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State of New Hampshire

DEPARTMENT OF ADMINISTRATIVE SERVICES
25 Capitol Street
Concord, New Hampshire 03301
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Charles M. Arlinghaus
Commissioner

Catherine A. Keane
Deputy Commissioner

Sheri L. Rockburn
Assistant Commissioner

July 31, 2026

Her Excellency, Governor Kelly A. Ayotte
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 a fully-insured group Medicare Advantage and Prescription Drug Plan (MA/PDP) agreement with Emphesys Insurance Company, d/b/a Humana (Humana) (VC#578388), in Louisville, Kentucky, for members covered under the State's Medicare-eligible Retiree Health Benefit Plan (HBP) in an amount not to exceed **$215,227,000**, effective upon Governor and Executive Council approval for the period of January 1, 2027 through December 31, 2029, with an option to extend for up to three (3) additional one-year extensions. **Approximately 64% General Funds, 1% Enterprise Funds, 13% Highway Funds, 1% Turnpike Funds and 21% Other Funds.**

Funding from the Employee Benefit Risk Management Fund is available in SFY2027 and funding for SFY2028, SFY2029, and SFY2030 is anticipated to be available with the authority to adjust encumbrances in each of the State fiscal years through the Budget Office if needed and justified:

MEDICARE ADVANTAGE with PRESCRIPTION DRUG PLAN (MAPD)

Fully-Insured Plan Costs	SFY2027	SFY2028	SFY2029	SFY2030
01-14-14-140560-66500000, Health Insurance for Retirees 102-500731	$29,484,000	$65,238,500	$78,129,500	$42,375,000
FISCAL YEAR TOTALS	$29,484,000	$65,238,500	$78,129,500	$42,375,000
GRAND TOTAL				$215,227,000

EXPLANATION

The Commissioner of the Department of Administrative Services (DAS) is authorized, pursuant to RSA 21-I:28, to enter into contracts with any organization necessary to administer and provide a health plan. DAS currently contracts with Anthem Health Plans of NH, Inc. (Anthem) (G&C approval dated July 19, 2023, Item 75; amended October 29, 2025, Item 72) to provide a fully insured Group Medicare Advantage with Prescription Drug (MAPD) plan for more than 11,000 Medicare-eligible retirees, spouses, and eligible dependents, in accordance with RSA 21-I:30. The Anthem contract expires on December 31, 2026.

With the assistance of its health benefits consultant, the Segal Group (Segal), DAS issued a Request for Proposal (RFP) on March 13, 2026, for administration of the State's fully insured group MAPD plan. Notice of the RFP was published on the DAS Division of Procurement and Support Services website. All major national Medicare Advantage carriers with passive PPO networks in New Hampshire—including Aetna, Anthem, UnitedHealthcare (UHC), and Humana—were contacted. A passive PPO provides consistent benefits nationwide when a provider accepts Medicare, regardless of network status, offering essential flexibility for State retirees residing across the country.

DAS required bidders to submit two fully insured proposals: one for a "combined MAPD plan" (MAPD), consistent with the State's existing arrangement, and another for a medical-only MA plan paired with a standalone Prescription Drug Plan also referred to as a "separated MA and PDP" (MA/PDP). The core distinction between these options lies in the level of federal funding provided by the Centers for Medicare & Medicaid Services (CMS), which applies different payment formulas, benchmarks, and risk-adjustment methodologies to combined MAPD plans versus separate MA/PDP structures. The RFP results would guide DAS in determining which model maximizes federal funding to offset costs under the Medicare Retiree Health Benefit Plan. The State reserved the right to select a proposal from either category.

Federal legislation and ongoing structural changes to the Medicare Advantage program continue to create significant pricing uncertainty in the marketplace. Most notably, the Inflation Reduction Act (IRA) of 2022 reshaped the financial framework of Medicare Advantage plans by capping prescription drug costs and shifting additional financial risk to carriers and plan sponsors. Each April, CMS issues a Call Letter that outlines regulatory requirements and operational guidance for the upcoming plan year. Carriers rely on the Call Letter to design, price, and administer their plans—specifically for calendar year 2027 in this procurement cycle. Future years, however, remain uncertain and therefore pose greater financial risk to carriers, contributing to more conservative pricing assumptions and contractual caveats.

