goals. A Measure should be defined in quantitative terms whenever possible, with both 6-month and 12-month targets.

Y. **MEDICAL TREND**. Medical Trend is the increase in average cost from one measurement period to the next and the full definition is outlined in the calculation methodology herein.

Z. **PAID CLAIM**. The amount charged to the State for Covered Services or services provided during the term of this Agreement. Paid Claims shall also include any applicable interest, Claim surcharges or other surcharges assessed by a state or government agency and any Claims paid pursuant to pilot or test programs as described more fully in Article 2(g). Paid Claims shall be determined as follows:

Hospital, Provider and Subcontractor Claims. Except as otherwise provided in this Agreement, Paid Claims shall mean the amount the Contractor actually pays the Hospital, Provider or Subcontractor (whether the Contractor reimburses a Hospital on a percentage of charges basis, a fixed payment basis, or a global fee basis, etc. or whether such amount is more or less than the Hospital's, Provider's or Subcontractor's actual Billed Charges for a particular service or supply). In the event that the Hospital, Provider, or Subcontractor participates in any the Contractor program where performance incentives or bonuses are paid (the "Performance Payments"), Paid Claims shall also mean an amount the Contractor adds to the Hospital, Provider, or Subcontractor payment for services or supplies under the terms of that program designed to reward for effectively managing the care of Enrollees. Such Performance Payments may be added on a per claim, lump sum, per Enrollee, or per Member basis or on a pro-rata apportionment. The amount charged to the State may be greater than the amount actually paid to any one particular Provider or Subcontractor pursuant to the terms of the contract with such Provider or Subcontractor. In no event shall the amount charged to the State be greater than its proportionate share of total Performance Payments. Paid Claims may also include a portion of the Contractor's negotiated discounts with Hospitals, Providers or Subcontractors. Paid Claims may also include fees paid to Providers or Subcontractors for managing the care or cost of care for Enrollees. In addition, Paid Claims may also include an amount the Contractor charges to oversee programs. The parties shall meet to negotiate in good faith if the State's participation in the Contractor programs described herein will result in an additional administrative charge.

1. Providers or Subcontractors Reimbursed on a Capitated Basis. Paid Claims shall mean the amount per Member per month which the Contractor actually pays the Provider or Subcontractor, irrespective of whether services are actually rendered to Enrollees, plus any portion of the capitation or percent of premium equivalent that is retained by the Contractor to fund Performance Payments designed to support effective quality and utilization or reward Providers or Subcontractors for effective management under the terms of the contracts with such Providers and Subcontractors. Paid Claims shall also include any sums paid to a Provider as administrative fees charged by and retained by the Contractor to manage the Providers or Subcontractors. The State acknowledges and agrees that a portion of the amounts discussed in this paragraph may be retained or withheld by the Contractor and that, as a result, the capitation fee or percent of the premium equivalent charged to the State may be greater than the fees actually paid to the Providers or Subcontractors pursuant to the terms of the contracts with such Providers or Subcontractors. The parties shall meet to negotiate in good faith if the State's participation in these Contractor programs described herein will result in an additional administrative charge.

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2. Claims Payment Pursuant to any Judgment, Settlement, Legal or Administrative Proceeding. Paid Claims shall include any amount paid as the result of a settlement, judgment, or legal, regulatory or administrative proceeding brought against the Program and/or the Contractor with respect to the decisions made by the Contractor, which are authorized by the Agreement or otherwise approved by the State, regarding the coverage of services under the terms of the Program, as well as any legal fees and costs awarded to any adverse party or incurred by the Contractor in such litigation, regulatory or administrative proceeding. Paid Claims also includes any amount paid as a result of the Contractor's billing dispute resolution procedures.

3. Claims Payment Pursuant to Inter-Plan Programs and other BCBSA Programs. Paid Claims shall include any amount paid for Covered Services that are processed through Inter-Plan Programs or for any amounts paid for Covered Services provided through another BCBSA program (e.g., BCBSA Blue Distinction Centers for Transplant). More information about the Inter-Plan Program is found in Article 9 of this EXHIBIT B.

AA. **PARTICIPATING PROVIDER.** A physician, health professional, hospital, pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Contractor to provide Covered Services to Enrollees at negotiated fees.

BB. **PATIENT-CENTERED MEDICAL HOME.** The patient-centered medical home (PCMH) is a model of care that aims to transform the delivery of comprehensive primary care to children, adolescents, and adults. Through the medical home model, practices seek to improve the quality, effectiveness, and efficiency of the care they deliver while responding to each patient's unique needs and preferences. (source: AAFP)

CC. **POPULATION-BASED PAYMENT.** A comprehensive payment to a group of providers to account for all or most of the care that will be received by a group of patients for a defined period of time.

DD. **PRIMARY CARE CLINICIAN.** A Provider who focuses his or her practice on the provision of primary care; a Primary Care Clinician may include pediatricians, family physicians, nurse practitioners, internists, and based on a plan Participant's diagnoses, may also include a specialty physician upon agreement by that physician and approval by the Contractor.

EE. **PROGRAM and GROUP HEALTH PROGRAM.** The employee and retiree health benefit program established by the State, in effect during the Agreement Period, as it may be amended from time to time.

FF. **PROGRAM ADMINISTRATOR.** The Program Administrator is the State.

GG. **PROGRAM DOCUMENTS.** The documents that set forth the terms of the Program, which documents include the Benefit Booklet.

HH. **PROVIDER.** A duly licensed person, organization or facility that provides health services or supplies within the scope of an applicable license and meets any other requirements set forth in the Benefit Booklet.

II. **SHARED RISK.** A payment arrangement that allows providers to share in a portion of any savings they generate as compared to a set target for spending, but also puts them at financial risk for any overspending. Shared risk provides both an upside and downside financial incentive for providers or provider entities to meet quality targets and to reduce unnecessary spending for a defined population of patients or an episode of care.

JJ. **STATISTICALLY SIGNIFICANT.** The likelihood that a desired change in performance results from chance is no more than 10%. For the purpose of assessing whether Anthem's performance improvement on selected quality measures was statistically significant, the State and Anthem shall apply a one-tailed

significance test to assess whether performance improved. A t-test should be applied to determine whether improvement occurred at a level of p <= .10.

KK. **SUBCONTRACTOR**. A person or entity other than a Provider or an affiliate of the Contractor that provides services pursuant to a written contract with the Contractor.

LL. **SUBSCRIBER** or **PROGRAM SUBSCRIBER**. An employee or retiree of the State or other eligible person (other than a dependent) who is enrolled in the Program.

MM. **VALUE-BASED PURCHASING SPECIFICATIONS.** A detailed description of performance requirements and Measures. The Purchasing Specifications are contained in Appendix A.

ARTICLE 2 - ADMINISTRATIVE SERVICES PROVIDED BY THE CONTRACTOR

A. All of Contractor's services provided under this Agreement shall be provided consistent with state and/or federal law.

B. The Contractor shall administer the enrollment of eligible persons and termination of Enrollees as directed by the State, subject to the provisions of this EXHIBIT B. The Contractor shall, with the assistance of the State, respond to all direct routine inquiries made to it by employees and other persons concerning eligibility in the Program. Unless otherwise specifically provided in the Benefit Booklet or under this Agreement, the Contractor shall apply its standard administrative practices and procedures and enrollment policies, which may be revised or modified from time to time, in connection with the performance of its responsibilities hereunder.

C. Due to the existence of collective bargaining agreements and required legislative authorization, The Contractor shall modify the active and retiree benefits or plan designs as directed by the State at any time during the term of this Agreement.

1. The Contractor shall administer the current Active Employee Point of Service (POS) plan and the current Active Employee Health Maintenance Organization (HMO) plan with no benefit or plan design deviations.

2. The Contractor shall administer the non-Medicare Retiree POS plan and non-Medicare PPO plan with no benefit or plan design deviations. Anthem agrees to offer two plans available to non-Medicare Retirees; BlueChoice New England POS plan, intended for retirees who maintain full or part-time residence in New England, and Preferred Blue PPO plan, intended for retirees residing full-time outside of New England. Benefits, cost-sharing and premium contributions will be equal under these plans.

3. The Contractor will process enrollment files received from the State as mutually agreed to.

D. At no additional cost to the State, the Contractor shall agree to work with the State and/or the State's designated data management team for EDI 834 data interface file production and/or other data transfer matters. Any changes to the standard file format will be as specified by the State.

The Contractor agrees to accept and process an interface file from the State twice per week, on dates agreed upon by the State and Contractor, to ensure timely subscriber eligibility and enrollments. Upon acceptance of the file by the Contractor, the Contractor agrees to process each file within 2 business days of receipt of file.

The Contractor agrees to comply with State's requests for implementing subscriber division reporting and grouping under each plan policy number assigned by the Contractor for billing and tracking purposes. The Contractor agrees to work with the State to add, subtract or make other changes to division or agency groups under each plan, at any time as identified as necessary by the State during the Agreement period. The Contractor shall collaborate with the State when reviewing current systems and processes and make recommendations for improvement.

The State's standard is to exchange data with its contractors using the State of New Hampshire's Secure File Exchange Server. This Secure File Exchange Server is password protected and accessible by designated, State-approved Contractor staff via Internet access. All data files on this server are encrypted while at rest. The data stays protected until downloaded by the receiver. Unless otherwise mutually agreed upon, Contractor and any subcontractors and/or affiliates shall retrieve eligibility and enrollment data, from this server. In addition, Contractors and/or subcontractors and/or affiliates will be required to use this method for sending/receiving any other agreed upon data files to the State.

E. Site of Service Provision

The Contractor shall offer the option for eligible members to avoid paying the deductible for covered services if the member chooses to use an approved Site-of-Service (SOS) lab or Ambulatory Surgery Center, or other service provider as directed by the State. The Contractor agrees to offer SOS locations in all geographic regions of the State. The Contractor shall work with the State to promote the SOS program to increase utilization and cost savings. The Contractor shall provide the State with semi-annual reports on SOS provider utilization and cost comparison to non-SOS providers on a year over year basis or as otherwise directed by the State.

F. "SmartShopper-like" Program

The Contractor shall provide a voluntary employee incentive program that offers taxable cash payments to employees and non-Medicare retirees who utilize cost-effective health care providers. The Contractor shall provide the State with reports on utilization and cost savings on a year over year basis or as otherwise directed by the State.

G. The Contractor shall perform the following Claims administration services:

1. Process Claims with a Claim Incurred Date during the Agreement Period, including investigating and reviewing such Claims to determine what amount, if any, is due and payable with respect thereto in accordance with the terms and conditions of the Benefit Booklet, and this Agreement. In processing Claims, the Contractor shall perform coordination of benefits ("COB") services, and the State hereby authorizes the Contractor to perform such services in accordance with the Contractor's standard policies, procedures and practices which may be revised or modified from time to time, unless alternative provisions for COB are indicated in the Benefit Booklet.

2. In connection with its Claims processing function, disburse to the person or entities entitled thereto (including any Provider and Subcontractor entitled to payment under an appropriate contract with the Contractor or otherwise under the terms of the Benefit Booklet) payments that it determines to be due in accordance with the provisions of the Benefit Booklet. If applicable to the Program benefits as indicated in EXHIBIT B to this Agreement, the Contractor may utilize its standard medical policy, utilization management and quality improvement policies, case management and administrative practices and procedures (including any Claims bundling procedures) which may be revised or modified from time to time to determine benefit payments.

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H. The State designates the Contractor to serve as a fiduciary solely to determine claims for benefits under the plan and authority to determine appeals of any adverse benefit determinations under the plan. The Contractor shall have all the powers necessary and appropriate to enable it to carry out its Claims appeal processing duties. This includes, without limitation, the right and discretion to interpret and construe the terms and conditions of the Program benefits described in the Benefit Booklet, subject to the Claims review provisions as described in this Agreement. The Contractor's interpretation and construction of this Agreement and Benefit Booklet in the course of its processing of any appeal of an adverse benefit determination shall be binding upon the Program, the State, and Enrollees. The Contractor shall be deemed to have properly exercised such authority unless an Enrollee proves that the Contractor has abused its discretion or that its decision is arbitrary and capricious. The State designates the Contractor to undertake fiduciary responsibilities exclusively in connection with the processing of appeals of adverse benefit determinations. The Contractor and the State agree that the Contractor shall not act as the administrator of the plan and shall have no fiduciary responsibility in connection with any other element of the administration of the Program.

I. The Contractor shall administer complaints, appeals and requests for independent review according to any applicable law and regulations and the Contractor's complaint and appeals policy, unless the Benefit Booklet provides otherwise. Enrollees shall be provided with a mandatory first level internal appeal, a voluntary second level internal appeal, and provided a mandatory first level appeal has been completed, an independent External Review of eligible adverse benefit determinations pursuant to federal law. The Contractor shall provide External Review services which are comparable to those offered to residents of New Hampshire according to RSA 420-J:5-a *et seq* and in compliance with federal law applicable to *governmental* group health plans. In addition, the Contractor reserves the right to exclude any such extra-contractual payments from performance guarantee calculations.

J. The Contractor shall have the authority to build and maintain its Provider network. The Contractor shall administer referral, authorization or certification requirements. The Contractor shall also have the authority to waive any such referral, authorization or certification requirement if such waiver will not adversely impact the effective and efficient Claims administration. In addition, the Contractor shall have the authority to change its administrative practices and procedures which it deems are necessary or appropriate for the effective utilization and administration of Covered Services. The Contractor shall provide the State with advance notice as practicable of any material change to any of its practices and/or procedures contemplated in this paragraph G. In addition, the Contractor shall provide notice to the State of the number and identity of the Enrollees impacted by such change (See Attachment 3 – Value-Based Purchasing).

K. If applicable to the Program benefits and as indicated in EXHIBIT B of this Agreement, and after consultation with and approval from the State, the Contractor shall have the authority, in its discretion, to institute from time to time, pilot or test programs regarding case management, disease management or health improvement and wellness services which may result in the payment of benefits not otherwise specified in the Benefit Booklet. The Contractor reserves the right to discontinue a pilot or test program at any time with advance notice.

L. In the event that the Contractor determines that it has paid a Claim in an amount less than the amount due under the Benefit Booklet, the Contractor will promptly adjust the underpayment. If it is determined by the Contractor or the State that any benefit payment has been made for an ineligible person, that an overpayment has been made, or that a sum is due to the State under the coordination of benefits or subrogation provisions, the Contractor will make reasonable efforts to collect such amounts but shall not be required to initiate or maintain any judicial proceeding to make the recovery as described in Article 14 of this EXHIBIT B. The Contractor shall, during the term of this Agreement, refund to the State any overpaid amounts successfully recovered.

In the event the Contractor discovers a systemic claims processing error that results in the payment of claims that does not conform to the State's benefit design, the Contractor, upon discovering such error,

shall notify the State about the claims processing error including type of claims, total number of claims paid, and total amount of claims paid. If applicable, the Contractor shall re-adjudicate such systemic claims processing errors to reimburse the State for the erroneous paid claims. The State must provide approval prior to the Contractor taking any action to collect erroneous claims payments from a member(s).

In the event the Contractor makes a systemic change in coverage levels that results in payment of claims prior to notification being provided to the State of the change, the Contractor, upon discovering such change in coverage level, shall notify the State about the change in coverage and how the claims will be paid including type of claim, total number of claims paid, and total amount of claims paid prior to notification.

Overpayments resulting from Contractor error that are not recovered or recoverable shall be returned to the State by the Contractor.

Overpayments resulting from Contractor error shall not be subject to the recovery or Program Integrity program fees charged by the Contractor.

M. The Contractor shall provide the State with information about the Contractor's recovery programs and the success of those programs. In addition, the Contractor shall provide a report on a quarterly basis that reflects all the detailed claims payments of all recovery programs (including, but not limited to, Program Integrity).

N. The Contractor shall respond to inquiries by Enrollees regarding Claims for benefits under the Program.

O. The Contractor shall provide designated customer service representatives that are knowledgeable of the State's plan via a toll-free phone number to be answered by a live person in the United States from, at a minimum, weekday hours from 8AM to 8PM ET Monday to Thursday and 8AM to 5PM ET on Fridays, year round and shall provide customer service on all dates that are recognized as work days for state employees. In addition, the State's members can email the Customer Service team at any time.

The Contractor shall provide 24 hour a day access to an Interactive Voice Response system (IVR). Members shall be able to request a facsimile be sent to them with the information requested via the IVR by entering their fax number when prompted. Faxes should be sent immediately after the call. Through the IVR, members shall be able to:

- Obtain medical eligibility and benefit information
- Request member ID cards
- Request EOB forms
- Order claim forms
- Request a provider directory

For non-emergent health-related questions, the State's Members shall have access to a 24/7 NurseLine or access to a healthcare provider via an online telemedicine application or website (like LiveHealth Online) for guidance on caring for acute conditions and behavioral health services.

The Contractor must have a timely and organized system(s) for resolving Members' complaints and formal grievances. The Contractor must inform Members through the Benefit Booklet about services provided, access to services, charges, and scheduling, and must be in compliance with all State and Federal laws that are required of self-insured plans. The Booklet describes the translation services available to non-English speaking Members. Member information must be comprehensible and well-designed as determined by the State.

P. In processing Claims in accordance with the Benefit Booklet, the Contractor shall provide notice in writing when a Claim for benefits has been denied, setting forth the reasons for the denial, the right to a full and fair review of the denial under the terms of the Program, and otherwise satisfying applicable regulatory requirements governing notice of a denied Claim.

Q. The Contractor shall issue identification cards to each Enrollee, unless otherwise agreed upon by the Contractor and the State. Web Online Enrollment and Employer Access tools are available for the State to request ID Cards as well as print temporary ID Cards as needed in "real time". Such identification cards shall be for the administration of Enrollees' health care benefits under the Program only. Such identification cards shall include any information required by state or federal law.

R. The Contractor shall provide certificates of creditable coverage as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") with respect to Enrollees' participation in the Program for which the Contractor provides services, unless otherwise instructed by the State. The State agrees to provide the Contractor, within a reasonable timeframe, with any information relating to a Subscriber's employment history as may be necessary for the Contractor to provide the certificates of creditable coverage.