Due to market uncertainty, carriers have increasingly included substantial caveats in their pricing submissions, often allowing year-to-year rate adjustments. To encourage rate stability, DAS incorporated a Price Proposal Commitment score into the financial evaluation criteria, rewarding bidders that offered rate guarantees through mechanisms such as rate caps, gain sharing provisions (in the event actual claims experience is lower-than-expected, the State receives a percentage of the savings), and limited caveats. Financial proposals were due April 24, 2026, following release of the 2027 CMS Call Letter, providing sufficient time for carriers to incorporate federal guidance into their pricing submissions.

DAS received compliant proposals from all four major carriers; no additional vendors responded to the RFP. Although the carriers had access to the Call Letter, some did not commit to

a 2027 rate, and three of the four submitted significant caveats for premium rates beyond 2027, such that Segal was forced to extrapolate rates in order to complete the financial analysis for 2028 and 2029. These caveats reflect carriers' sensitivity to the federal government's ongoing commitment to MAPD plans, especially in light of recent CMS changes that have increased carrier costs while limiting their ability to improve performance scores and earn higher CMS payments. The more significant the caveats, the greater the opportunity for carriers to shift costs to the State. While these caveats were evaluated under the Price Proposal Commitment scoring, they were not incorporated into the financial cost projections.

While DAS did not choose to move forward with a MAPD combined option, the bid results are informational. Humana's combined MAPD proposal received the highest score (93.3), driven primarily by its strong price commitment, which provided the greatest rate stability over the three-year period while still offering the second-lowest 2027 combined MAPD rate. Anthem submitted the lowest-cost proposal, followed by Humana (1.3 percent higher), Aetna (1.8 percent higher), and UHC (23.6 percent higher). Attachment A (Financial Analysis of Total Projected Cost - Combined MAPD) reflects Humana's rank as the second-lowest bidder based solely on price, while Attachment B (Overall Scoring Results- Combined MAPD) places Humana first overall due to its pricing commitments.

For the separate MA/PDP option that is the basis of this proposed contract, Humana again ranked first, with a total score of 94.5. Humana offered both the strongest pricing commitments and the lowest projected costs for 2027 and the full three-year contract term. Even with Humana's limited caveats, they included language to allow them to shift risk to the State under certain circumstances beyond their proposed rate caps. Humana's proposal was followed in projected cost rankings by Aetna (0.7 percent higher), Anthem (2.0 percent higher), and UHC (22.1 percent higher). Attachments C and D present the financial and overall scoring results for the separate MA/PDP proposals, confirming Humana as the highest-ranked bidder.

The non-financial section of the proposal was identical for both bidding options; therefore, each bidder received a single set of scores for this portion of the bid analysis. This section encompasses network match and access, account management, member and claims payment services, data reporting and Star Rating maximization, enrollment, implementation and communication processes, medical management and member case management, and pharmacy formulary and clinical program management. It also includes the agreement with Performance Guarantees (PGs). PG responses were evaluated with particular scrutiny due to the challenges experienced during the 2024 CarelonRx implementation under Anthem. Although those issues were specific to that contract period, DAS ensured adequate service guarantees were included to prevent similar disruptions and to ensure adequate protections for the State and its retirees.

To determine whether maintaining a combined MAPD structure or transitioning to separate MA/PDP plans was in the State's best interest, DAS analyzed overall cost and pricing commitments. Across all bidders, the separate MA/PDP proposals offered meaningfully lower per-member-per-month (PMPM) rates:

2027 PMPM Rates	Aetna	Anthem	Humana	UnitedHealthcare
Combined MAPD	$473.00	$464.51	$470.45	$574.30
Separate MA/PDP	$414.55	$420.03	$411.64	$502.76

Humana's 2027 MA/PDP rate of $411.64 PMPM is guaranteed. They also provided capped rates for 2028 ($492.02) and 2029 ($563.93), with a commitment to adopt lower rates if warranted through the annual rate-setting process. Although Humana included fewer caveats than other carriers, they still reserved the right to adjust rates under specific circumstances that fall outside their 2028 and 2029 rate caps.

Humana's limited caveats permit rate renegotiation beyond their rate caps only when:

(1) substantial federal Medicare Advantage law changes occur, including significant shifts in federal reimbursement;
(2) a natural disaster or pandemic affects the Medicare Advantage market;
(3) high-cost specialty drugs significantly increase pharmacy expenses;
(4) State-provided data is materially inaccurate; or
(5) Medicare enrollment varies by more than ten percent.

The price limitation of $215,227,00 is based upon the agreed-upon $411.64 PMPM for 2027, the rate caps for 2028 and 2029, and a contingency amount to accommodate potential enrollment growth over the three-year contract. Rate adjustments beyond the rates stated above are subject to Governor and Executive Council approval.

Over the years, DAS successfully contained rising retiree healthcare costs through strategic procurement and by maximizing federal funding. For comparison, Humana's projected 2027 PMPM cost is only ten percent (10%) higher than the 2016 PMPM cost for the Medicare-eligible population, and 2026 marked the first year premiums increased since 2018. However, those cost-containment strategies are no longer effective in today's healthcare environment —particularly in the Medicare Advantage market—leaving DAS with very limited ability to negotiate rates.

The federal government is shifting more pharmacy costs to carriers while simultaneously flattening the rates paid to them to cover beneficiaries. At the same time, overall healthcare costs continue to rise due to inflation, increased utilization of high-cost drugs, higher demand for medical services, advancements in technology, and the ongoing impact of an aging population. These combined pressures significantly limit DAS's leverage and contribute to the higher projected costs.

Upon approval, DAS will begin working with Humana to transition more than 11,000 retirees and spouses from Anthem to Humana by October 2026 to comply with CMS notification and enrollment requirements. Although DAS will work closely with Humana and retirees to minimize disruption, some member disruption is anticipated. Member disruption refers to the challenges retirees experience when switching to a new Medicare Advantage carrier, including changes in provider networks, pharmacy processes, and administrative requirements. Expected types of disruption include learning about their new carrier, updating insurance information with existing provider offices, adjusting to new prescription-filling processes (such as a new mail-order pharmacy), and replacing their Anthem member ID card with a Humana card on or after January 1, 2027. To assist with the transition, Humana has committed to enhanced provider outreach to expand in-network access and inform existing providers of the changes ahead for their patients.

Approval of this contract aligns with DAS's ongoing efforts to manage healthcare expenditures. Since implementing a fully insured Medicare Retiree Health Benefit Plan in 2019, the State has realized approximately $59.5 million in savings. As market uncertainty increases and carriers assume greater financial risk, premiums have risen accordingly. DAS elected to conduct a

competitive procurement rather than extend the Anthem contract to secure the most competitive pricing. Humana's proposal provides the greatest rate stability through formal contractual commitments.

DAS is confident that Humana's fully-insured group MA/PDP plan will provide State retirees and spouses the same level of coverage and service they have become accustomed to over the years. In addition to CMS performance requirements, DAS negotiated contractual performance guarantees and quality measures to ensure strong oversight of Humana's administration of the plan. DAS looks forward to establishing a productive partnership with Humana over the next three years. Based on the foregoing, DAS respectfully recommends approval of the agreement with Humana.

Respectfully submitted,

Charles M. Arlinghaus

Financial Analysis

Attachment A

Total Projected Cost – Combined MAPD

Combined MAPD	Aetna	Anthem	Humana	UHC
Fully Insured Premium				
Year 1 - Calendar Year 2027	$62,697,000	$61,571,000	$62,360,000	$76,125,000
Year 2 - Calendar Year 2028	$69,501,000	$68,253,000	$69,127,000	$84,386,000
Year 3 - Calendar Year 2029	$77,043,000	$75,660,000	$76,629,000	$93,543,000
Total Projected 3-Year Costs	**$209,241,000**	**$205,483,000**	**$208,115,000**	**$254,053,000**
Difference from Lowest Cost Proposal - $	$3,758,000	$0	$2,632,000	$48,570,000
Difference from Lowest Cost Proposal - %	1.8%	0.0%	1.3%	23.6%
Financial Score*	**48.2**	**50.0**	**48.7**	**26.4**
Financial Rank	**3**	**1**	**2**	**4**

*** The Most Competitive proposal's Financial Score equals 50 points. 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.**

Important Notes:

1. Projections assume enrollment of 11,046
2. Caveats to these proposals are scored separately as part of the Price Proposal Commitment
3. CY 2028 and 2029 rates were estimated using a composite estimated trend of 10.9% for all bidders.