S. The Contractor shall provide the State access to an online directory of providers contracted with the Contractor ("Provider Directories"). Such Provider Directories shall also be available and distributed in booklet format upon the State's request. Directories shall be maintained and updated as required by state or federal law.

The Provider Directories shall contain information such as medical specialty, office addresses and telephone number(s).

T. The Contractor shall provide the State with information necessary to enable Enrollees to effectively access Program benefits described in the Benefit Booklet, including, but not limited to, Claim forms and Claim filing instructions.

U. The Contractor reserves the right to make benefit payments to either Providers or Subscribers. The State agrees that during the Agreement Period, the terms of the Program will provide for such discretion in determining the direction of payment (including, but not limited to, the inclusion of a provision in the Program that an Enrollee may not assign rights to receive payment under the Program).

V. The Contractor is the responsible reporting entity ("RRE") for the plan as that term is defined pursuant to Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. In order to fulfill its RRE obligation, the Contractor requires information from the State, including, but not limited to, Member Social Security Numbers. State shall cooperate with the Contractor and timely respond to any request for information made by the Contractor.

W. The Contractor will provide the State with Summary of Benefits and Coverage ("SBC") accurately reflecting plan information related to the elements of the plan that The Contractor administers. The Contractor will provide assistance in the preparation of the SBC. The State is responsible for ensuring the accuracy of the SBC and for finalizing and distributing SBCs to subscribers. Notwithstanding the provisions in Article 16, if the State's open enrollment period is at a time other than 30 days prior to the end of an Agreement Period, the State agrees to provide the Contractor with any changes to the benefits the Contractor administers as soon as administratively possible prior to the start of the open enrollment period.

X. If applicable to the Program benefits and as indicated in EXHIBIT B to this Agreement, the Contractor will provide or arrange for the following managed care services. The Contractor may subcontract managed care services consistent with the P-37 and Exhibit A of this Agreement. Managed care services shall include, but are not limited to:

1. Conduct utilization review. Such review may include preadmission review to evaluate and certify the medical necessity of an admission or procedure and appropriate level of care, and to authorize an initial length of stay for inpatient admissions, with concurrent review throughout the admission for certification of additional days of care as warranted by the patient's medical condition.

2. Provide access to a specialty network of Providers if the Program includes a specialty network. The Contractor reserves the right to establish specialty networks for certain specialty or referral care.

3. Provide any other managed care services incidental or necessary to perform the services set forth in Article 2 or other managed care services, including the right to make benefit exceptions from time to time on a case by case basis.

Y. If a catastrophic event (whether weather-related, caused by a natural disaster, or caused by war, terrorism, or similar event) occurs that affects Members in one or more locations, and such catastrophic event prevents or interferes with the Contractor's ability to conduct its normal business with respect to such Members or prevents or interferes with Members' ability to access their benefits, the Contractor shall have the right, without first seeking consent from the State, to take reasonable and necessary steps to process Claims and provide managed care services in a manner that may be inconsistent with the Benefits Booklet in order to minimize the effect such catastrophic event has on Members. As soon as practicable after a catastrophic event, the Contractor shall report its actions to the State to include a report including any implications to State administration of the Program and cooperate in any remedial action the State may need to take after the catastrophic event. The State shall reimburse the Contractor for amounts paid in good faith under the circumstances and such amounts shall constitute Paid Claims, even if the charges incurred were not for services otherwise covered under the Benefits Booklet.

Z. Upon request of the State, the Contractor will produce and maintain a master copy of the Benefit Booklet. The Contractor shall make changes and amendments to the master copy of the Benefit Booklet and within 30-days of notice of the change shall incorporate the approved changes or amendments pursuant to Article 8 of this EXHIBIT B. Such master copy shall reflect applicable state and/or federal law.

AA. Upon written request, the Contractor will provide the State with Program data and assistance necessary for preparation of the State's information returns and forms required by federal or state laws. The Contractor shall prepare and mail all IRS Form 1099's and any other similar form that is given to Providers or brokers.

BB. The Contractor shall have the authority to build and maintain its Provider network. Nothing in this Agreement shall be interpreted to require the Contractor to maintain negotiated fees or reimbursement arrangements or other relationships with certain Providers or Subcontractors. The Contractor shall notify the State as soon as practicable in advance of or following termination of a New Hampshire facility and related physician(s) affecting State membership so that the State can proactively provide notice to the State's stakeholders. The Contractor shall provide the State with an impact analysis.

Subject to Attachment 3 and Appendix A, the Contractor will be solely responsible for acting as a liaison with Providers including, but not limited to, responding to Provider inquiries, negotiating rates with Providers or auditing Providers. The Contractor has oversight responsibility for compliance with Provider and Subcontractor contracts, including discount and multi-year compliance audits. The Contractor shall have authority to enter into a settlement or compromise regarding enforcement of these contracts. The State acknowledges and agrees that the Contractor shall retain any recoveries made from a Provider or Subcontractor resulting from these audits if the total recovery from one Provider or Subcontractor with respect to all of the Contractor's group-sponsored health benefit plans is $1,000 or less.

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CC. If the Contractor retains outside Subcontractors, auditors, or counsel to conduct audits or reviews of or to enforce Provider or Subcontractor contracts or activities, and recoveries or cost avoidance is a result of such audits, reviews or enforcement activities, then the Contractor shall provide the State a credit, after a reduction in such recovery or cost avoidance amount of its expenses and a five percent (5%) fee. The Contractor shall credit the State a proportionate share of the net recovery equal to the ratio of (1) Enrollees' Paid Claims to such Provider or Subcontractor for the audit/review period, to (2) all Paid Claims to such Provider or Subcontractor for the audit/review period. The State acknowledges and agrees to the Contractor's retention of such 5% fee, and agrees that the fee will be charged on all recoveries or cost avoidance resulting from such audits, reviews or enforcement activities, including audits or reviews of Claims incurred prior to the Agreement Period.

The Contractor shall provide the State with a summary report of all audits of NH providers/Subcontractors. The report shall include information about recoveries and any fees charged to the State.

DD. The Contractor agrees to provide a dedicated resource to assist the State with member eligibility and enrollment, claim system and data issues that may arise during the term of this Agreement.

EE. The obligations, responsibilities, promises and statements as to scope of services to be provided contained in the Contractor's Response to the State's Request for Proposal (RFP), is incorporated as if fully set forth herein (see Attachment 1). In the event of a conflict between the RFP responses (Attachment 1) and this Agreement, this Agreement shall control.

FF. The Contractor shall be responsible for any initial notice, open enrollment communication, election form, collection of fees, or communication regarding Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or any other applicable law governing continuation of health care coverage. The Contractor shall provide the State with monthly COBRA premium reports by division. Contractor agrees to process all Member enrollments, changes and terminations on a timely basis upon receipt of notice of those changes from COBRA administrator.

Select state laws require employers to finance health related initiatives through residency-based assessments and/or surcharges added to certain Paid Claims. After the State completes the applicable forms, the Contractor shall make all assessment and/or surcharge payments on behalf of the State to the appropriate pools administered by the respective states, based primarily upon the Contractor's Paid Claims information and Member information provided to the Contractor by the State. Examples of such assessments and surcharges include but are not limited to, the Massachusetts Health Safety Net Trust Fund, the New York Health Care Reform Act and the Michigan Health Insurance Claims Assessment Act. Contractor shall perform reporting on behalf of the State where allowed under state-specific requirements.

GG. Healthcare Reform Initiatives: the Contractor shall actively support such payment reform and other initiatives undertaken by the State of New Hampshire Employee and Retiree Health Benefit Program to control costs and improve the quality of health care in New Hampshire as may be reasonably requested by the State.

HH. State may negotiate with area providers for an additional discount to be paid directly from those providers to the State, provided that such agreement does not impact Anthem's administration of this Agreement. Anthem is not responsible for any additional adjudication of claims related to such discounts. State is responsible for allocating the share of any such discounts to the members if required by law.

II. The Contractor agrees to work with the State and its selected vendor, if applicable, to implement a specialty network (e.g., Centers of Excellence network).

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JJ. Nothing in this Agreement shall be construed in a manner that would directly or indirectly restrict the Plan from sharing information described in Title II, Section 201 of the Consolidated Appropriations Act, 2021 (the "CAA"). The Contractor warrants that its contracts with applicable providers do not contain any gag clauses as described in Title II, Section 201 of the CAA.

ARTICLE 3 - OBLIGATIONS OF STATE

A. The State, or its subcontractor, shall furnish to the Contractor initial information regarding Enrollees. The State is responsible for determining eligibility of persons and advising t Contractor in a timely manner, through a method agreed upon by the Contractor, including eligibility reports, electronic transmissions and individual applications, as to which employees, dependents, and other persons are to be enrolled Enrollees. The State shall keep such records and furnish to the Contractor such notification and other information as may be required by the Contractor for the purpose of enrolling Enrollees, processing terminations, effecting COBRA coverage elections, effecting changes in single or family contract status, effecting changes due to an Enrollee becoming eligible for Medicare, effecting changes due to an Enrollee becoming disabled or being eligible for short-term or long-term disability, determining the amount payable under this Agreement, or for any other purpose reasonably related to the administration of this Agreement.

The Contractor will have no obligation to pay Claims for persons no longer eligible for coverage. Further, if the Contractor has paid Claims for persons no longer eligible because the Contractor was provided inaccurate eligibility information, the Contractor did not receive timely notification of termination, or the Contractor received notice of a retroactive change to enrollment, then State shall reimburse the Contractor for all unrecovered amounts it has paid on Claims. In the event that the State has already reimbursed the Contractor for such unrecovered amounts paid on Claims, no further sums are owed under this Article 3(A).

The Contractor reserves the right to limit retroactive changes to enrollment to a maximum of sixty (60) days from the date notice is received unless otherwise requested by the State. Acceptance of payment of fees from the State or the payment of benefits to persons no longer eligible will not obligate the Contractor to continue to administer benefits.

B. In determining any individual's right to benefits under the Benefit Booklet, and in performing its other obligations as set forth in Article 2, the Contractor shall rely on eligibility information furnished by the State. It is mutually understood that the effective performance of this Agreement by the Contractor will require that it be advised on a timely basis by the State during the term of this Agreement of the identity of employees, dependents, and other persons eligible for benefits under the Program. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided in accordance with the terms of this Agreement with such other information as may reasonably be required by the Contractor for the proper administration of Program benefits described in the Benefit Booklet. The State acknowledges that prompt and complete furnishing of the required eligibility information is essential to the timely and efficient administration by the Contractor of Claims.

C. The State acknowledges that it serves as Program Administrator, and shall have all discretionary authority and control over the management of the Program, and all discretionary authority and responsibility for the administration of the Program except as provided in Article 2 (G) of this Agreement. The Contractor does not serve either as Program Administrator or as a Named Fiduciary of the Program other than as a fiduciary for processing appeals of Claims. All functions, duties and responsibilities of the Contractor are governed exclusively by this Agreement and the Benefit Booklet and applicable state and federal law.

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D. The State acknowledges that it is the State's sole responsibility, and not the Contractor's, to comply with the Family and Medical Leave Act ("FMLA") in connection with certain Subscribers on leave.

E. The State agrees to and shall notify Subscribers of their right to apply for health benefits and make available to them Claim forms and Claim filing instructions as provided by Contractor pursuant to Article 2, T above. Claim forms and Claim filing instructions shall also be supplied to the Enrollees by the Contractor upon request.

F. The State agrees to and shall notify all Subscribers in the event of termination of this Agreement.

G. The Parties shall agree upon the terms of the Benefit Booklet to be provided to Enrollees. Material changes and/or modifications to the Benefit Booklet shall be made according to Article 8. The State shall be responsible for making Benefit Booklets available to Subscribers and Enrollees.

H. The State shall prepare and is responsible to make all governmental filings except as otherwise provided in this Agreement.

I. The State shall reimburse the Contractor for all payments made on behalf of the State pursuant to demand letters forwarded by the Centers for Medicare and Medicaid Services (CMS) or other government agency to recover a refund when Medicare has erroneously paid as the primary coverage.

J. The Parties agree during the implementation period to collaborate and establish protocols and processes for managing dependent eligibility, including such things as "qualified" medical child support orders, as more fully set forth in paragraph N below, and the age when dependents "age-off" the State's Program.

K. The State shall have the responsibility to develop procedures and determine if a medical child support order is a "qualified" medical child support order, and shall perform all administration relating to such determinations, including providing all appropriate notifications to the Contractor.

L. The State is responsible for complying with all unclaimed property or escheat laws, and for making any required payment or filing any required reports under such laws.

M. The State shall provide or designate others to provide all other services required to operate and administer the Program that is not expressly the responsibility of the Contractor under this Agreement.

ARTICLE 4 - CLAIMS PAYMENT METHOD

A. The State shall pay the Contractor for Paid Claims according to the Claims Payment Method described in Section 2 of EXHIBIT C. In addition, from time to time, the Parties acknowledge that the appropriateness of a Claim payment may be reviewed. During the course of the period of time for review, the Contractor shall not hold the Claim payment and the State shall reimburse the Contractor for such Claim payment.

B. The Parties acknowledge that, from time to time, a Claims adjustment is necessary as a result of coordination of benefits, subrogation, workers' compensation, payment errors and the like, and that the adjustment takes the form of a debit (for an additional amount paid by the Contractor) or a credit (for an amount refunded to the Contractor). The Parties agree that such Claims adjustments shall be treated as an adjustment to the Claims payment made in the billing period in which the adjustment occurs, rather than as a retroactive adjustment to the Claim as initially paid. No Claims adjustment shall

be made beyond the Claims Runout period following the Completion Date or termination of this Agreement or conclusion of the claims audit process, whichever is later.

ARTICLE 5 - ADMINISTRATIVE SERVICES FEE

A. The State shall pay the Contractor the Administrative Services Fee, as described in EXHIBIT C, during the term of this Agreement.

ARTICLE 6 - CLAIMS RUNOUT

A. The Contractor shall pay the Claims Runout for the period of time described in Section 4 of EXHIBIT C. Following the Completion date or termination of this Agreement, the terms of this Agreement shall continue to apply with respect to the processing and payment of such Claims Runout and Administrative Services Fee. The State acknowledges and agrees that the Contractor shall have no obligation to process or pay any Claims Runout or return Claims filed with the Contractor to the State beyond the Claims Runout period designated in Section 4 of EXHIBIT C, including any Claims incurred by a Enrollee under a continuation of coverage provision of the Benefit Booklet, and the State acknowledges and agrees that any amounts recovered beyond the Claims Runout period shall be retained by the Contractor.

ARTICLE 7 - RENEWAL SCHEDULES

A. The State reserves the right, during the second and third Terms of the Agreement Period, to implement other retiree coverages and/or programs for its eligible retirees which may be administered in whole or in part by administrators other than the Contractor.

ARTICLE 8 - CHANGES IN THE BENEFIT BOOKLET AND AGREEMENT

A. The Contractor and the State shall agree upon any changes to the Benefit Booklets that may be necessary and/or in the best interest of Enrollees. In the event changes to the provisions of the Benefit Booklet are mandated as a result of a change to any state and/or federal law, the Parties shall meet and determine the best manner to change the terms of the Benefit Booklets to conform to such law. In the event of material changes to a Benefit Booklet, the State will provide timely notice of such changes to Enrollees.

B. Upon the occurrence of one or more of the following events: (1) a change to the plan benefits initiated by the State that results in a substantial change in the services to be provided by the Contractor; (2) a change in the total number of Members resulting in either an increase or decrease of 10% or more of the number of Members enrolled for coverage on the date the Administrative Services Fee was last modified; (3) a change in the State contribution; (4) a change in applicable law that results in a material increase in the cost of administrative services from those currently being provided by the Contractor under this Agreement, the Parties shall meet to negotiate in good faith a corresponding

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adjustment in the Administrative Services Fee and such adjustment shall be made in accordance with Article 18 of the P-37. To the extent that the parties are unable to come to a mutually agreeable adjustment to the Administrative Services Fee, either Party shall have the right to terminate this Agreement by giving written notice of one hundred and twenty (120) days.

C. No change to a Benefit Booklet shall be effective unless and until approved in writing by an authorized representative of the Contractor and the State.

ARTICLE 9 – INTER-PLAN ARRANGEMENTS

Contractor has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements operate under rules and procedures issued by BCBSA. Whenever Members access healthcare services outside the geographic area Contractor serves (the "Contractor Service Area"), the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the Contractor Service Area, Members obtain care from healthcare Providers that have a contractual agreement ("Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("Non-Participating Providers") with the Host Blue. Contractor remains responsible for fulfilling its contractual obligations to the State. Contractor's payment practices in both instances are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that dental care, Prescription Drug or vision benefits may not be processed through Inter-Plan Arrangements.

If the plan covers only limited healthcare services received outside of Contractor's Service Area, services other than those listed as Covered Services (e.g., emergency services) in the Benefits Booklet will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Contractor. Providers providing such non-Covered Services will be considered Non-Participating Providers.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the Contractor Service Area, the Host Blue will be responsible for contracting and handling all interactions with its Participating Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim

   a. Member Liability Calculation

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Unless subject to a fixed dollar copayment, the calculation of the Member liability on Claims for Covered Services will be based on the lower of the Participating Provider's Billed Charges or the negotiated price made available to Contractor by the Host Blue.

b. Employer Liability Calculation

The calculation of the State's liability on Claims for Covered Services will be based on the negotiated price made available to Contractor by the Host Blue. Sometimes, this negotiated price may be greater for a given service or services than the Billed Charges in accordance with how the Host Blue has negotiated with its Participating Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the Billed Charges, the State may be liable for the excess amount even when the Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Participating Provider, even when the contracted price is greater than the Billed Charges.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Participating Provider contracts. The negotiated price made available to Contractor by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a Claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a Claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other Claim- and non-Claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a Claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of Billed Charges in effect at the time a Claim is processed representing the aggregate payments negotiated by the Host Blue with all of its Participating Providers or a similar classification of its Participating Providers and other Claim- and non-Claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the State pays on a specific Claim and the actual amount the Host Blue pays to the Participating Provider. However, the BlueCard Program requires that the amount paid be a final price; no future price adjustment will result in increases or decreases to the pricing of past Claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future Claim prices. As

a result, the amounts charged to the State will be adjusted in a following year, as necessary, to account for over- or under-estimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from the State. Upon termination, the State will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

B. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, Contractor may process Claims for Covered Services through negotiated arrangements. A negotiated arrangement is an agreement negotiated between Contractor and one or more Host Blues for any Employer that is not delivered through the BlueCard Program ("Negotiated Arrangement").