Attachment B

Overall Scoring Results – Combined MAPD

Category	Allocated Points	Aetna Percent	Aetna Points	Anthem Percent	Anthem Points	Humana Percent	Humana Points	UHC Percent	UHC Points
Financial: Total Projected Costs	50	96%	48.2	100%	50.0	97%	48.7	53%	26.4
Financial: Price Proposal Commitment	5	20%	1.0	0%	0.0	80%	4.0	40%	2.0
Network Match and Access	5	100%	5.0	89%	4.5	97%	4.8	98%	4.9
Performance Guarantees	10	87%	8.7	87%	8.7	86%	8.6	88%	8.8
Administrative, Member, & Claim Paying Services	8	94%	7.5	92%	7.4	92%	7.4	90%	7.2
Data Reporting & Star Rating Maximization	4	83%	3.3	83%	3.3	89%	3.5	98%	3.9
Enrollment, Implementation, & Communication	8	87%	7.0	91%	7.3	89%	7.1	92%	7.4
Medical Management & Member Case Management	5	95%	4.8	93%	4.6	90%	4.5	93%	4.6
Rx Formulary and Clinical Program Management	5	90%	4.5	88%	4.4	91%	4.5	88%	4.4
Total Score*	100		**89.9**		**90.1**		**93.3**		**69.7**
Total Rank			**[3]**		**[2]**		**[1]**		**[4]**

* The sum of category scores may not tie back to total score due to rounding.

Financial Analysis

Attachment C

Total Projected Cost – Separate MA/PDP

Separate MA/PDP	Aetna	Anthem	Humana	UHC
Fully Insured Premium				
Year 1 - Calendar Year 2027	$54,949,000	$55,675,000	$54,564,000	$66,642,000
Year 2 - Calendar Year 2028	$60,912,000	$61,717,000	$60,486,000	$73,874,000
Year 3 - Calendar Year 2029	$67,523,000	$68,415,000	$67,050,000	$81,891,000
Total Projected 3-Year Costs	**$183,384,000**	**$185,808,000**	**$182,100,000**	**$222,406,000**
Difference from Lowest Cost Proposal - $	$1,284,000	$3,708,000	$0	$40,306,000
Difference from Lowest Cost Proposal - %	0.7%	2.0%	0.0%	22.1%
Financial Score*	**49.3**	**48.0**	**50.0**	**27.9**
Financial Rank	**2**	**3**	**1**	**4**

*** The Most Competitive proposal's Financial Score equals 50 points. 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.**

Important Notes:

1. Projections assume enrollment of 11,046
2. Caveats to these proposals are scored separately as part of the Price Proposal Commitment
3. CY 2028 and 2029 rates were estimated using a composite estimated trend of 10.9% for all bidders.

Attachment D

Overall Scoring Results – Separate MA/PDP

Category	Allocated Points	Aetna Percent	Aetna Points	Anthem Percent	Anthem Points	Humana Percent	Humana Points	UHC Percent	UHC Points
Financial: Total Projected Costs	50	99%	49.3	96%	48.0	100%	50.0	56%	27.9
Financial: Price Proposal Commitment	5	20%	1.0	0%	0.0	80%	4.0	40%	2.0
Network Match and Access	5	100%	5.0	89%	4.5	97%	4.8	98%	4.9
Performance Guarantees	10	87%	8.7	87%	8.7	86%	8.6	88%	8.8
Administrative, Member, & Claim Paying Services	8	94%	7.5	92%	7.4	92%	7.4	90%	7.2
Data Reporting & Star Rating Maximization	4	83%	3.3	83%	3.3	89%	3.5	98%	3.9
Enrollment, Implementation, & Communication	8	87%	7.0	91%	7.3	89%	7.1	92%	7.4
Medical Management & Member Case Management	5	95%	4.8	93%	4.6	90%	4.5	93%	4.6
Rx Formulary and Clinical Program Management	5	90%	4.5	88%	4.4	91%	4.5	88%	4.4
Total Score*	100		**91.0**		**88.1**		**94.5**		**71.2**
Total Rank			**[2]**		**[3]**		**[1]**		**[4]**

* The sum of category scores may not tie back to total score due to rounding.

FULLY INSURED GROUP MEDICARE ADVANTAGE AGREEMENT BETWEEN THE STATE OF NEW HAMPSHIRE, AND EMPHESYS INSURANCE COMPANY

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Subject: Fully-Insured Group Medicare Advantage Plan Administration

FORM NUMBER P-37 (version 2/23/2023)

Notice: The 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		1.2 State Agency Address 25 Capitol Street, Concord, NH 03301	
1.3 Contractor Name Emphesys Insurance Company (dba Humana)		1.4 Contractor Address 101 East Main Street, Louisville, Kentucky 40202	
1.5 Contractor Phone Number Joe Cowles, 859-983-2561	1.6 Account Unit and Class 60-66500000-102	1.7 Completion Date 12/31/2029	1.8 Price Limitation $215,227,000
1.9 Contracting Officer for State Agency Joyce I. Pitman, Director of Risk and Benefits		1.10 State Agency Telephone Number (603) 271-3080	
1.11 Contractor Signature Jill Tobin Date: 07/30/2026		1.12 Name and Title of Contractor Signatory Jill Tobin, SVP Group Medicare	
1.13 State Agency Signature Date: 7/30/26		1.14 Name and Title of State Agency Signatory Charles M. Arlinghaus, 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: Christen Lavers On: 7/30/26			
1.17 Approval by the Governor and Executive Council *(if applicable)* G&C Item number: G&C Meeting Date:			

Contractor Initials JT
Date 07/30/2026

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, 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.