In addition, if Contractor and the State agree that (a) Host Blue(s) shall make available (a) custom healthcare Provider network(s) in connection with this Agreement, then the terms and conditions set forth in Contractor's Negotiated Arrangement(s) with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of Claims when Members access such network(s). In negotiating such arrangement(s), Contractor is not acting on behalf of or as an agent for the State, the Program or Members.

Member Liability Calculation

If Contractor has entered into a Negotiated Arrangement with a Host Blue, the calculation of Member cost-sharing will be based on the lower of either Billed Charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to Contractor and that allows Members access to negotiated participation agreement networks of specified Participating Providers outside of Contractor's service area.

C. Special Cases: Value-Based Programs

Definitions

1. **Accountable Care Organization (ACO):** A group of Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.
2. **Care Coordination:** Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.
3. **Care Coordinator:** An individual within a Provider organization who facilitates Care Coordination for patients.
4. **Care Coordinator Fee:** A fixed amount paid by a Host Plan to Providers periodically for Care Coordination under a Value-Based Program.

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5. **Global Payment/Total Cost of Care:** A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient, such as outpatient, physician, ancillary, hospital services, and prescription drugs.
6. **Patient-Centered Medical Home (PCMH):** A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.
7. **Provider Incentive:** An additional amount of compensation paid to a Provider by a Host Blue, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.
8. **Shared Savings:** A payment mechanism in which the Provider and the payer share cost savings achieved against a target cost budget based on agreed upon terms and may include downside risk.
9. **Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Value-Based Programs Overview

Members may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program

Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways: retrospective settlements, Provider Incentives, a share of target savings, Care Coordinator Fees and/or other allowed amounts.

The Host Blue may pass these Provider payments to Contractor, which Contractor will pass directly on to the State as either an amount included in the price of the Claim or an amount charged separately in addition to the Claim. Contractor shall provide a quarterly summary detailing the Value Based provider payments provided to Host Blue shared savings and care coordination fees and charged to the State.

When such amounts are included in the price of the Claim, the Claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the Claim. These charges are passed to the State via an enhanced Provider fee schedule.

(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the Claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the Claim amount). The supplemental factor may be adjusted from time to time. This pricing method may be used only for non-attributed Value-Based Programs.

When such amounts are billed separately from the price of the Claim, they may be billed using a Per

Member Per Month billing for Value-Based Programs incentives/Shared Savings settlements to accounts outside of the Claim system. Contractor will pass these Host Blue charges directly through to the State as a separately identified amount on the State billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard Claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If the Agreement terminates, the State will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid Claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of Claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Members will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

Host Blues may also bill Contractor for Care Coordinator Fees for Provider services which Contractor will pass on to the State as follows:

1. PMPM billings; or
2. Individual Claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

Contractor and the State will not impose Member cost-sharing for Care Coordinator Fees.

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Value-Based Programs under Negotiated Arrangements

If Contractor has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Members, Contractor will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted above.

D. Non-Participating Providers Outside Contractor's Service Area

1. Allowed Amounts and Member Liability Calculation

Unless otherwise described in the Benefits Booklet, when Covered Services are provided outside of Contractor's Service Area by Non-Participating Providers, Contractor may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount the Member pays for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, the Member may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment Contractor will make for the covered services as set forth in this paragraph subject to applicable state or federal law.

2. Exceptions

In certain situations, which may occur at the State's direction, Contractor may use other pricing methods, such as Billed Charges, the pricing Contractor would use if the healthcare services had been obtained within Contractor's Service Area, or a special negotiated price to determine the amount Contractor will pay for services provided by Non-Participating Providers. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Contractor makes for the Covered Services as set forth in this paragraph subject to applicable state or federal law.

E. Blue Cross Blue Shield Global Core

General Information

If Members are outside the United States (hereinafter, "BlueCard Service Area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is not served by a Host Blue. As such, when Members receive care from Providers outside the BlueCard Service Area, Members will typically have to pay the Providers and submit the Claims themselves to obtain reimbursement for these services.

Inpatient Services

In most cases, if Members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member Claims to the Blue Cross Blue Shield Global Core Service Center to initiate Claims processing. However, if the Member paid in full at the time of service, the Member must submit a Claim to obtain reimbursement for Covered Services. Members must contact Contractor to obtain precertification for non-emergency inpatient services.

Outpatient Services

Physicians, urgent care centers and other outpatient Providers located outside the BlueCard Service Area will typically require Members to pay in full at the time of service. Members must submit a Claim to obtain reimbursement for Covered Services.

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F. Return of Overpayments

Recoveries of overpayments can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits, utilization review refunds and unsolicited refunds. Recoveries will be applied, in general, on either a Claim-by-Claim or prospective basis. If recovery amounts are passed on a Claim-by-Claim basis from a Host Blue to Contractor, they will be credited to the State. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments. The fees of such a third party may be charged to the State as a percentage of the recovery.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, Contractor will request the Host Blue to provide full refunds from Participating Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original Claim. For Care Coordinator Fees associated with Value-Based Programs, Contractor will request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of Claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements or (c) would jeopardize the Host Blue's relationship with its Participating Providers, notwithstanding to the contrary any other provision of this Agreement.

G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees or compensation are generally made effective January 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes resulting in an increase in fees paid by the State, Contractor shall provide the State with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and the State right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If the State fails to respond to the notice and does not terminate this Agreement during the notice period, the State will be deemed to have approved the proposed changes, and Contractor will then allow such modifications to become part of this Agreement.

H. Fees and Compensation

The State understands and agrees to reimburse Contractor for certain fees and compensation which Contractor is obligated under the applicable Inter-Plan Arrangements described in Article 9 of this Agreement to pay to the Host Blues, to BCBSA and/or to vendors of Inter-Plan Arrangement -related services. The specific Inter-Plan Arrangement fees and compensation, including any administrative and/or network access fee that a Host Blue may charge under the BlueCard Program, a Negotiated Arrangement, and Blue Cross Blue Shield Global Core are charged to the State and described below. The various Inter-Plan Program Fees and compensation may be revised from time to time as described in section G.

A description of the various Claim processing fees is as follows:

Access Fee: The Access Fee is charged by the Host Blue to Contractor for making its applicable Provider network available to Members. The Access Fee will not apply to Non-Participating Provider Claims. The Access Fee is charged on a per Claim basis and is charged as a percentage of the discount/differential Contractor receives from the applicable Host Blue subject to a maximum of $2,000 per Claim. When charged, Contractor passes the Access Fee directly on to the State.

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Instances may occur in which the Claim payment is zero or Contractor pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Contractor will pay the Host Blue's Access Fee and pass it along directly to the State as stated above even though the State paid little or had no Claim liability.

Administrative Expense Allowance (AEA) Fee: The AEA Fee is a fixed per Claim dollar amount charged by the Host Blue to Contractor for administrative services the Host Blue provides in processing Claims for the State's Members. The dollar amount is normally based on the type of Claim (e.g. institutional, professional, international, etc.) and can also be based on the size of group enrollment. When charged, Contractor passes the AEA Fee directly on to the State.

Per Subscriber Per Month (PSPM) Fee: The PSPM Fee is a financial arrangement negotiated between the Host Blue and Contractor and replaces all other fees, including the Access Fee and AEA Fee. The PSPM dollar amount is charged on a per Subscriber per month basis by the Host Blue to Contractor for administrative services the Host Blue provides in processing Claims for the State's Members. The dollar amount can also be based on the size of group enrollment. When charged, Contractor passes the PSPM Fee directly on to the State.

Non-Standard AEA Fee: The Non-Standard AEA Fee is a financial arrangement negotiated between the Host Blue and Contractor and replaces all other fees, including the Access Fee and AEA Fee. The Non-Standard AEA is a fixed per Claim dollar amount charged by the Host Blue to Contractor for administrative services the Host Blue provides in processing Claims for the State's Members. When charged, Contractor passes the Non-Standard AEA Fee directly on to the State.

Central Financial Agency (CFA) Fee: The CFA Fee is a fixed dollar amount per payment notice and is paid by Contractor to the BCBSA. This fee applies each time Contractor receives an electronic payment notice from the CFA indicating that a Host Blue incurred Claim-related liability on Contractor's behalf and requesting that Contractor either approve or deny payment. When charged, Contractor passes the CFA Fee directly on to the State. The CFA Fee supports ongoing operations of BCBSA programs and services, including but not limited to Blue Cross Blue Shield AXIS® Data Services, network solutions, and BlueCard Program-related applications.

Inter-Plan Teleprocessing System (ITS) Transaction Fee: The ITS delivery platform allows all Blue Cross and/or Blue Shield Licensees to connect with each other through a standardized system to facilitate the operation of Inter-Plan Arrangements. The ITS Transaction Fee applies each time a Claims transaction interchange occurs between Contractor and a Host Blue. When a Host Blue receives a Claim, it applies Provider pricing information, sets forth its discount and related savings and sends this information to Contractor electronically. Contractor then adjudicates the Claim, computes the approved Provider payment amount, calculates the AEA Fee and Access Fee, computes net liability and sends a response electronically to the Host Blue. The Host Blue then pays the Provider and issues an electronic payment notice to Contractor via the CFA. The ITS Transaction Fee is five cents per interchange and is paid to the BCBSA. For each Claim, there are a minimum of three interchanges, but there could be more depending on the complexity of the Claim. When charged, Contractor passes the ITS Transaction Fee directly on to the State.

ARTICLE 10 – REPORTING, IT and DATA REPORTS

A. **Data Reports.** Upon the State's request and as permitted by the Business Associate Agreement entered into between the Parties, the Contractor will provide data reports pursuant to the Contractor's standard

reporting package. The Contractor's standard utilization reporting package is available online via Client Information Insights. In addition, the State will have access to reports such as:

1. A monthly accounting of Paid Claims paid by the Contractor in accordance with this Agreement and this EXHIBIT B and of payments to the Contractor for Administrative Services Fee and other costs, if any;

2. A summary annual accounting of Paid Claims during the Agreement Period (Annual Claims Utilization Report) which were paid by the Contractor in accordance with this Agreement and EXHIBIT B and of payments to the Contractor of Administrative Services Fee and other costs during the Agreement Period and assistance in interpretation of such report will be provided within 90 days of the end of the contract year;

3. A summary annual statement of Post-Settlement Amounts allocated to the State, if any, including the methodology used to determine the such allocation; and

4. Additional reports mutually agreed to by the State and the Contractor. The Contractor shall also provide clinical and analytical reports and support in interpretation of same. Contractor shall also provide any data and reports necessary for the State to comply with applicable state or federal law.

A. **Call Center Reporting.** Call Center reporting will identify incoming calls that originated from the State's Program Staff and Agency HR Staff, and the associated metrics, including "issue type". These calls are considered escalated and should be included in general reporting by category, and should be segregated and reported as requested by the State.

Call Center reporting shall be delivered to the State quarterly and shall contain detailed reporting broken out by call type, allowing for meaningful analysis of the types of issues received as they relate to plan administration.

B. **Ad-Hoc Requests.** The Contractor agrees to provide data to the State within three (3) business days for a standard request, and within seven (7) business days for the majority of ad-hoc requests (certain ad-hoc requests that require additional programming in order to access appropriate data may extend beyond this seven day period). Standard reports are existing reports that the Contractor can run by changing report parameters, of which such parameters are limited to incurred date, paid date and maximum dollar amount. Ad-hoc requests include non-standard reports, or reports entailing actuarial or underwriting analysis. Such reports shall be provided by the Contractor at no additional cost to the State.

C. **Data Sharing.** The Contractor will also:

1. Receive pharmacy claims data feed from the State's Pharmacy Benefits Manager to be used as mutually agreed to by the State and Contractor.

2. Agrees to share member and claim information to designated third-parties as mutually agreed to or as required for compliance with applicable state or federal law.

If the State requests the Contractor to provide a data extract or report to any third party engaged by the State (a "Plan Contractor") for use on the State's behalf, the Contractor agrees to do so:

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a) to the extent such extract or report includes protected health information ("PHI") as defined in HIPAA, the Contractor's disclosure of the PHI and Plan Contractor's subsequent obligations with respect to the protection, use, and disclosure of the PHI will be governed by the State's applicable business associate agreements with the Contractor and the Plan Contractor; and

b) to the extent such data or report includes the Contractor's Proprietary Information and/or the Contractor's Confidential Information, the State acknowledges and agrees that the State shall protect the Contractor's proprietary and confidential information subject to RSA 91-A and any third party engaged by the State shall enter into a confidentiality agreement with the Contractor (or amend an existing one, as applicable) prior to the Contractor's release of the extract or report; and

c) the State agrees not to contact, or to engage or permit a Plan Contractor to contact on the State's behalf, any Provider concerning the information in any reports or data extracts provided by the Contractor unless the contact is coordinated by the Contractor.

d) in addition to their limited rights to use the Contractor's Proprietary Information and Confidential Information, the Contractor and the Contractor Affiliates shall also have the right to use and disclose other Claim-related data collected in the performance of services under this Agreement or any other agreement between the parties, so long as:

1) The data is de-identified in a manner consistent with the requirements of HIPAA; or

2) The data is used or disclosed for research, health oversight activities, or other purposes permitted by law. Contractor shall use appropriate safeguards to prevent use or disclosure of the information other than as provided for herein, and ensure that any agents or subcontractors to whom it provides such information agree to the same restrictions and conditions that apply to Contractor; or

3) A Member has consented to the release of his or her individually identifiable data.

4) The data used or disclosed pursuant to subsections 1 through 3 above shall be used for a variety of lawful purposes including, but not limited to, research, monitoring, benchmarking and analysis of industry and health care trends.

5) State data will not be sold or aggregated for external reporting purposes without first consulting the State.

ARTICLE 11 - CLAIMS AUDIT

A. At the State's expense, the State shall have the right to audit Claims on the Contractor's premises, during regular business hours and in accordance with the Contractor's audit policy, which may be revised from time to time. A copy of the audit policy shall be made available to the State upon request.

B. If the State elects to utilize a third-party auditor to conduct an audit pursuant to this Agreement and the Contractor's audit policy, the Contractor will agree to work with the third party auditor provided they are not paid on a contingency fee or other similar basis. An auditor or consultant must execute a confidentiality and indemnification agreement with the Contractor pertaining to the Contractor's Proprietary and Confidential Information prior to conducting an audit.

C. The State may conduct an audit once each calendar year and the audit may only relate to Claims processed during the current year or immediately preceding calendar year (the "Audit Period") and neither the State nor anyone acting on the State's or the plan's behalf, shall have a right to audit Claims processed prior to the Audit Period. The scope of the audit shall be agreed to in writing by the Parties prior to the commencement of the audit. In the event a discrepancy in claims processing is discovered, the State reserves the right to request more detailed information that may span more than one audit period.

D. The State shall provide to the Contractor copies of all drafts, interim and/or final audit reports at such time as they are made available by the auditor or consultants to the State. Any errors identified and/or amounts identified as owed to the State as the result of the audit shall be subject to the Contractor's review and approval prior to initiating any recoveries of Paid Claims pursuant to Article 14 of this Agreement. The Contractor reserves the right to terminate any audit being performed by or for the State if the Contractor determines that the confidentiality of its information is not properly being maintained or if the Contractor determines that the State or auditor is not following the Contractor audit policy.

ARTICLE 12 – USE OF SUBCONTRACTORS

A. The Contractor is accountable for the Subcontractors' performance and liability.

B. The Subcontractor's performance is held to the same performance standards and Subcontractor failure to perform places the Contractor at risk.

C. The Contractor shall be responsible for all performance guarantee penalties (See Article 16) that may result from underperformance of the Subcontractor.

D. The Contractor shall demonstrate to the State's satisfaction adequate oversight of any functions performed by or responsibilities assumed by Subcontractors and compliance with all federal and state laws, rules, and regulations.

E. The Contractor shall provide the State with a minimum 90-day notice prior to engaging a Subcontractor that impacts the State's health benefit program and shall work closely with the State on communications relating to transition.

ARTICLE 13 - CONTRACT ADMINISTRATION

A. The State shall be solely and directly liable for the payment of any and all benefits due and payable under the Program.

B. The Contractor is providing administrative services only with respect to the portion of the Program described in the Benefit Booklet. The Contractor only has the authority granted it pursuant to this Agreement. The Contractor is not the insurer or underwriter of any portion of the Program, notwithstanding any monetary advances that might be made by the Contractor.

C. The Contractor does not insure or underwrite the liability of the State under this Agreement. The Contractor is strictly an independent contractor. The Contractor has no responsibility or liability for funding benefits provided by the Program, notwithstanding any advances that might be made by the Contractor. The State retains the ultimate responsibility and liability for all benefits and expenses incident to the Program, including but not limited to, any state or local taxes that might be imposed relating to the Program.

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D. The Parties acknowledge that the portion of the Program described in the Benefit Booklet is a self-insured plan and as such is not subject to state insurance laws or regulations.

E. The State shall ensure that sufficient amounts are available to cover Claims payments, the monthly Administrative Services Fee, and other fees or charges in accordance with the General Provisions of Form P-37, Section 5.

F. The State shall reimburse the Contractor for the actual costs charged the Contractor by any external reviewer. The Contractor shall provide the actual costs charged by the Contractor identified as a line-item as a part of the itemized weekly invoice.

ARTICLE 14 - THE CONTRACTOR AS RECOVERY AGENT

A. The State grants to the Contractor the sole right, to pursue recovery of Paid Claims administered on behalf of Enrollees under this Agreement. The Contractor shall establish recovery policies, determine which recoveries are to be pursued, initiate and pursue litigation when it deems this appropriate, incur costs and expenses and settle or compromise recovery amounts.

B. The Contractor will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. If the Contractor would recover the overpayment amount through an automatic recoupment mechanism, the Contractor will not pursue such recovery if the overpayment was in the amount of thirty dollars ($30.00) or less [Medicare COB is thirty-seven dollars and fifty cents ($37.50)]. If the Contractor would recover the overpayment amount through manual recovery, the Contractor will not pursue such recovery if the overpayment was in the amount of seventy-five dollars ($75.00) or less. The dollar amounts in this section may be revised from time to time, upon agreement by the parties.

C. Unless otherwise provided in EXHIBIT C, the Contractor shall charge a fixed percentage fee 25% (twenty-five percent) of gross subrogation recovery or, if outside counsel is retained, 15% (fifteen percent) of net recovery after a deduction for outside counsel fees for subrogation-related services. Subrogation recovery will occur on claims in aggregate of $750.00 or above. For these purposes, "subrogation-related services" are services in which the Contractor pursues recoveries to Enrollees by any other person, insurance company or other entity on account of any action, claim, request, demand, settlement, judgment, liability or expense that is related to a Claim for Covered Services. These fixed subrogation fees will be charged on all subrogation matters, including any that may have Claims incurred and paid in any prior Agreement Period. The Administrative Services Fee does not include any expenses associated with subrogation. Such subrogation expenses shall reduce amounts recovered for purposes of any adjustments applied toward the State's Claims as described in Article 4 of this Agreement.

ARTICLE 15 – ACCOUNT MANAGEMENT

A. The Contractor agrees to implement a Dedicated Support Account Management Model. The Contractor's dedicated Account Management team will meet with the State on a regular basis, as defined by the State, to provide day-to-day support, discuss reducing administrative burden, and resolve issues.

B. The Contractor's overarching objective will be to ensure high levels of satisfaction with all aspects of the Contractor's performance and areas of operations, including but not limited to:

1. Execution
2. Strategic engagement
3. Communication
4. Engagement in programs and services
5. Reporting and analytics.
6. Value based purchasing
7. Wellness services
8. Performance guarantee results
9. Claims processing system
10. Subcontractor services
11. Financial Invoicing and Tracking

C. Contractor's Responsibilities will include:

1. Creation, delivery and execution of a project plan, including development of Contractor dedicated support model organization chart, when applicable

2. Initial and on-going performance assessment may include but is not limited to

   a. Initial performance review will utilize prior audits, status of open service issues, and feedback from State interviews about all aspects of service performance and the Contractor staff involved in supporting the State's account.

   b. Subsequent assessment will use new Dedicated Support Model scorecards (described in Article 16), reporting and analytics, performance guarantee monitoring, surveys and other approaches as needed

3. Strategic consultation – in partnership with the State, identify opportunities to improve all aspects of performance and participation as well as identify communication needs and opportunities

4. Operational oversight

   a. The dedicated Account Management Team will identify and work with a designated resource from each of the Contractor's operational areas and/or any subcontractor who performs work on behalf of the State.

   b. The dedicated Account Management Team will require monthly metrics holding these areas to their committed service delivery

D. Contractor's Minimum Commitments will include:

1. **Meetings:** The dedicated Account Management Team is committed to attending monthly and quarterly meetings, in addition to developing regular weekly or bi-weekly check-in meetings with the State (either by phone or in person). Attendance at other regularly scheduled meetings or ad hoc meetings will be identified and scheduled as needed.

   Additionally, The State requires the Contractor and/or designated subcontractor, to attend open enrollment meetings at all State locations, as well as attendance at Agency and benefit fairs throughout the year.

2. **Calendar of Deliverables:** The dedicated Account Management Team, working with the State, will develop a calendar of deliverables (regularly scheduled reports, metrics, meeting attendance, etc.) and adhere to said schedule unless otherwise agreed to by the State.

3. **Metrics/Quality Control:** The dedicated Account Management Team will monitor Contractor metrics on a regular basis and report issues, concerns and trends to the State during regularly scheduled meetings. Ad hoc meetings for escalated items will be scheduled off-cycle as needed.

4. **Scorecards:** The dedicated Account Management Team shall work with the State to develop and implement a scorecard to measure the State's satisfaction with the Dedicated Support Model performance. The parties may mutually agree to amend the scorecard from time to time. The scorecard will then be used by the State to assess the Contractors performance every six months.

5. It is understood and agreed that these minimum commitments may be increased or modified upon mutual agreement by the State and Contractor.

E. Rollout:

1. Additionally, the following provisions shall apply:

   a. The State will require an annual performance or "stewardship" meeting within 180 days after calendar year-end, at which time the Contractor will, as directed by the State, summarize the Contractor's performance for the prior year.

   b. The dedicated Account Management Team shall remain constant, within the Contractor's control, for at least the first 18 months of the contact period. The Contractor shall not change assignments of the dedicated Account Management Team without a minimum of fourteen (14) days written notice of the change provided to the State. The State reserves the right to request assignment of a new dedicated Account Management Team or member and the Contractor shall make such change within 30 days of receipt of written notice from the State.

   c. Additionally, the Contractor shall not change the Contractor operational lead staff members identified on the final Contractor Dedicated Support Model organization chart without a minimum of fourteen (14) days written notice of the change to the State. The State reserves the right to request assignment of the designated operational lead staff members and the Contractor shall make such change within 30 days of receipt of written notice from the State.

   d. It is understood and agreed that these minimum commitments may be increased or modified upon mutual agreement by the State and Contractor.

ARTICLE 16 – PERFORMANCE GUARANTEES

A. General Conditions

1. The Performance Guarantees described in this Agreement shall be in effect for each term of the Agreement Period. The Schedule of Performance Guarantees contain the three categories:

   a. Operations Performance Guarantees

   b. Clinical Performance Guarantees

   c. Medical Trend Guarantee Withhold

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2. The Contractor shall be required to meet Performance Guarantees as outlined in the Schedule of Performance Guarantees or shall pay the State the associated Penalty at Risk according to the applicable time period.
3. Measurement of Operations Performance Guarantees will be based one of the following methods unless mutually agreed otherwise:

    a. The Contractor shall conduct an analysis of the data necessary to calculate a Performance Guarantees within its applicable timeframe.

    b. The results of the State's audit of contractor performance.

    c. The Dedicated Support Model Scorecard.

    d. A documented event or occurrence at any point of time during the term of the Agreement

4. Any audits performed by the Contractor to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level or on a demonstrated industry standard.

5. In the event the Agreement expires, the Contractor is obligated to make payment for any Performance Guarantees that apply to the final term of the Agreement Period.

6. For the purposes of calculating compliance with the Performance Guarantees contained in the Schedule of Performance Guarantees, if a delay in performance of, or inability to perform, a service underlying any of the Performance Guarantees is due to circumstances which are beyond the control of Anthem, including but not limited to any act of God, civil riot, floods, fire, acts of terrorists, or acts of war terrorism, such delayed or non-performed service will not count towards the measurement of the applicable Performance Guarantee.

B. Payment and Reconciliation:

1. All Operations Performance Guarantee or Clinical Performance Guarantee penalties shall be paid to the State in the form of a check.

2. All performance guarantees in the "Implementation" category will be measured, reported, reconciled and, if applicable, paid no later than three (3) months after the go-live date.

3. All performance guarantees in the "Operations" category will be measured and reported quarterly, reconciled and, if applicable, paid annually. Any payment due shall be made within three (3) months after the close of the applicable plan year.

4. The R1 and R2 performance guarantees in the "Reporting" category will be measured and reported quarterly, reconciled and, if applicable, paid annually. Any payment due shall be made within three (3) months after the close of the applicable plan year.

5. The R3 performance guarantee in the "Reporting" category will be reconciled within 180 days of policy year end.

6. All the performance guarantees in the "Clinical" category will be measured and reported quarterly, reconciled and, if applicable, paid annually. Any payment due shall be made within three (3) months after the close of the applicable plan year.

7. All occurrence based performance guarantees shall be reconciled within 30 days of the occurrence.

C. Schedule of Performance Guarantees

1. Operations Performance Guarantees

Ref #	Category	Guarantee	Penalty at Risk
I1	Implementation	A minimum of 95% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties. The implementation plan will be developed by Anthem and will contain tasks to be completed by Employer and/or Anthem and a timeframe for completion of each task. The implementation plan will also contain Measurement Periods specific to each task. Anthem's payment under this Guarantee is conditioned upon Employer's completion of all designated tasks by the dates specified in the implementation plan. This will be measured with Employer-specific Data, and available during year 1 and/or years in which there are system migrations/upgrades/enhancements	$100,000 Results: 95.0% or Greater: None Less than 95%: 100%
O1	Operations	85% of member calls resolved on first call	$15,000 per year
O2	Operations	Average speed to answer <= 45 seconds	$15,000 per year
O3	Operations	Call abandonment rate <= 3%	$15,000 per year
O4	Operations	Service outage (website, customer service, etc.) of 24 hours or more, or any outages that exceed 4 hours that occur more frequently than twice per month unless caused by force majeure (ex, acts of God, power outage, cyberattack) other than routine maintenance.	$2,000 per day, maximum $20,000 per occurrence
O5	Operations	Contractor shall notify the State, within three (3) business days of identification, about any situation that appears to negatively impact the administration or delivery of the program, plans, or benefits.	$1,000 per business day beyond the notification requirement.
O6	Operations	Electronic eligibility files received from the State twice a week processed within two business days of receipt of a clean and complete eligibility file in an agreed upon format	$500/day for the first 2 business days after two business day grace period and $1000/business day thereafter up to an annual payout maximum of $50,000.

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O7	Operations	100% of all eligibility discrepancies reported to the State to be resolved within two (2) business days of receipt of the State's resolution response	$500 per day for the 1st and 2nd business days out of compliance; one thousand dollars per business day thereafter
O8	Operations	Financial accuracy of claims payments ninety-nine percent (99%) or higher	$50,000 per year
O9	Operations	Claims payment accuracy shall be ninety-seven point five percent (97.5%) or higher	$50,000 per year
O10	Operations	The Contractor shall correctly adjudicate claims in accordance with the approved plan design	$500 per occurrence (defined as an individual claim). Max payout as agreed to is $75,000 annually.
O11	Operations	The Contractor shall reimburse network providers within fourteen (14) calendar days for ninety-two percent (92%) of clean claims and within thirty (30) calendar days for ninety-eight percent (98%) of all claims.	$50,000 per year if either of the targets are not met.
O12	Operations	The Contractor shall not distribute any materials to plan members without the State's express prior approval.	$2,500 per occurrence
O13	Operations	100% of all approved plan member communications are accurate	$2,500 per occurrence
O14	Operations	Contractor will respond to all independent auditor requests for information/clarification within 30 calendar days of auditor request date	$25,000 per audit
O15	Operations	Unless otherwise directed by the State, the Contractor shall correctly implement any plan design changes no later than sixty (60) days of written notification from the State.	$5,000 per day guarantee is not met, maximum $100,000 per occurrence
O16	Operations	Written documentation/confirmation provided to the State of quality control testing prior to implementation of all programs and program changes (including services of ancillary program vendors/subcontractors)	$10,000 per occurrence
O17	Operations	The Contractor shall establish and maintain systems and processes to import/export appropriate and relevant data from entities and vendors providing services under this Contract to	$1,000 per occurrence if data file is not submitted/uploaded

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		members (Incentive Shopping, Flu Clinics, COBRA,) including vendors under contract with the State (e.g., FSA/HRA, PBM, etc.) on a timely basis as agreed to by the State and Contractor.	as per mutually agreed upon calendar.
O18	Operations	The Contractor shall submit claims data to the State or its designated DSS vendor no later than twenty (20) days following the end of each calendar month	$500 per day for the first and second business days out of compliance; $1,000 per day thereafter
O19	Operations	The Contract shall document in a system issues log, to be reviewed with the State no less than biweekly, all system error details impacting claims payment/processing/eligibility, along with the proposed solution and the final solution as agreed upon by the State	$1,000 for the first subsequent or repeat error identical in nature. $2,000 for all additional errors identified in nature.
O20	Operations	Contractor agrees to issue monthly invoices for ASO fees and ancillary program fees, along with supporting documentation, within five (5) calendar days of mutually agreed upon date each month.	$250 per day after the 5th day, for each day until invoice is received
O21	Operations	Contractor agrees that all appeals shall be responded to within its established appeal process guidelines and decision timeframes.	$2,500 per appeal which is not processed and a decision issued according to established appeal process.
R1	Reporting	Contractor shall distribute to the State all reports required in the Contract within the time frame specified in the Contract	$500 per report not delivered to the State within the timeframe specified in the Contract
R2	Reporting	Contract shall distribute to the State ad hoc reports requested by the State within 7 business days unless a report delivery date is otherwise mutually agreed upon	$500 per day beginning on the 1st day after expected delivery date and each day thereafter until report is delivered.
R3	Reporting	Annual Claims Report delivered and presented to State within 180 days of policy year-end	$10,000 per year

2. Clinical Performance Guarantees

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7.5% of base ASO Administration Fees at risk

The total amount at-risk will be distributed evenly over the proposed guarantees or as mutually agreed upon between the State and the Contractor.

Ref #	Category	Guarantee	Targets
C1	Clinical	**Breast Cancer Screening** Defined as percentage of women ages 42 to 69 years old with evidence of breast cancer screening over the last 2 years (excluding women with past history of breast cancer).	2023: 72% 2024: 74% 2025: 76%
C2	Clinical	**Preventive Health Care Services and Outcomes** Defined ED diagnoses per 1000 members that can be treated in an alternative setting such as a retail health or urgent care facility, as determined by the carrier.	2023: 85.0 2024: 84.0 2025: 83.0
C3	Clinical	**Chronic Pain** Defined as medical claimants per 1000 attributed to specific lifestyle conditions associated with low back problems.	2023: 85.0 2024: 83.5 2025: 82.0
C4	Clinical	**Mental Health** Defined as comparable to HEDIS Measures for Behavioral Health for follow up after hospitalization for mental illness and ED visits for mental illness.	2023: 30% 2024: 31% 2025: 32%
C5	Clinical	**Hospitalization and Care Management** Defined as admissions per 1000 members among surgical, medical, maternity, mental health, substance abuse, newborn, skilled nursing, rehabilitation and readmissions.	2023: 56.0 2024: 55.0 2025: 54.0

3. Medical Trend Guarantee Withhold
   a. The State shall withhold 10 percent of monthly administrative payments to the Contractor to be earned and distributed according to the Contractor's performance relative to annual medical claims trend expectations established by the State.

   b. The State shall annually reconcile withhold distributions on a contract year basis following assessment of Contractor performance to the specified contract standards. If the Contractor fails to meet defined medical trend performance expectations, the State may impose financial sanctions including, but not limited to, retention of all or a portion of the Withhold. If the Contractor meets all specified performance expectations, the State shall distribute the full amount of the withheld funds to the Contractor.

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Annual Medical Trend Expectations for years one, two & three of the contract

Claims Trend Guarantee - The combined active and non-Medicare eligible retiree plans claims trend that your organization expected to achieve for each year of the contract is < 5.00%. The below chart notes the percentage of withhold that would be returned based on the actual trend achieved. If the actual trend is < 4.00%, the State will return the 10% withhold plus an additional amount up to 2%.

Medical Trend Expectation	Withhold Returned
Less than 3.00%	**10% + additional 2%**
From 3.00% to 3.99%	**10% + additional 1%**
From 4.00% to 4.99%	**10%**
From 5.00% to 5.99%	**7%**
From 6.00% to 6.99%	**3%**
7.00% or greater	**0%**

Trend guarantee will be based on the following methodology:

- The trend guarantee will apply to all claims incurred through all medical plans administered by the selected carrier for all participants (active and non-Medicare eligible retiree plans).
- The actual 2023 incurred claims number will be measured using medical claims that were incurred during the 2023 calendar year and paid during that calendar year and a six-month run-out period through June 2024, removing claims in excess of $250,000. This total will be divided by the actual enrollment during the policy year. (Same methodology applies for CY 2024 and 2025.)
- The actual 2022 incurred claims number will be measured using medical claims that were incurred during the 2022 calendar year and paid during that calendar year through June 2023, removing claims in excess of $250,000. This total will be divided by the actual enrollment during the policy year. All the necessary supporting claims and enrollment data for the 2022 calendar year will be obtained by the State from its current medical administrator and provided to the Contractor.
- Claims will include the amounts that are the responsibility of both the member and the employer to mitigate distortions created by plan design changes.
- Claims will also include any and all payments made to providers for attribution, provider incentive programs, bonus payments, etc. (e.g., Enhanced Personal Health Care payments).
- The actual 2023 trend will be calculated by dividing the adjusted 2023 incurred claims per member per month (calculated as described above) by the adjusted 2022 incurred claims per member per month (calculated as described above) less 1. (Same methodology applies for CY 2024 over 2023 and for CY 2025 over CY 2024.)
- A member continuously enrolled 12 months would count as 12 member months.
- The trend guarantee will be adjusted for significant benefits that are added or removed. Using total costs (including member cost sharing) for the trend analysis mitigates the need for plan value adjustments in most situations. However, when significant benefits are added or removed, such as in-vitro fertilization and bariatric surgery, an adjustment needs to be made since the

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total costs in the baseline period do not reflect this benefit. These adjustments will be mutually agreed upon between the State and the Contractor.

- A significant shift in the distribution of enrollment by plan design and/or significant change in offered plan designs as measured by a change in actuarial value of 5% will require a change in methodology to adjust for the impact on utilization due to plan design changes. The methodology for calculating actuarial value will be mutually agreed upon by the Parties.
- Claims experience will be adjusted to reflect the impact of catastrophic events such as a pandemic as defined by the World Health Organization. These adjustments will be mutually agreed upon between the State and the Contractor.

The base ASO fees as outlined in Exhibit C are subject to the Trend Guarantee each year.

Any Trend Guarantee settlement shall be finalized no later than eight months after the conclusion of each policy year with any applicable fee credits to occur no later than the end of the ninth month following each policy year.

Other Conditions

a.) In order for the Trend Guarantee to apply, Contractor must be the sole medical carrier for the State.

b.) The Trend Guarantee assumes an effective date of January 1, 2023 and is applicable for each policy period from 2023-2025.

c.) The Medical Trend Guarantee shall be subject to verification by annual audit.

d.) Should the State opt to engage its own vendor for cost containment strategies, the State and Contractor shall agree to meet and engage in good faith negotiations the purpose of which will be to mutually agree upon revised Medical Trend Guarantees.