3.3 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. 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 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, 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 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. 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.

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 80:7c or any other provision of law.

5.4 The State's liability under this Agreement shall be limited to monetary damages not to exceed the total fees paid. The Contractor agrees that it has an adequate remedy at law for any breach of this Agreement by the State and hereby waives any right to specific performance or other equitable remedies against the State.

6. COMPLIANCE BY CONTRACTOR WITH LAWS AND REGULATIONS/EQUALEMPLOYMENT 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 and the Governor's order on Respect and Civility in the Workplace, Executive order 2020-01. 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 age, sex, sexual orientation, race, color, marital status, physical or mental disability, religious creed, national origin, gender identity, or gender expression, and will take affirmative action to prevent such discrimination, unless exempt by state or federal law. The Contractor shall ensure any subcontractors comply with these nondiscrimination requirements.

Contractor Initials JT
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6.3 No payments or transfers of value by Contractor or its representatives in connection with this Agreement have or shall be made which have the purpose or effect of public or commercial bribery, or acceptance of or acquiescence in extortion, kickbacks, or other unlawful or improper means of obtaining business.

6.4. 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 this Agreement and all rules, regulations and orders pertaining to 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 The Contracting Officer specified in block 1.9, or any successor, shall be the State's point of contact pertaining to this Agreement.

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) calendar days from the date of the notice; and if the Event of Default is not timely cured, terminate this Agreement, effective two (2) calendar 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.

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) calendar 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) calendar 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. In addition, at the State's discretion, the Contractor shall, within fifteen (15) calendar days of notice of early termination, develop and submit to the State a transition plan for Services under the Agreement.

10. PROPERTY OWNERSHIP/DISCLOSURE.

10.1 As used in this Agreement, the word "Property" shall mean all data, 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.

Contractor Initials JT
Date 07/30/2026

10.3 Disclosure of data, information and other records shall be governed by N.H. RSA chapter 91-A and/or other applicable law. Disclosure 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 Contractor shall provide the State written notice at least fifteen (15) calendar days before any proposed assignment, delegation, or other transfer of any interest in this Agreement. No such assignment, delegation, or other transfer shall be effective without the written consent of the State.

12.2 For purposes of paragraph 12, 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.

12.3 None of the Services shall be subcontracted by the Contractor without prior written notice and consent of the State.

12.4 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. The Contractor shall indemnify, defend, and hold harmless the State, its officers, and employees from and against all actions, claims, damages, demands, judgments, fines, liabilities, losses, and other expenses, including, without limitation, reasonable attorneys' fees, arising out of or relating to this Agreement directly or indirectly arising from death, personal injury, property damage, intellectual property infringement, or other claims asserted against the State, its officers, or employees caused by the acts or omissions of negligence, reckless or willful misconduct, or fraud by the Contractor, its employees, agents, or subcontractors. 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 State's sovereign immunity, 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 any successor, a certificate(s) of insurance for all insurance required under this Agreement. At the request of the Contracting Officer, or any successor, the Contractor shall provide certificate(s) of insurance for all renewal(s) of insurance required under this Agreement. 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 any 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

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under applicable State of New Hampshire Workers' Compensation laws in connection with the performance of the Services under this Agreement.

16. WAIVER OF BREACH. A State's failure to enforce its rights with respect to any single or continuing breach of this Agreement shall not act as a waiver of the right of the State to later enforce any such rights or to enforce any other or any subsequent breach.

17. 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.

18. 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.

19. CHOICE OF LAW AND FORUM.

19.1 This Agreement shall be governed, interpreted and construed in accordance with the laws of the State of New Hampshire except where the Federal supremacy clause requires otherwise. 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.

19.2 Any actions arising out of this Agreement, including the breach or alleged breach thereof, may not be submitted to binding arbitration, but must, instead, be brought and maintained in the Merrimack County Superior Court of New Hampshire which shall have exclusive jurisdiction thereof.