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EXHIBIT C: CONTRACT PRICE/LIMITATION ON PRICE/PAYMENT

This EXHIBIT C shall govern the Agreement Period and each Term of the Agreement Period. This EXHIBIT C shall supplement the terms and provisions of EXHIBIT B. Words defined in EXHIBIT B shall have the same meaning in this EXHIBIT C unless expressly defined otherwise herein. If there are any inconsistencies between the terms of EXHIBIT B and this EXHIBIT C, the terms of this EXHIBIT C shall control.

Section 1. Agreement Period:

The terms and conditions of this EXHIBIT C shall apply to and govern the Agreement Period and each Term of the Agreement Period, including any extension thereof.

The initial Claim Incurred Date for purposes of this Agreement shall be the first date of the Agreement Period, except that the Contractor shall administer Claims on behalf of the State as provided in the Agreement for Covered Persons who are inpatients in a facility on and after the first date of the Agreement Period.

Section 2. Claims Payment Method:

The State shall reimburse the Contractor for all Claims the Contractor pays for and on behalf of Enrollees in the Program. Contractor shall pay benefits for Claims incurred by Enrollees according to the terms of the Agreement. Contractor shall provide notice to the State via electronic means, or other means acceptable to the Parties, of the amount of Claims paid by Contractor no later 12:00 p.m. on each Monday of the Agreement Period and the first Monday following the end of the Agreement Period (including any extensions thereof). The notice shall be for Claims paid during the week immediately preceding the date of notice. Contractor shall supply to the State supporting documentation, as mutually agreed to by the Parties, documenting the Claim payments made. The State shall issue payment to Contractor via wire transfer to a bank account specified by Contractor not later than close of business on Friday in same week as the State receives notice from Contractor. In the event any Monday or Friday falls on a holiday for the State and/or Contractor, notice shall be sent or payment shall be made on the next regular business day.

The State shall not issue payment to the Contractor for Claims paid based upon verbal instruction or information from the Contractor.

Section 3. Administrative Services Fee:

A. Payment of Administrative Services Fee and Invoicing

1. Administrative Services Fees shall be billed to the State on a monthly basis.

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2. The Contractor shall ensure that invoices, with supporting documentation, for all administrative and wellness program services performed or provided each month will be issued to the State no later than three (3) business days following the end of each month during the term of the Agreement. The State and the Contractor agree to identify and mutually agree upon the specific supporting documentation to accompany each monthly invoice issued.

3. The State shall issue payment to the Contractor for Administrative Services Fees within fourteen (14) business days following receipt of the invoice and documentation from the Contractor.

4. The State shall not issue payment to the Contractor for the Administrative Services Fee based upon verbal instruction or information from the Contractor.

A. Amount of Administrative Services Fees

1. The Administrative Services Fee for the Agreement Period shall be as depicted in the chart below:

Administrative & Program Fees: Active HMO/POS Plans			
	CY 2023 PEPM	**CY 2024 PEPM**	**CY 2025 PEPM**
Medical Administration / Claims Processing	$29.75	$29.75	$29.75
Network Access/Leasing Fees	included	included	included
Utilization Management Fees	included	included	included
ID Cards	included	included	included
Provider Directory	included	included	included
Benefit Booklets/SPDs	*See Below	*See Below	*See Below
Data and Performance Reporting	included	included	included
Data Sharing	included	included	included
Disease Management	included	included	included
Medical Info Line	included	included	included
Incentive Shopper Program-Sapphire Digital	$2.60	$2.60	$2.60
COBRA Administration	included	included	included
Start Up/Implementation Costs	N/A	N/A	N/A
Other			
All Inclusive Fee (PEPM)	$32.35	$32.35	$32.35

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Administrative & Program Fees: Non-Medicare Retiree POS/PPO Plan			
	CY 2023 PEPM	**CY 2024 PEPM**	**CY 2025 PEPM**
Medical Administration / Claims Processing	$29.75	$29.75	$29.75
Network Access/Leasing Fees	included	included	included
Utilization Management Fees	included	included	included
ID Cards	included	included	included
Provider Directory	included	included	included
Benefit Booklets/SPDs	*See Below	*See Below	*See Below
Data and Performance Reporting	included	included	included
Data Sharing	included	included	included
Disease Management	included	included	included
Medical Info Line	included	included	included
Incentive Shopper Program-Sapphire Digital	$2.60	$2.60	$2.60
COBRA Administration	included	included	included
Start Up/Implementation Costs	N/A	N/A	N/A
Other			
All Inclusive Fee (PEPM)	$32.35	$32.35	$32.35

*** Anthem provides the State with a master benefits booklet that describes the benefit program under the terms of the plan administered by Anthem. The State produces the SPD and may incorporate the benefits booklet. On behalf of the State, Anthem produces and maintains the master copy of the benefits booklet and makes amendments to the master copy incorporating an approved changes.**

2. In the event the State exercises its right to extend the duration of this Agreement beyond the Agreement Period, the Parties shall agree not later than ninety (90) days prior to the commencement of any such extension to the amount of the Administrative Services Fee.

A. Reconciliation and Settlement

1. Reconciliation and Settlement. The Parties agree that Administrative Services Fees will be reconciled from time to time and settlements shall occur as defined herein. For purposes of all reconciliation and settlements, enrollment data supplied by the State shall be considered the "source of truth".

2. Fiscal Year Reconciliation and Settlement Calculations. The Parties agree that an interim reconciliation and settlement shall occur no later than thirty-one (31) days following the close of the State's Fiscal Year. The State's Fiscal Year is July 1 through June 30.

3. Calendar Year End Reconciliation and Settlement Calculation. The Parties agree that a final calendar year end reconciliation and settlement shall occur no later than ninety (90) days following the close of each calendar year.

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4. Settlement Payments. If, based on the reconciliation and settlement calculations, the Contractor owes the State a settlement payment under the terms of the Agreement, then the Contractor shall pay the State said amount no later than thirty-one (31) days after the close of the State's Fiscal Year for the interim settlements and no later than ninety (90) days after the close of the calendar year for each year end settlement. If, based on the reconciliation and settlement calculations, the State owes the Contractor a settlement payment under the terms of this Agreement, then the State shall pay the Contractor said amount no later than thirty-one (31) days after the close of the State's Fiscal Year for the interim settlements and no later than ninety (90) days after the close of the calendar year for each year end settlement.

Section 4. Fees on Claims Runout:

There shall be no Administrative Services Fee for Claims Runout Services. Fees on Claims Runout means those Administrative Services Fee and other fees for services provided by Contractor following the Termination of the Agreement.

A. Claims Runout Services

1. Claim Processing. Contractor will process and pay Claims on behalf of the State any Claim covered by the State's Program which has a Claim Incurred Date during the Agreement Period (or portion thereof if the Agreement is terminated prior to the end of the Agreement Period), provided, however, that Contractor shall have no responsibility to process or pay any Claim with a Claim Incurred Date after the Agreement Period (or portion thereof if the Agreement is terminated prior to the end of the Agreement Period) or after the expiration of 18 months following the Termination Date of this Agreement (the "Runout Period"), unless a different period is otherwise described in the Benefit Booklet.

2. Coordination of Benefit (COB). COB payments that are received by Contractor during the Claims Runout Period shall be credited to the State in accordance with the Agreement. All such payments received by Contractor after the end of the applicable Claims Runout Period will be retained by Contractor.

3. Right of Recovery. Recovery amounts recovered during the Claims Runout Period by Contractor shall be credited to the State in accordance with this Agreement. All such amounts received after the Claims Runout Period will be retained by Contractor.

Section 5. Special Services:

A. External Review.. Contractor shall make available to Enrollees External Review services once Enrollees have exhausted first and second level appeals. Contractor shall invoice the State in conjunction with the invoice for Administrative Services Fees, the fees and costs associated with administration of External Review. Costs incurred for engaging the services of an Independent Review Organization ("IRO") shall be billed "at cost" to the State. Upon reasonable request by the State, Contractor shall supply to the State of copy of the IRO's invoice.

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B. Fee for Overpayment Identification and Claims Prepayment Analysis Activities.
The charge to the State is 25% not to exceed $3.50 per employee per month (PEPM) of (i) the amount recovered from review of Claims and membership data and audits of Provider and vendor activity to identify overpayments and (ii) the difference between the amount the State would have been charged absent prepayment analysis activities and the amount that was charged to the State following performance of the prepayment analysis activities. This includes but is not limited to COB, contract compliance, and eligibility. The fee for Overpayment Identification and Claims Prepayment Analysis Activities will not exceed $25,000 per Claim.

Contractor agrees to complete an annual reconciliation by the end of the second quarter of the following year and shall issue the State a credit for any amount over the PEPM limitation.

Section 6. Wellness Program Administrative Fees:

A. Upon implementation of the various components of the Wellness Programs as provided in Attachment 2, the Wellness Program Administrative Fee(s) shall be as follows:

Administrative Fee - Wellness Program: ALL Active Plans			
	CY 2023 PEPM	CY 2024 PEPM	CY 2025 PEPM
Customized Website	included	included	included
Health Risk Assessment/Tool (HAT)	included	included	included
HAT Reporting	included	included	included
Member Communications	included	included	included
Onsite Health Screenings ($/screening)*	$55.00	$55.00	$55.00
Wellness Promotion/Incentive Program	Included through Mobile Health Consumer	Included through Mobile Health Consumer	Included through Mobile Health Consumer
Wellness Counseling	included	included	included
Fitness Counseling	included	included	included
Educational Sessions - Seminars	Included through SONH dedicated Health Coach	Included through SONH dedicated Health Coach	Included through SONH dedicated Health Coach
Educational Sessions - Webinars	Included through SONH dedicated Health Coach	Included through SONH dedicated Health Coach	Included through SONH dedicated Health Coach

Telephonic Coaching	Included through SONH dedicated Health Coach	Included through SONH dedicated Health Coach	Included through SONH dedicated Health Coach
Workplace Influenza Vaccinations*	$33.00 per vaccine	$33.00 per vaccine	$33.00 per vaccine
Start Up/Implementation Costs	N/A	N/A	N/A
Other			
*Mobile Health Consumer***	$0.87	$0.87	$0.87
My Health Advantage Gold w/Daily Reminders	$0.75	$0.75	$0.75

*Lab Corp administering

** Mobile Health Consumer cost above includes the cost of the Amazon gift card *(Shipping not included)*. However, if the SONH wishes to offer a Visa Card instead, there will be an additional charge of $3.00/card.

*** Anthem will continue to fund a dedicated Health Coach to assist in the State's Wellness Programs.

1. The Wellness Administrative Fees shall be billed to the State on a monthly basis as part of the monthly administrative fee invoice with appropriate supporting documentation.

2. The Contractor shall provide the State with an invoice and other documentation as mutually agreed to by the Parties which display the services and costs which make up the Wellness Program Administrative Fee. The invoice and documentations shall be provided by the Contractor to the State no later than three (3) business days following the end of each month during the Agreement Period. The State shall issue payment to the Contractor for Administrative Services Fees within fourteen (14) business days following receipt of the invoice and documentation from the Contractor.

Section 7. Right to Remove or Add Services:

The State reserves the right to remove the following services from the medical administration contract. Removing these services will have the indicated impact on the State's medical administration fee. If the services or program have their own independent fees, fees for removed services or programs will no longer be charged to the State.

Possible services removed from medical administration contract	**Change to Medical Administration Fee**
All Wellness program administration	Decreases by $1.00 PEPM to $28.75 PEPM for the three contract years 2023 to 2025
Flu Vaccination / Biometric screening	No change to medical administration fee – these services have their own independent fees
Health Coach Program	No change to medical administration fee – this program has its own independent fees
Digital Health Application	No change to fees

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Incentive Reward Administration	No change to medical administration fee – this service has its own independent fees
Health Assessment Tool (HAT)	No change to medical administration fee
COBRA program administration	No change to medical administration fee
CHERP (Community Health Education Reimbursement Program)	No change to medical administration fee
Program Integrity or Enhanced Fraud and Abuse Program	Increases by $3.50 PEPM to $33.25 PEPM for the three contract years 2023 to 2025
Incentive Shopping Program	No change to medical administration fee – this program has its own independent fees
Non-Medicare Retiree Plan administration	Increases by $2.50 PEPM to $32.25 PEPM for the three contract years 2023 to 2025

The State reserves the right to add the following services to the medical administration contract. Adding these services will have the indicated impact on the State's medical administration fee and/or will have its own additional independent fee indicated.

Possible services added to medical administration contract	**Change to Medical Administration Fee**
Health Reimbursement Arrangement (HRA) administration, including FSA and/or Commuter reimbursement benefits	This service has its own independent fees of $2.60 PEPM for the three contract years 2023 to 2025 (No change to medical administration fee)
Fitness Reimbursement	No change to medical administration fee

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ATTACHMENTS

Attachment 1	Incorporation of RFP Response
Attachment 2	Wellness Program
Attachment 3	Value-Based Purchasing
Attachment 4	Required Protection of Confidential Information

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ATTACHMENT 1: INCORPORATION OF RFP RESPONSE

The Contractor's response to RFP 2596-22 is hereby incorporated by reference.

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ATTACHMENT 2: WELLNESS PROGRAM

The Contractor shall administer the State's Wellness Program and collectively bargained Wellness Program components or provisions as determined by the State. The Wellness Program components include, but are not limited to, the following:

A. **Online Lifestyle Management Program**: The Contractor shall implement and support the management and operation of a voluntary online lifestyle management program that offers a health assessment tool (HAT), personalized online health coaching and resources for well-being as an interactive approach to help all subscribers to address key behaviors and set appropriate goals associated with identified health risks.

   a. The Contractor shall have the ability to track HAT completions and offer incentives only to subscribers eligible for the incentives. The Contractor shall transmit subscriber eligibility information and HAT completion data as requested by the State to other State approved vendors at no additional cost, ex. health reimbursement account and incentive administration data.

B. **Biometric Screening Program**: The Contractor shall administer a voluntary biometric screening program that provides eligible subscribers the opportunity for screening by competent professional staff for Body Mass Index (BMI) – based on height and weight measurements, waist circumference, blood pressure, cholesterol, blood sugar. The Biometric Screening process shall include the following:

   a. Biometric screening staff shall:

      1) provide a site visit 2-3 days prior to the screening event for calibration of equipment and inventory of supplies.

      2) arrive to the screening site on the date of the event 60 minutes prior to the screening start time.

      3) provide registration support on the day of the event.

      4) conduct the screenings and review the results with each participant, including providing education on managing any identified health issues and referring enrollees to further health management programs or their primary care provider for follow-up or maintaining current health status.

      5) provide each participant with screening results and other relevant health information.

      6) survey each participant, using a mutually approved survey tool, on their satisfaction of screening process and biometric screening staff member and provide completed surveys to the State upon completion of each event. The State reserves the right to request a staffing change as needed.

      7) return the screening room to the original configuration and state it was in when they arrived.

   b. The Contractor shall integrate the biometric screening program with the health promotion incentive program to allow subscribers to meet screening participation or outcomes-based incentives, as applicable.

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c. The Contractor shall provide subscribers with alternatives to worksite biometric screenings to obtain biometric data including, but not limited to, physician offices and community urgent care locations. The alternative methods of screening shall also integrate with the health promotion incentive program to allow subscribers to meet screening participation or outcomes-based incentives, as applicable.

C. **Health Promotion Incentive Program**: The Contractor shall administer a voluntary health promotion incentive program that offers payments per eligible subscriber per calendar year for participation in health activities as required by the State.

a. The Contractor shall offer eligible subscribers with incentives for completing certain State-sponsored health education and well-being programs in various forms including, but not limited to consumer gift cards and debit cards that do not expire..

b. The Contractor shall accept data as necessary to track eligible subscriber activity, completion of activity, and reward including redemption of reward cashed in as required by and in accordance with program parameters

c. The State, through the Manager of Employee Relations, shall consult with all employee organizations as provided by their respective Collective Bargaining Agreements regarding the design and implementation of the program.

d. Nothing herein shall obligate the State to any specific level of incentives. The State will be solely responsible for funding the incentives used in administering the program.

B. **Reporting:** The Contractor shall provide the State aggregate reporting to measure effectiveness of each Wellness Program component including, but not limited to, participation and satisfaction, on a monthly basis or as requested by the State. The State and the Contractor shall agree on the outcome measures to be contained in such reports.

C. **Incentives:** Nothing herein shall obligate the State to any specific level of incentives. The State will be responsible for funding the incentives used in administering the program.

D. **Promotion:** The Contractor shall promote the Wellness Program and all of its components by developing a State-approved marketing and educational campaign utilizing various media including print, email, and online multi-media designed to engage eligible subscribers to maximize participation in the program.

a. Emails: Distributed monthly to eligible subscribers about health improvement/wellness services such as the HAT, lifestyle management programs, and incentive offerings.

b. Print: Distributed quarterly to eligible employee and retiree subscribers about health and wellness benefits. Each of the four (4) quarterly mailings per calendar year shall occur no more than 15 business days after the start of the quarter.

c. Reminders: Distributed electronically as needed to remind subscribers who have partially completed or have not completed their HAT or other component of the Wellness Program.

E. **On-Site Education:** Within seven business days of a request by the State, the Contractor shall provide staff to conduct on-site educational sessions about the Wellness Program and all of its components.

F. **Changes in Eligibility:** The State may, at any time during the term of the Agreement, alter the eligibility requirements of the Wellness Program, or any of its individual components. The State will provide as much notice as administratively possible of such change in eligibility. Upon changes in eligibility, all associated Per Subscriber Per Month (PSPM) administrative charges and payments shall adjust.

G. **Discontinuation**: The State may, at any time during the term of the Agreement, discontinue the Wellness Program or any of its components. The State will provide as much notice as administratively possible of such change. Upon termination, all associated Per Subscriber Per Month (PSPM) administrative charges and payments shall cease.

H. **New Hire Orientation**: The Contractor shall conduct periodic meetings for new hire orientations for the purpose of educating such employees regarding the State's health benefit plan including development and distribution of new hire packets that educate new employees on the Wellness Program, HAT, health benefits, and incentives. The new hire packets shall be approved by the State and be distributed by request within 14 business days to the State.

I. **Influenza Vaccination Program**: The Contractor shall administer a workplace influenza vaccination program during the months of September, October, November and December.

J. **National Diabetes Prevention Program**: The Contractor shall administer the National Diabetes Prevention Program for active and non-Medicare retiree subscribers.

K. **Compliance**: The Contractor shall ensure that the Wellness Program and all of its components are compliant with federal and state laws and regulations including, but not limited to the Americans with Disabilities Act (ADA), Genetic Information Nondiscrimination Act (GINA), Health Insurance Portability and Accountability Act (HIPAA), and Affordable Care Act (ACA).

L. **Dedicated Health and Wellness Specialist**: The Contractor agrees to provide a dedicated Health and Wellness Specialist equal to 1 FTE to the State to support worksite health improvement and wellness services. The Health and Wellness Specialist shall be available Monday through Friday to State employees, retirees, and dependents (plan members).

a. The Health and Wellness Specialist should possess the following qualifications:

1) Bachelor's degree from a recognized college or university with a major in community health nursing, health education, public health, or related field.

2) Specialty certification in an area such as in Health Coaching, ACE Personal Trainer, Worksite Wellness Program Management, Athletics and Fitness Association of America, or registered Allied Health Profession.

3) Minimum of 1 year experience supporting and facilitating positive behavior change using coaching or motivational interviewing techniques.

4) Ability to create clear, concise and effective educational, marketing and communication tools using web-based technology, print, multi-media, and social media provided by the Contractor and approved by the State such as webinars, websites, and on-demand recorded classes and presentations.

b. Working in conjunction with the State's Wellness Administrator, the Health and Wellness Specialist job duties include:

1) developing, delivering, monitoring and evaluating any and all aspects of the State Employee and Retiree Health Benefit Plan Wellness Programs.

2) serving as a health coach/educator developing, implementing and evaluating health promotion, prevention and condition programs for individuals and groups.

3) fostering individual responsibility and individualized plans to maximize a member's ability to adhere to a care plan.

4) making appropriate referrals, and implementing and monitoring health and wellness interventions for State of New Hampshire employees and other groups as identified.

5) monitoring and evaluating the coaching program for overall quality and performance improvement and shall monitor and evaluate the coaching plans for individual members and groups.

6) utilizing health assessment and biometric measures, when available, to assist members in managing self-care and setting goals.

7) collaborating with other professionals in the development of program planning and care plans, including the State's Employee Assistance Program, Agency Human Resources personnel, the Division of Personnel, Bureau of Education and Training and other appropriate professionals.

8) supporting peer activities and facilitation of worksite group fitness, yoga, or other wellness activities.

9) teaching or leading health related wellness classes, including employee health education programs and the effective use of health and wellness benefits in groups or one on one with members.

10) maintaining adherence to evidence based standards of practice for health and wellness services.

11) developing, implementing, marketing and evaluating Health Benefit Committee Workgroup interventions consisting of the Contractor care management, wellness programs and medical benefits.

12) collaborating and maintaining communication with other public and private employers including the Contractor affiliates to share information about Wellness Plans, outcomes-based risk reduction programs, health benefits plan designs and wellness incentives to apply to State benefit design.

13) developing creative and effective strategies to achieve short term and long term objectives of the State Employee Health Improvement Plan using evidence and comparative research.

14) participating in an annual professional and technical performance review conducted by the State Wellness Program Administrator.

15) identifying ways to engage retirees with wellness programs, benefits, and group activity.

16) participating in and attend HBC meetings, HBC Workgroup meetings, wellness coordinator trainings, the Contractor vendor meetings, and additional meetings as requested.

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ATTACHMENT 3: VALUE-BASED PURCHASING

A. Provider Contracting Partnership: The Contractor will inform the State every six months regarding the alternative contracting strategies being employed by the Contractor. This shall include receipt of reports which detail the portions of the State's population that are utilizing providers contracted in a certain manner. The State shall be notified of the Contractor's strategies regarding these alternative contracting methods and shall be notified when assessment of these strategies is completed.

The Contractor shall notify the State sixty (60) days in advance of facility and /or physician group contract negotiations taking place with Accountable Care Organizations (ACO) with State membership; as well as at the State's top five hospitals and physician groups, by volume. Once agreement has been reached between the Contractor and the ACO, facility and/or physician group, the Contractor agrees to provide the State with an estimated percentage change in contracting terms so that the State can perform financial impact analysis.

B. Performance Payments. The Contractor may pay Performance Payments to Providers or Subcontractors as described in the definition of Paid Claim in this Agreement. The Contractor may perform a periodic settlement or reconciliation based on the Provider's or Subcontractor's performance and experience against established Performance Targets that would:

1. require the Provider or Subcontractor to repay a portion of a Performance Payment previously paid by the Contractor; or

2. require the Contractor to make additional payments.

The State acknowledges and agrees that it has no responsibility for additional payments to Providers or Subcontractors nor any right in any discounts or excess money refunded or paid to the Contractor from Providers or Subcontractors pursuant to such settlement/reconciliation arrangements, and neither it nor the plan has any legal right or beneficial interest in such sums retained by the Contractor.

Similarly, if Providers or Subcontractors do not achieve established Performance Targets, the Contractor is not obligated to refund any amounts previously charged the State. In turn, if under any such settlement/reconciliation the Contractor is required to pay Providers or Subcontractors excess compensation for Member management performance, risk-sharing rewards, or other performance incentives, it shall not seek payment from the State or the plan, and neither the State nor the plan shall have any liability in connection with such amounts. Such Providers or Subcontractors may include Contractor Affiliates. In calculating any Member co-insurance amounts in accordance with the Benefits Booklet, the Contractor does not take into account these settlement/reconciliation arrangements.

The Contractor shall provide the State with detailed reports reflecting any additional administrative charges, member management performance, risk-sharing rewards or other incentive payments, per Capita payments or other provider payments that may be charged to the State as part of any of the Contractor's Value Based or Provider Performance program. The State and the Contractor shall work together to design the content and establish the frequency of these reports.

C. Provider Access. The Contractor shall make a reasonable effort to encourage primary care providers within the Contractor's New Hampshire network to extend their office hours as a way of increasing access to care for State employees. On an annual basis, the Contractor shall provide the State with a

listing of primary care providers who offer non-standard hours. Non-standard hours shall mean weekdays after 6:00 PM and any weekend hours.

D. In addition to the provisions above, the Contractor shall:

1. Agree to meet the requirements of each Value-Based Purchasing Specification contained in Appendix A. The Purchasing Specifications include:

   a. Value-Based Activity Regarding Care Delivery

   b. Enrollee Services

   c. Claim Administration and Services

   d. Other Reporting

2. Agree to implement all plans, strategies, and timelines described in the Contractor's response to the RFP referenced in Attachment 1;

3. Agree to develop with the State, by a date specified in the Contract, Improvement Goals and associated Measures related to the Contractor's performance of Contractor responsibilities and the Value-Based Purchasing Specifications contained in Appendix A for each year of the Agreement.

4. Identify and propose Improvement Goals in collaboration with the State no later than six weeks prior to the end of each Contract Year, including Measures and time frames for demonstrating that such Quality Improvement Goals are met;

5. Implement, with the State's approval, processes to achieve the Improvement Goals over the course of Contract Year;

6. Ensure that key staff participate in meetings with the State and/or contracted providers or Subcontractors to develop strategies to ensure that the Improvement Goals are met;

7. Participate in semi-annual meetings with the State during each Contract Year for the primary purpose of reviewing progress towards the achievement of the annual Improvement Goals and the Contractor's performance to contract standards. For the purposes of such meetings, the Contractor shall:

   a. Provide the State with a written update and presentation, detailing progress toward meeting the annual Improvement Goals, prior to each semi-annual meeting;

   b. Review its Contract performance with regards to the requirements of the annual Improvement Goals;

   c. Collaborate in advance with the State to develop a presentation of the annual improvement goals' results to ensure targeted messages are clear and concise for the broader audience;

   d. Meet with the State at the time and place requested by the State;

   e. If the State determines that the Contractor is not in compliance with the requirements of the annual Improvement Goals, prepare and submit a corrective action plan to the State for its approval.

8. Cooperate in any audits that may be required and conducted by the State, or its designee.

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E. The State's Responsibilities. The State shall designate the Commissioner of the Department of Administrative Services (DAS), or his or her designee(s), to act as a liaison between the Contractor and the State for the duration of the Contract. The State reserves the right to change its representative, at its sole discretion, during the term of the Contract, and shall provide the Contractor with written notice of such change. The State representative shall be responsible for:

1. Representing the State on all matters pertaining to the Contract. The representative shall be authorized and empowered to represent the State regarding all aspects of the Contract;
2. Monitoring compliance with the terms of the Contract;
3. Responding to all inquiries and requests related to the Contract made by the Contractor, under the terms and in the time frames specified by the Contract;
4. Meeting with the Contractor's representative on a periodic or as-needed basis and resolving issues which arise, and

F. In addition to the provisions above, the State shall:

1. Monitor and evaluate the Contractor's compliance with the terms of the Contract;
2. In consultation with the Contractor, develop a Performance Indicator Dashboard to assemble performance indicators that assess important dimensions of the Contractor's performance and identify the standards by which the Contractor's performance will be assessed on each measure;
3. Meet with the Contractor at a minimum of twice a year for formal contract management meetings to comprehensively assess the performance of the Contractor relative to the annual Improvement Goals and the performance of the Contractor on Performance Dashboard measures and according to specified performance standards;
4. Review reports submitted by the Contractor.. The State shall determine the acceptability of the reports. If they are not deemed acceptable, the State shall notify the Contractor and explain the deficiencies and require resubmission;
5. Request additional reports that the State deems necessary for purposes of monitoring and evaluating the performance of the Contractor under the Contract;
6. Perform periodic programmatic and financial reviews of the Contractor's performance of responsibilities. This may include, but is not limited to, on-site inspections and audits by the State or its agent of both the Contractor's and Providers' records;
7. Give the Contractor prior notice of any on-site visit by the State or its agents to conduct an audit, and further notify the Contractor of any records which the State or its agent may wish to review;
8. Inform the Contractor of the results of any performance evaluations conducted by the State and annually complete the reconciliation of withheld funds consistent with Exhibit B, Article 16, section C3 Medical Trend Guarantee Withhold;
9. Inform the Contractor of any dissatisfaction with the Contractor's performance and include requirements for corrective action.

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ATTACHMENT 4: REQUIRED PROTECTION OF CONFIDENTIAL INFORMATION

In performing its obligations under the Agreement, Contractor, inclusive of any subsidiaries and related entities shall gain access to State Confidential information and with respect to such will comply with the following terms and conditions. Protection of State Confidential Information shall be an integral part of the business activities of Contractor. Contractor shall take steps to prevent the inappropriate or unauthorized use of State data and information.

1. Definitions
    a. Confidential Information. Personally identifiable information (PII), and other personal private, and/or sensitive information or data as defined under applicable law.
2. Contractor Responsibilities
    a. Confidential Information obtained by Contractor shall remain the property of the State and shall at no time become the property of Contractor unless otherwise explicitly permitted under the Agreement.
    b. Contractor shall develop and implement policies and procedures to safeguard the confidentiality, integrity and availability of the State's Confidential Information.
    c. Contractor shall not use the State's Confidential Information developed or obtained during the performance of, or acquired or developed by reason set forth within the Agreement, except as necessary for Contractor's performance under the Agreement, or unless otherwise permitted under the Agreement.
    d. In the event Contractor stores Confidential Information, such information shall be encrypted by Contractor both at rest and in motion.
    e. Contractor shall have, and shall ensure that any Subcontractors or related entities have, reasonable security measures in place for protection of the State's Confidential Information. Such security measures shall comply with HIPAA and all other applicable State and federal data protection and privacy laws.
3. Controls. Contractor shall, and shall ensure that any Subcontractors or related entities use at all times proper controls for secured storage of, limited access to, and rendering unreadable prior to discarding, all records containing the State's Confidential Information. Contractor shall not store or transfer Confidential Information collected in connection with the services rendered under this Agreement outside of the North America. This includes backup data and disaster recovery locations.
4. Breach Notification.
    a. Contractor shall notify the State of any security breach, or potential breach of Contractor or any Subcontractors or related entities, that jeopardizes, or may jeopardize the State's Confidential Information. For purposes of reporting under this Section, security breach or potential breach shall be limited to the successful or attempted unauthorized access, use, disclosure, modification, or destruction of information, or the successful or attempted interference with system operations in an information system that compromises the security, confidentiality or integrity of such Confidential Information consistent with applicable laws. For purposes of clarity, potential breaches shall not include incidents that do not compromise the security, confidentiality or integrity of the State's Confidential Information consistent with applicable laws, such as pings and other broadcast attacks on Contractor's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above.
    b. Contractor shall notify the State of a security breach, or potential breach of Contractor or any Subcontractors or related entities upon discovery. Contractor will treat a security breach or potential breach as being discovered as of the first day on which such incident is known to Contractor, or by exercising reasonable diligence, would have been known to Contractor.

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Contractor shall be deemed to have knowledge of a security breach or potential breach if such incident is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer or other agent of Contractor.

c. A report of the security breach or potential breach of Contractor or any Subcontractors or related entities shall be made and include all available information. Contractor shall: make efforts to investigate the causes of the security breach or potential breach; promptly take measures to prevent any future breach; and mitigate any damage or loss. In addition, Contractor shall inform the State of the actions it is taking, or will take, to reduce the risk of further loss to the State.

d. All legal notifications required as a result of a breach of information, or potential breach, collected pursuant to this Agreement shall be made at the Contractor's cost and coordinated with the State to the extent practicable.

5. Liability and Damages. In addition to Contractor's liability as set forth elsewhere in the Agreement, if Contractor or any of its Subcontractors or related entities is determined by forensic analysis or report, to be the likely source of any loss, disclosure, theft or compromise of State's Confidential Information, the State shall recover from Contractor all costs of response and recovery resulting from the security breach or potential breach, including but not limited to: credit monitoring services, mailing costs and costs associated with website and telephone call center services. A security breach or potential breach may cause the State irreparable harm for which monetary damages would not be adequate compensation. In the event of such an incident, the State is entitled to seek equitable relief, including a restraining order, injunctive relief, specific performance and any other relief that may be available from any court, in addition to any other remedy to which the State may be entitled at law or in equity. Such remedies shall not be deemed exclusive, but shall be in addition to all other remedies available at law or in equity, subject to any express exclusion or limitations in the Agreement to the contrary.
6. Data Breach Insurance. In addition to Contractor's insurance obligations as set forth in the form contract P-37, Contractor shall carry cybersecurity insurance coverage for unauthorized access, use, acquisition, disclosure, failure of security, breach of Confidential Information, privacy perils, in an amount not less than $10 million per annual aggregate, covering all acts, errors, omissions, at minimum, during the full term of this Agreement. Such coverage shall be maintained in force at all times during the term of the Agreement and during any period after the termination of this Agreement during which Contractor maintains State Confidential Information.
7. Data Recovery. Contractor shall be responsible for ensuring backup and redundancy of the State's Confidential Information for recovery in the event of a system failure or disaster event within Contractor's data storage systems. Contractor shall ensure that its Subcontractor or related entities provide similar backup and redundancy of the State's Confidential Information.
8. Return or Destruction of Confidential Information. Upon termination of the Agreement for any reason, Contractor shall:
   a. Retain only that Confidential Information which is necessary for Contractor to continue its proper management and administration or to carry out its legal responsibilities;

   b. Destroy, in accordance with applicable law and Contractor's record retention policy that it applies to similar records, the remaining Confidential Information that Contractor still maintains in any form;

   c. Continue to use appropriate safeguards and comply with applicable law to prevent use or disclosure of the Confidential Information, other than as provided for in this Section, for as long as Contractor retains the Confidential Information;

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d. Not use or disclose the Confidential Information retained by Contractor other than for the purposes for which such Confidential Information was retained and subject to the same conditions set out in this Agreement which applied prior to termination; and

e. Destroy in accordance with applicable law and Contractor's record retention policy that it applies to similar records, the Confidential Information retained by Contractor when it is no longer needed by Contractor for its proper management and administration or to carry out its legal responsibilities.

9. Survival. This Attachment 4 *Required Protection of Confidential Information* shall survive termination or conclusion of the Agreement.

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APPENDICES

Appendix A Value-Based Purchasing Specifications

Appendix B List of Subcontractors and Affiliates

Appendix C Business Associate Agreement

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APPENDIX A: VALUE-BASED PURCHASING SPECIFICATIONS

Specification Contents:

A. Primary Care Transformation
B. Value-Based Payment (Alternative Payment Models)
C. Performance Measurement
D. Clinical Performance Data
E. Engaging Members in Improving Care and Health Status
F. Quality Improvement
G. Utilization Management
H. Clinical Pathways and High-Cost Condition Management Programs
I. Provider Network and Access
J. Behavioral Health Services
K. Member Services

All work conducted pursuant to the following Value-Based Purchasing (VBP) Specifications is subject to review and approval by the State. The State may require the Contractor to take corrective action if it finds the Contractor is not providing services in conformance with the Value-Based Purchasing specifications.

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A. Primary Care Transformation

1. The Contractor shall support primary care transformation, ensuring that the level and method of compensation support Patient-Centered Medical Home primary care infrastructure, through the use of enhanced fee schedules, supplemental payments and/or primary care capitation.

   a. The Contractor shall report annually on specific steps it has taken to support transformed primary care practice, including through Value-Based payment arrangements.

2. Primary Care Clinician. The Contractor shall ensure that each Member, including those Members enrolled in HMO, PPO and POS products, has an identified Primary Care Clinician (PCC) and that the PCC establishes a relationship with every attributed Member if one does not already exist at the time of enrollment.

   a. The Contractor shall annually report on the percentage of Members electing a PCC.