20. CONFLICTING TERMS. In the event of a conflict between the terms of this P-37 form (as modified in EXHIBIT A) and any other portion of this Agreement including any attachments thereto, the terms of the P-37 (as modified in EXHIBIT A) shall control.

21. THIRD PARTIES. This Agreement is being entered into for the sole benefit of the parties hereto, and nothing herein, express or implied, is intended to or will confer any legal or equitable right, benefit, or remedy of any nature upon any other person.

22. 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.

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

24. FURTHER ASSURANCES. The Contractor, along with its agents and affiliates, shall, at its own cost and expense, execute any additional documents and take such further actions as may be reasonably required to carry out the provisions of this Agreement and give effect to the transactions contemplated hereby.

25. 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.

26. 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

The terms of this Form Number P-37 are modified as follows:

Section 4 "Conditional Nature of Agreement" shall be deleted in its entirety and replaced with the following: 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. 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 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, the State shall have the right to withhold payment until such funds become available, if ever and shall have the right to terminate Services under this Agreement immediately upon giving Contractor notice of such reduction or termination. Notwithstanding the foregoing, Contractor shall continue to provide coverage to members as required by CMS. 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.

Section 6.4 shall be amended to read: The Contractor agrees to permit the State or United States access to any of the Contractor's books, records and accounts directly related to the performance of this Agreement for the purpose of ascertaining compliance with this Agreement and all rules, regulations and orders pertaining to the covenants, terms and conditions of this Agreement.

Section 6.5 shall be added to read: The Contractor shall comply with all applicable requirements of the Centers for Medicare & Medicaid Services ("CMS"), including but not limited to 42 C.F.R. Parts 422 and 423, and all CMS guidance, instructions, and directives applicable to Medicare Advantage organizations and Part D plan sponsors operating Employer Group Waiver Plans.

Section 6.6 shall be added to read: The Contractor shall guarantee adherence to New Hampshire RSA 420-J:8-a regarding prompt pay, which mandates timeframes for all claims (15 days electronic, 30 days paper claims, overdue interest payment if timeframes are not met, denied and pended claims within 15 days electronic or 30 days paper and adjudicate within 45 days of receipt of additional information).

Section 8.2 shall be amended to read: Upon the occurrence of any Event of Default, the non-defaulting Party may take any one, or more, or all, of the following actions:

Section 8.2.1 shall be deleted in its entirety and replace with the following: 8.2.1 give the defaulting Party 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) calendar days from the date of the notice;

and if the Event of Default is not timely cured, terminate this Agreement, effective no sooner than thirty (30) calendar days after giving the defaulting Party notice of termination;

Section 9.3 shall be added to read: The Contractor may terminate this Agreement upon two hundred ten (210) days' prior written notice or a different timeframe that is mutually agreed upon subject to Exhibit C.

Section 10.2 shall be deleted in its entirety and replaced with the following: All data and any Property which has been received from the State, 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.

Section 12.1 shall be deleted in its entirety and replaced with the following: Contractor shall provide the State written notice within fifteen (15) calendar days of any proposed assignment, delegation, or other transfer of any interest in this Agreement becoming public knowledge.

Section 12.4 shall be deleted in its entirety and replaced with the following: The State is entitled to relevant portions of all subcontracts and assignment agreements, subject to mutually agreeable redactions of confidential and proprietary information, and shall not be bound by any provisions contained in a subcontract or an assignment agreement to which it is not a party.

Section 14.1 shall be deleted in its entirety and replaced with the following: The Contractor shall, at its sole expense, obtain and continuously maintain in force the following insurance.

Section 14.1.3 shall be added to read: data security and cyber-liability insurance in an amount not less than $10 million.

Section 14.4 shall be added to read: Contractor shall ensure that subcontractors maintain insurance commensurate with the service provided by subcontractor.

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EXHIBIT B - SCOPE OF SERVICES

This EXHIBIT B sets forth the services and obligations to be performed by the contractor in the Agreement between the State of New Hampshire ("State") and Emphesys Insurance Company (hereinafter referred to as "Contractor" or "Humana") and sets forth the services and obligations to be performed by the Contractor.

Emphesys Insurance Company holds a contract with CMS. ~~and~~ Humana Inc. is the parent entity of Emphesys Insurance Company. Emphesys Insurance Company, Humana Insurance Company, and Humana Insurance Company of New York are all subsidiaries of Humana Inc. and are affiliates to each other (collectively Humana).

This Agreement shall commence upon approval of the Governor and Executive Council (the "effective date"), through December 31, 2029, with the option to extend for up to three (