3. Patient-Centered Medical Home (PCMH). The Contractor shall encourage its contracted primary care practices to operate as high-functioning Patient-Centered Medical Homes.

   a. The Contractor's contracted PCMHs shall be encouraged to provide patient-centered, team-based care across appropriate disciplines, including behavioral health, in part through the application of a common, shared care plan and clinical information exchange.

   b. The Contractor shall ensure providers are knowledgeable in the clinical evidence for patient-centered team-based care and are increasingly practicing in such manner over the term of the contract.

   c. The Contractor shall support PCMHs with needed data, not limited to high-risk patient lists, costs of referral providers, information regarding non-primary care utilization (e.g., inpatient care, emergency and urgent care services), quality information, utilization measures and cost measures for attributed Members.

   d. The Contractor shall hold PCMHs accountable for performance, including for operating as a PCMH and for quality and cost efficiency.

   e. The Contractor shall annually report on the percentage of Members electing a PCC that operates as a PCMH.

4. PCMH care coordination. The Contractor shall ensure the provision of care coordination by PCMHs for patients at high-risk of future intensive service use. Because care coordination is frequently provided by entities in addition to PCMHs, including hospitals, behavioral health providers, ACOs and the Contractor, the Contractor shall ensure these efforts are coordinated and not duplicative. See Section H below for language specific to Contractor care coordination activity.

B. Value-Based Payment (Alternative Payment Models)

1. Population-based contracting (total cost of care). The Contractor in coordination with and on behalf of the State shall pursue population-based shared risk ACO contracts with providers serving a substantial number of Members.

   a. The contract shall be a total cost of care contract that includes nearly all, if not all, covered services, including physician services, hospital services and prescription drugs.

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b. The distribution of any shared savings shall be contingent on achievement of clinical quality performance expectations, with greater reward for higher levels of demonstrated meaningful quality improvement over time.

c. To support providers entering into population-based contracts with the Contractor, the Contractor shall furnish claim data to the contracting provider entity in a manner approved by the State.

d. By the end of Contract Year One, claims for at least 30% percent of Members shall be covered under a multi-year population-based contract with risk sharing arrangements that meets standards identified by the State in consultation with the Contractor.

2. Pay providers differentially according to performance. Contractor shall evaluate and implement successful programs to differentiate providers who meet or exceed state or national standards for quality and efficiency. Payment to effective and efficient providers should reflect their performance. Examples include quality-based incentive payments, differential fee schedules, and fee increases at risk based on provider performance.

3. Develop episode-based payment strategies. Contractor shall work with the State and its provider network to evaluate and implement episode-based payment strategies designed to bundle a set of services together that are related to a defined condition or treatment (e.g., knee replacement surgery). Priority shall be placed on referral services delivered by providers not participating in a population-based contract on behalf of the State and with high Member service volume.

4. Design payment and coverage approaches that cut medically unnecessary spending while not diminishing quality, including by reducing unwarranted payment variation. Contractor shall evaluate, and propose to the State for implementation, successful approaches to payment designed to cut medically unnecessary spending while not diminishing quality. Examples include, but are not limited to, reference pricing, non-payment for avoidable complications and hospital-acquired infections, lower payment for non-indicated services and warranties on discharges for patients who undergo procedures.

C. Performance Measurement

1. Aligned measure set. If so directed by the State, the Contractor shall collaborate with New Hampshire providers, payers and employer purchasers to adopt an aligned set of performance measures to which Network Providers will be held accountable, including commonly defined measures in each of the following domains: a) access, b) quality, c) patient experience, e) service utilization, and f) cost.

2. Contractor health informatics. The Contractor shall perform analysis of claims and clinical data to identify a) population characteristics, b) variations in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or Clinical Pathways, d) patients at risk for future high-intensity service use. Results shall be presented to the State in writing and during meetings with interpretation and recommendations.

3. Contractor-level measurement. The Contractor shall measure performance across all provider types and providers with meaningful volume for the Contractor's book of business. For high-volume providers, the Contractor shall create provider profile reports for use in network management and Quality Improvement (QI) activity. Results shall be presented to the State in writing and during meetings with interpretation and recommendations.

4. Provider-level measurement. The Contractor shall require contracted providers to measure performance at the clinician, practice team and/or practice site, and organizational levels.

5. Population measurement adjustment. The Contractor shall apply clinical risk adjustment techniques when measuring provider performance.

D. Clinical Performance Data

1. The Contractor shall annually report its complete HEDIS data set inclusive of CAHPS, and including State-specific data for claims-based measures, and total Contractor New Hampshire commercial book-of-business data, including enrollment, quality, Member satisfaction, and utilization data. Such a report shall be provided and presented to the State no later than July 1 of each year for performance during the preceding calendar year.

2. The Contractor shall collect and report to the State on performance using the aligned measure set referenced above in C.1, including performance of high-volume providers.

3. The Contractor shall report on performance related to annual Quality Improvement Goal achievement, consistent with the terms of the Goals and Measures approved by the State.

E. Engaging Members in Improving Care and Health Status

1. The Contractor shall collaboratively design and implement a State-approved strategy for activating Members to manage their health and to be prudent purchasers of health care through education, including health care and health insurance literacy education and through health promotion activities.

2. The Contractor shall provide education to Members on the important role a Member-PCC relationship plays in their health to encourage Member PCC selection, even when not required under the plan design.

3. The Contractor shall provide education to Members on how to access and use comparative provider price and quality information including but not limited to information available at https://nhhealthcost.nh.gov/.

4. The Contractor shall promote use of behavioral health services programs to support behavioral health and wellness to Members and remove the social stigma associated with behavioral health illness and services. Such efforts shall also make mention of the State's Employee Assistance Program and how its services may be accessed.

5. The Contractor shall evaluate the impact of health promotion programs and act on such information by adding, eliminating, or altering programs, based on such evaluations. At a minimum, evaluations should study effectiveness/impact, attendance and Member satisfaction resulting from such programs. The plan shall demonstrate that such findings were used in a meaningful way to improve the quality of health promotion programs.

F. Quality Improvement (QI)

1. Organizational arrangements and responsibilities for QI process are clearly defined and assigned to appropriate individuals. It is clearly indicated which persons are physicians or other clinicians.

2. There is an annual QI work plan for New Hampshire, submitted to the State, that includes the following:

   a. Objectives, scope and planned projects or activities for the year;

   b. Planned monitoring of previously identified issues, including tracking of issues over time; and

   c. Planned evaluation of the QI program.

3. Hospital Quality Improvement. The Contractor shall develop a program to manage quality of care provided by network hospitals. At a minimum, such a program shall include:

a. Identification of data-driven opportunities to improve quality; and

b. Collection of Leapfrog survey responses from hospitals.

Using this, and other available information, the Contractor shall actively manage its contracted network hospitals. If the Contractor identifies deficiencies in data obtained through this process, the Contractor shall take appropriate actions (e.g., plan of correction and follow-up, financial penalties) with such hospitals.

4. Clinician Quality Improvement. The Contractor shall develop a program to manage quality of care provided by network primary care, specialty care physicians and non-physician behavioral health clinicians. At a minimum, such a program shall focus on data-driven opportunities to improve quality through active management of network physicians. If the Contractor identifies deficiencies in data obtained through this process, the Contractor shall take appropriate actions (e.g., plan of correction, financial penalties) with such clinicians.

5. Health Information Exchange. Contracted physician, behavioral health and hospital providers shall be encouraged to use real-time electronic clinical information exchange across all care settings.

G. Utilization Management

1. The Contractor shall have policies and procedures in place to evaluate the appropriate use of new medical technologies or new applications of established technologies, including medical procedures, drugs, and devices, as well as long-standing treatments. Procedures should include careful consideration of Comparative Effectiveness Research in order to a) protect the health and safety of Members, and b) reduce unnecessary spending.

2. The Contractor shall have a process for assessing patient compliance with prescriptions.

3. The Contractor shall have a process for assessing under-utilization and over-utilization.

4. The Contractor shall produce an annual report of the findings on quality and utilization measures and completed or planned interventions to address under or over-utilization patterns of care for physical and behavioral health, including pharmaceutical use. The following measures set shall be reported in the annual report:

   a. Potentially preventable hospitalizations, including readmissions, and

   b. Potentially avoidable emergency department visits.

5. The Contractor shall annually track programs that traditionally include utilization management/review so that it can be reviewed by the State, e.g., prior approval of advanced imaging, prior approval of physical therapy. The Contractor shall annually identify and report to the State the cost-effectiveness of such activity, and opportunities to improve program effectiveness.

H. Clinical Pathways and High-Cost Condition Management Programs

1. The Contractor shall be accountable for adopting and using Clinical Pathways or explicit criteria that are based on reasonable scientific evidence and reviewed by Contractor- contracted providers. The Contractor shall implement a process for updating the guidelines periodically and for communicating the Clinical Pathways to the Contractor's network. The Contractor shall assess provider performance against the Clinical Pathways and act on the performance results. The results of the assessment and ensuing action shall be reported to the State annually.

2. Contracted providers shall be required to specify and implement Clinical Pathways reflective of evidence-based practice, designed to maximize patient health status, clinical outcomes and efficiency, and to eliminate overuse. For example, a Clinical Pathway may include treatment steps for treating an individual with COPD.

3. The Contractor shall develop and implement a program of care coordination for Members one or more high-cost, high-frequency conditions or diseases to maximize their health status and ensure appropriate service utilization. The Contractor shall implement such programs based on a) the profile of high-risk Members, and b) the prevalence of associated conditions and diseases in the enrolled population. Such conditions and diseases might include: High-Risk Pregnancy, Chronic Obstructive Pulmonary Disease, Diabetes, Depression, Cardiovascular Disease, Low Back Pain, and/or Hypertension.

4. The Contractor shall stratify high-risk Members based on consideration of clinical and social determinant-of-health factors.

    a. The Contractor shall report annually on its method for stratifying the Member population to identify potentially high-cost Members, including how it is capturing and considering social-determinant-of-health factors.

I. Provider Network and Access

1. The Contractor maintains and monitors a network of qualified providers in sufficient numbers, mix, and geographic locations throughout the state, and where appropriate in regions contiguous to the state, for the provision of all covered services.

    a. The Contractor will maintain the following geographic access standards from the individual patient's residence:

        i. Hospital – Licensed medical-surgical, pediatric, obstetrical and critical care services associated with acute care hospital services within 45 miles

        ii. Primary Care – Two open-panel primary care providers within 15 miles

        iii. Outpatient mental health and substance use treatment – One provider within 25 miles

        iv. Specialist Care – One provider within 45 miles for: Allergists, Cardiologists, General surgeons, Neurologists, Obstetrician/gynecologists, Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Psychiatrists, and Urologists

    b. The Contractor shall adopt NH Insurance Department (NHID) standards of access for all other services and maintain provider network data and shall submit provider network data to the State annually. The provider network data will support Member PCC selection and shall therefore include an accurate provider directory.

2. The Contractor shall establish and comply with access standards that are no longer than the following (standards shall be measured from the initial request for an appointment):

    a. Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.

    b. Urgent, symptomatic office visits shall be available within twenty-four (24) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not emergent.

c. Non-urgent, symptomatic (i.e., routine care) office visits, including behavioral health services, shall be available within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

d. Non-symptomatic (i.e., preventive care) office visits within ninety (90) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

e. Transitional health care services by a PCC shall be available for clinical assessment and care planning within 48 hours of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

The Contractor shall report on compliance with these requirements in a manner and frequency defined by the State after consultation with the Contractor. Failure to meet network or appointment access standards may, at the State's sole discretion, result in sanctions.

3. Within the first 12 months of the contract start, the Contractor shall provide the State with information on strategic options for implementing Centers of Excellence, and including options regarding how to engage Members if a Centers of Excellence program is implemented voluntarily for members. Should the State decide to pursue a Centers of Excellence program, the Contractor will support the State by creating such a program.

J. Behavioral Health Services

1. The Contractor shall provide direct access without referral to behavioral health service providers within the network and communicate such availability to Members.

2. The Contractor shall employ a process to ensure that early detection and referral for depression and/or substance use problems in Members occurs and that primary care physicians are adequately trained to perform, code and bill such screenings.

3. Treatment shall be delivered based upon clinical assessment of individual patient need.

4. The Contractor shall take action to support the advancement of integrated care that addresses behavioral health needs and social determinants of health concurrently with physical health needs. The Contractor shall do so:

   a. Through innovative contracting and payment models that support integrated care in both co-located and non-co-located arrangements and foster joint accountability for physical and behavioral health needs;

   b. Through training and technical assistance opportunities regarding best practice in integrated care, including but not limited to the Collaborative Care Model, and

   c. Protocols for provider information exchange of behavioral health data to support improved patient care, as permitted by law.

5. The Contractor shall address New Hampshire's opioid epidemic by a) making conformance with the New Hampshire Board of Medicine guidelines for physicians who prescribe opioids a contractual requirement, and b) facilitating Member access to Medication-Assisted Treatment and other appropriate modalities of care.

K. Member Satisfaction

1. The Contractor shall actively seek and utilize input from consumers as an integral part of its quality management programs. Consumer input must include data obtained from individuals who are either chronically ill or who utilize a substantial amount of services. The Contractor must also obtain input from information available within the plan including, but not limited to, data on the resolution of member inquiries, complaints, grievances and appeals as well as from at least one of the following sources:

    a. Member focus groups;

    b. Member surveys (telephone and/or mail or email), and

    c. Open meetings to obtain Member input.

2. The Contractor shall provide quarterly reports summarizing member satisfaction survey results.

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APPENDIX B: LIST OF SUBCONTRACTORS AND AFFILIATES

Affiliates:

- Elevance Health, Inc.
- Carelon Holdings, Inc.
- American Imaging Management, Inc. (d/b/a AIM Specialty Health)
- Beacon Health Options, Inc. and Beacon Health Strategies, LLC
- IngenioRx, Inc.
- Wellpoint Health Solutions, Inc.

Subcontractor/Vendor Services Include:

- SmartShopper (MDX Medical, Inc.)
- Mobile Health Consumer, Inc.
- Solera Health, Inc.
- Sword Health Inc.
- LabCorp
- HealthEquity, Inc.
- LiveHealth Online (Amwell)
- Learn to Live, Inc.

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APPENDIX C: BUSINESS ASSOCIATE AGREEMENT

The Contractor identified in Section 1.3 of the General Provisions of the Agreement agrees to comply with the Health Insurance Portability and Accountability Act, Public Law 104-191 and with the Standards for Privacy and Security of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 and those parts of the HITECH Act applicable to business associates. As defined herein, "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Agreement, shall mean Contractor. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Agreement shall mean the State of New Hampshire Department of Administrative Services Employee and Retiree Health Benefit Program. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

BUSINESS ASSOCIATE AGREEMENT

1. Definitions

    a. The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

    b. All terms not otherwise defined herein shall have the same meaning as those set forth in the HIPAA Rules.

2. Privacy and Security of Protected Health Information (PHI)

    a. Permitted Uses and Disclosures

        i. Business Associate shall not use, disclose, maintain or transmit PHI except as reasonably necessary to provide the services set forth in this Agreement or any agreement between the parties, or as required by law.

        ii. Business Associate is authorized to use PHI to de-identify the information in accordance with 45 CFR 164.514(a)-(c). Business Associate shall de-identify the PHI in a manner consistent with HIPAA Rules. Uses and disclosures of the de-identified information shall be limited to those consistent with the provisions of this Agreement.

        iii. Business Associate may use PHI as necessary to perform data aggregation services, and to create Summary Health Information and/or Limited Data Sets. Contractor shall use appropriate safeguards to prevent use or disclosure of the information other than as provided for herein, shall ensure that any agents or subcontractors to whom it provides such information agree to the same restrictions and conditions that apply to Contractor, and not identify the Summary Health Information and/or Limited Data Sets or contact the individuals other than for the management, operation and administration of the plan.

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iv. Business Associate may use and disclose PHI (a) for the management, operation and administration of the plan, (b) for the services set forth in the ASO Agreement, which include (but are not limited to) Treatment, Payment activities, and/or Health Care Operations as these terms are defined in this Agreement and 45 C.F.R. § 164.501, and (c) as otherwise required to perform its obligations under this Agreement and the ASO Agreement, or any other agreement between the parties provided that such use or disclosure would not violate the HIPAA Regulations.

v. Business Associate may disclose, in conformance with the HIPAA Rules, PHI to make disclosures of De-identified Health Information, Limited Data Sets, and Summary Health Information. Contractor shall use appropriate safeguards to prevent use or disclosure of the information other than as provided for herein, ensure that any agents or subcontractors to whom it provides such information agree to the same restrictions and conditions that apply to Contractor, and not identify the De-identified Health Information., Summary Health Information and/or Limited Data Sets or contact the individuals. Business Associate may also disclose, in conformance with the HIPAA Regulations, PHI to Health Care Providers for permitted purposes including health care operations.

vi. Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of Business Associate. To the extent Business Associate discloses PHI to a third party, Business Associate must obtain, prior to making any such disclosure, (a) reasonable assurances from the third party that such PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party; and (b) an agreement from such third party to notify Business Associate of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.

vii. To the extent practicable, Business Associate shall not, unless such disclosure is reasonably necessary to provide services outlined in the Agreement, disclose any PHI in response to a request for disclosure on the basis it is required by law without first notifying Covered Entity. In the event Covered Entity objects to the disclosure it shall seek the appropriate relief and the Business Associate shall refrain from disclosing the PHI until Covered Entity has exhausted all remedies.

b. Minimum Necessary. Business Associate will, in its performance of the functions, activities, services, and operations specified above, make reasonable efforts to use, to disclose, and to request only the minimum amount of PHI reasonably necessary to accomplish the intended purpose of the use, disclosure, or request, except that Business Associate will not be obligated to comply with this minimum-necessary limitation if neither Business Associate or Covered Entity is required to limit its use, disclosure, or request to the minimum necessary under the HIPAA Rules. Business Associate and Covered Entity acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with the HITECH Act and the HIPAA Rules.

c. Prohibition on Unauthorized Use or Disclosure. Business Associate may not use or disclose PHI except (1) as permitted or required by this Agreement, or any other agreement between the parties, (2) as permitted in writing by Covered Entity, or (3) as authorized by the individual or (4) as Required by Law. This agreement does not authorize Business Associate to use or disclose Covered Entity's PHI in a manner that would violate the HIPAA Rules if done by Covered Entity, except as permitted for Business Associate's proper management and administration as described herein.

3. Information Safeguards

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a. Privacy of Protected Health Information. Business Associate will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. The safeguards must reasonably protect PHI from any intentional or unintentional use or disclosure in violation of the Privacy Rule and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Agreement. To the extent the parties agree that the Business Associate will carry out directly one or more of Covered Entity's obligations under the Privacy Rule, the Business Associate will comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligations.

b. Security of Covered Entity's Electronic Protected Health Information. Business Associate will comply with the Security Rule and will use appropriate administrative, technical and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI that Business Associate creates, receives, maintains or transmits on Covered Entity's behalf.

c. No Transfer of PHI Outside United States. Business Associate will not transfer PHI outside the United States without the prior written consent of the Covered Entity. In this context a "transfer" outside the United States occurs if Business Associate's workforce members, agents, or Subcontractors physically located outside the United States are able to, store, copy or disclose PHI.

d. Subcontractors. Business Associate will require each of its Subcontractors to agree, in a written agreement with Business Associate, to comply with the provisions of the Security Rule; to appropriately safeguard PHI created, received, maintained, or transmitted on behalf of the Business Associate; and to apply the same restrictions and conditions that apply to the Business Associate with respect to such PHI.

e. Prohibition on Sale of Protected Health Information. Business Associate shall not engage in any sale (as defined in the HIPAA rules) of PHI.

f. Prohibition on Use or Disclosure of Genetic Information. Business Associate shall not use or disclose Genetic Information for underwriting purposes in violation of the HIPAA rules.

g. Penalties for Noncompliance. Business Associate acknowledges that it is subject to civil and criminal enforcement for failure to comply with the HIPAA Rules, to the extent provided with the HITECH Act and the HIPAA Rules.

4. Compliance With Electronic Transactions Rule

a. If Business Associate conducts in whole or part electronic Transactions on behalf of Covered Entity for which HHS has established standards, Business Associate will comply, and will require any Subcontractor it involves with the conduct of such Transactions to comply, with each applicable requirement of the Electronic Transactions Rule and of any operating rules adopted by HHS with respect to Transactions.

5. Individual Rights and PHI

a. Access

i. Business Associate shall respond to an individual's request for access to his or her PHI as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the individual or the individual's personal representative. Business Associate shall respond to the request with regard to PHI that Business Associate and/or its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

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ii. In addition, Business Associate shall assist Covered Entity in responding to requests made to Covered Entity by individuals to invoke a right of access under the HIPAA Privacy Regulation. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate shall make available to Covered Entity, or at Covered Entity's direction to the individual (or the individual's personal representative), any PHI about the individual created or received for or from Covered Entity in the control of Business Associate's and/or its Subcontractors for inspection and obtaining copies so that Covered Entity may meet its access obligations under 45 CFR 164.524, and, where applicable, the HITECH Act. Business Associate shall make such information available in an electronic format where required by the HITECH Act.

b. Amendment

i. Business Associate shall respond to an individual's request to amend his or her PHI as part of Business Associate's normal customer service functions, if the request is communicated to Business Associate directly by the individual or the individual's personal representative. Business Associate shall respond to the request with respect to the PHI Business Associate and its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

ii. In addition, Business Associate shall assist Covered Entity in responding to requests made to Covered Entity to invoke a right to amend under the HIPAA Privacy Regulation. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate shall amend any portion of the PHI created or received for or from Covered Entity in the custody or control of Business Associate and/or its Subcontractors so that Covered Entity may meet its amendment obligations under 45 CFR 164.526.

c. Disclosure Accounting

i. Business Associate shall respond to an individual's request for an accounting of disclosures of his or her PHI as part of Business Associate's normal customer service function, if the request is communicated to the Business Associate directly by the individual or the individual's personal representative. Business Associate shall respond to a request with respect to the PHI Business Associate and its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

ii. In addition, Business Associate shall assist Covered Entity in responding to requests made to Covered Entity by individuals or their personal representatives to invoke a right to an accounting of disclosures under the HIPAA Privacy Regulation by performing the following functions so that Covered Entity may meet its disclosure accounting obligation under 45 CFR 164.528:

iii. Disclosure Tracking. Business Associate shall record each disclosure that Business Associate makes of individuals' PHI, which is not excepted from disclosure accounting under 45 CFR 164.528(a)(1).

iv. Disclosure Information. The information about each disclosure that Business Associate must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom Business Associate made the disclosure, (c) a brief description of the PHI disclosed, and (d) a brief statement of the purpose of the disclosure or a copy of any written request for disclosure under 45 Code of Federal Regulations §164.502(a)(2)(ii) or §164.512. Disclosure Information also includes any information required to be provided by the HITECH Act.

v. Repetitive Disclosures. For repetitive disclosures of individuals' PHI that Business Associate makes for a single purpose to the same person or entity (including to Covered Entity or Employer), Business Associate may record (a) the Disclosure Information for the first of these repetitive disclosures, (b) the frequency, periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.

vi. Exceptions from Disclosure Tracking. Business Associate will not be obligated to record Disclosure Information or otherwise account for disclosures of PHI if Covered Entity need not account for such disclosures under the HIPAA Rules.

vii. Disclosure Tracking Time Periods. Unless otherwise provided by the HITECH Act and/or any accompanying regulations, Business Associate shall have available for Covered Entity the Disclosure Information required by Section 3.j.iii.2 above for the six (6) years immediately preceding the date of Covered Entity's request for the Disclosure Information.

d. Confidential Communications

i. Business Associate shall respond to an individual's request for a confidential communication as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the individual or the individual's personal representative. Business Associate shall respond to the request with respect to the PHI Business Associate and its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation. If an individual's request, made to Business Associate, extends beyond information held by Business Associate or Business Associate's Subcontractors, Business Associate shall refer individual to Covered Entity. Business Associate assumes no obligation to coordinate any request for a confidential communication of PHI maintained by other business associates of Covered Entity.

ii. In addition, Business Associate shall assist Covered Entity in responding to requests to it by individuals (or their personal representatives) to invoke a right of confidential communication under the HIPAA Privacy Regulation. Upon receipt of written notice (including fax and email) from Covered Entity, Business Associate will begin to send all communications of PHI directed to the individual to the identified alternate address so that Covered Entity may meet its access obligations under 45 CFR 164.524.

e. Restrictions

i. Business Associate shall respond to an individual's request for a restriction as part of Business Associate's normal customer service function, if the request is communicated to Business Associate directly by the individual (or the individual's personal representative). Business Associate shall respond to the request with respect to the PHI Business Associate and its Subcontractors maintain in a manner and time frame consistent with requirements specified in the HIPAA Privacy Regulation.

ii. In addition, Business Associate shall promptly, upon receipt of notice from Covered Entity, restrict the use or disclosure of individuals' PHI, provided the Business Associate has agreed to such a restriction. Covered Entity agrees that it will not commit Business Associate to any restriction on the use or disclosure of individuals' PHI for treatment, payment or health care operations without Business Associate's prior written approval.

6. Breach

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Date 09/07/22

a. Business Associate shall report to Covered Entity, in writing, any use or disclosure of PHI in violation of the Agreement promptly upon discovery of such incident, including any Security Incident involving PHI, ePHI, or Unsecured PHI as required by 45 CFR 164.410. Such report shall not include instances where Business Associate inadvertently misroutes PHI to a provider, as long as the disclosure is not a Breach as defined under 45 CFR §164.402. The parties acknowledge and agree that attempted but Unsuccessful Security Incidents (as defined below) that occur on a daily basis will not be reported. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.

b. Business Associate shall report a Breach or a potential Breach to Covered Entity upon discovery of any such incident. Business Associate will treat a Breach or potential Breach as being discovered as of the first day on which such incident is known to Business Associate, or by exercising reasonable diligence, would have been known to Business Associate. Business Associate shall be deemed to have knowledge of a Breach or potential Breach if such incident is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer or other agent of Business Associate. If a delay is requested by a law-enforcement official in accordance with 45 CFR § 164.412, Business Associate may delay notifying Covered Entity for the applicable time period. Business Associate's report will include at least the following, provided that absence of any information will not be cause for Business Associate to delay the report:

    i. Identify the nature of the Breach, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;

    ii. Identify the scope of the Breach, including the number of Covered Entity members involved as well as the number of other individuals involved;

    iii. Identify the types of PHI that were involved in the Breach (such as whether full name, Social Security number, date of birth, home address, account number, diagnosis, or other information were involved);

    iv. Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;

    v. Identify what corrective or investigational action Business Associate took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects, and to protect against any further Breaches;

    vi. Identify what steps the individuals who were subject to a Breach should take to protect themselves;

    vii. Provide such other information as Covered Entity may reasonably request.

c. Security Incident. Business Associate will promptly upon discovery of such incident report to Covered Entity any Security Incident of which Business Associate becomes aware. Business Associate will treat a Security Incident as being discovered as of the first day on which such incident is known to Business Associate, or by exercising reasonable diligence, would have been known to Business Associate. Business Associate shall be deemed to have knowledge of a Security Incident if such incident is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Security Incident, who is an employee, officer or other agent of Business Associate. If any such Security Incident resulted in a

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Date 09/07/22

disclosure not permitted by this Agreement or Breach of Unsecured PHI, Business Associate will make the report in accordance with the provisions set forth above.

d. Mitigation. Business Associate shall mitigate, to the extent practicable, any harmful effect known to the Business Associate resulting from a use or disclosure in violation of this Agreement.

e. Breach Notification to Third Parties. Business Associate will handle breach notifications to individuals, the United States Department of Health and Human Services Office for Civil Rights, and, where applicable, the media. Should such notification be necessary, Business Associate will ensure that Covered Entity will receive notice of the breach prior to such incident being reported.

7. Term and Termination

a. The term of this Agreement shall be effective as of January 1, 2023, or Governor and Executive Council approval, and shall terminate on December 31, 2025 or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

b. In addition to general provision #10 of this Agreement the Covered Entity may, as soon as administratively feasible, terminate the Agreement upon Covered Entity's knowledge of a material breach by Business Associate of the Business Associate Agreement set forth herein as Appendix C. Prior to terminating the Agreement, the Covered Entity may provide an opportunity for Business Associate to cure the alleged breach within a reasonable timeframe specified by Covered Entity. If Covered Entity determines that neither termination nor cure is feasible, Covered Entity may report the violation to the Secretary.

c. Upon termination of this Agreement for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained or received by Business Associate on behalf of Covered Entity, shall:

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

ii. Destroy, in accordance with applicable law and Business Associate's record retention policy that it applies to similar records, the remaining PHI that Business Associate still maintains in any form;

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

iv. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out in this Agreement which applied prior to termination; and

v. Destroy in accordance with applicable law and Business Associate's record retention policy that it applies to similar records, the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

d. The above provisions shall apply to PHI that is in the possession of any Subcontractors of Business Associate. Further Business Associate shall require any such Subcontractor to certify to Business Associate that it has returned or destroyed all such information which could be returned or destroyed.

Contractor Initials mmp
Date 09/07/22

e. Business Associate's obligations under this Section 7.c. shall survive the termination or other conclusion of this Agreement.

8. Covered Entity's Responsibilities

a. Covered Entity shall be responsible for the preparation of its Notice of Privacy Practices ("NPP"). To facilitate this preparation, upon Covered Entity's request, Business Associate will provide Covered Entity with its NPP that Covered Entity may use as the basis for its own NPP. Covered Entity will be solely responsible for the review and approval of the content of its NPP, including whether its content accurately reflects Covered Entity's privacy policies and practices, as well as its compliance with the requirements of 45 C.F.R. § 164.520. Unless advance written approval is obtained from Business Associate, Covered Entity shall not create any NPP that imposes obligations on Business Associate that are in addition to or that are inconsistent with the HIPAA Rules.

b. Covered Entity shall bear full responsibility for distributing its own NPP.

c. Covered Entity shall notify Business Associate of any change(s) in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such change(s) may affect Business Associate's use or disclosure of such PHI.

9. Miscellaneous

a. Definitions and Regulatory References. All terms used, but not otherwise defined herein, shall have the same meaning as those terms in the HIPAA Rules as in effect or as amended.

b. Amendment. Covered Entity and Business Associate agree to take action to amend the Agreement as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

c. Business Associate shall make available all of its internal practices, policies and procedures, books, records and agreements relating to its use and disclosure of Protected Health Information to the United States Department of Health and Human Services as necessary, to determine compliance with the HIPAA Rules and with this Appendix C.

d. Interpretation. The parties agree that any ambiguity in the Agreement shall be interpreted to permit compliance with the HIPAA Rules.

e. Severability. If any term or condition of this Appendix C or the application thereof to any person(s) or circumstance is held invalid, such invalidity shall not affect other terms or conditions which can be given effect without the invalid term or condition; to this end the terms and conditions of this Appendix C are declared severable.

f. Survival. Provisions in this Appendix C regarding the use and disclosure of PHI, return or destruction of PHI, confidential communications and restrictions shall survive the termination of the Agreement.

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Date 09/07/22

IN WITNESS WHEREOF, the parties hereto have duly executed this Appendix C.

The State of New Hampshire Employee and Retiree Health Benefit Program	Anthem Health Plans of NH, Inc. d/b/a Anthem Blue Cross and Blue Shield of NH
Signature of Authorized Representative	Signature of Authorized Representative
Charles Arlinghaus	Maria M. Proulx
Name of Authorized Representative	Name of Authorized Representative
Commissioner	President & GM, Anthem BCBS NH
Title of Authorized Representative	Title of Authorized Representative
9-9-22	September 7, 2022
Date	Date

Contractor Initials mmp
Date 09/07/22

State of New Hampshire

Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC. is a New Hampshire corporation registered on June 30, 1999. I further certify that articles of dissolution have not been filed with this office.

INFORMATION REGARDING ANNUAL REPORTS AND/OR FEES MUST BE OBTAINED FROM THE NEW HAMPSHIRE INSURANCE DEPARTMENT.

Business ID: **320378**

Certificate Number: **0005854056**

IN TESTIMONY WHEREOF,

I hereto set my hand and cause to be affixed

the Seal of the State of New Hampshire,

this 31st day of August A.D. 2022.

David M. Scanlan

Secretary of State

CERTIFICATION
OF
KATHLEEN S. KIEFER, SECRETARY
ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC.

I, Kathleen S. Kiefer, Corporate Secretary of Anthem Health Plans of New Hampshire, Inc. certify that **Maria M. Proulx** is the President of Anthem Health Plans of New Hampshire, Inc. d/b/a Anthem Blue Cross and Blue Shield ("Anthem"), and as such President, and consistent with Anthem policies, has the signatory authority to bind Anthem in contracts with the State of New Hampshire. I further certify that it is understood that the State of New Hampshire will rely on this certificate as evidence that the person listed above currently occupy the position indicated and that they have full authority to bind the corporation. To the extent that there are any limits on the authority of any listed individual to bind the corporation in contracts with the State of New Hampshire, all such limitations are expressly stated herein. This authority **remains valid for thirty (30)** days from the date of this Certification.

Kathleen S. Kiefer, Secretary

STATE OF INDIANA

COUNTY OF MARION

On this the 6th day of September, 2022, before me, Kimberly Kay Lindley the undersigned officer, personally appeared Kathleen S. Kiefer who acknowledged herself to be the Corporate Secretary of Anthem Health Plans of New Hampshire, Inc., d/b/a Anthem Blue Cross and Blue Shield, a corporation, and that she, as such Corporate Secretary being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by herself as Corporate Secretary.

IN WITNESS WHEREOF I hereunto set my hand and official seal.

My commission expires: 2-16-2023

Notary Public/Justice of the Peace

My county of Residence is Hendricks

KIMBERLY KAY LINDLEY
Notary Public
SEAL
HENDRICKS COUNTY, STATE OF INDIANA
My Commission Expires 2-16-2023

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 9/6/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Arthur J. Gallagher & Co.
Insurance Brokers of CA, Inc. License #0726293
505 N. Brand Boulevard, Suite 600
Glendale CA 91203-3944

CONTACT NAME: Stephanie Powell
PHONE (A/C, No, Ext): 818.539.1366 **FAX (A/C, No):** 818.539.1666
E-MAIL ADDRESS: Stephanie_Powell@ajg.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Zurich American Insurance Company	16535
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED ANTHINC-02
Elevance Health, Inc. and Its Subsidiaries
Anthem Health Plans of New Hampshire, Inc.
2015 Staples Mill Road Mail Drop VA2001-N350
Richmond VA 23230

COVERAGES **CERTIFICATE NUMBER:** 272654778 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY			GLO 0853238-00	5/1/2022	5/1/2023	EACH OCCURRENCE	$ 2,000,000
	CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
							MED EXP (Any one person)	$ 25,000
							PERSONAL & ADV INJURY	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 25,000,000
	[X] POLICY [ ] PRO-JECT [X] LOC						PRODUCTS - COMP/OP AGG	$ 4,000,000
	OTHER:						Per Occurence Ded	$ 2,000,000
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ONLY / NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						PER STATUTE / OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] N/A						E.L. EACH ACCIDENT	$
	(Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Subject to policy terms, conditions and exclusions.

CERTIFICATE HOLDER

Evidence of Insurance

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 9/8/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Arthur J. Gallagher & Co. Insurance
Brokers of California, Inc. License #0726293
505 N. Brand Boulevard, Suite 600
Glendale CA 91203

CONTACT NAME: Stephanie Powell
PHONE (A/C, No, Ext): 818.539.1366 FAX (A/C, No): 818.539.1666
E-MAIL ADDRESS: Stephanie_Powell@ajg.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : American Zurich Insurance Company	40142
INSURER B : Zurich American Insurance Company	16535
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED ANTHINC-02
Elevance Health, Inc. and Its Subsidiaries
Anthem Health Plans of New Hampshire, Inc.
2015 Staples Mill Road
Richmond VA 23230

COVERAGES **CERTIFICATE NUMBER:** 1211362362 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
A B B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N	N / A		WC9299269-21 EWS5347154-17 WC9376766-20	1/1/2022 1/1/2022 1/1/2022	1/1/2023 1/1/2023 1/1/2023	X PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)						E.L. EACH ACCIDENT	$ 2,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 2,000,000
							E.L. DISEASE - POLICY LIMIT	$ 2,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Subject to policy terms, conditions & exclusions.

CERTIFICATE HOLDER

Evidence of Insurance

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE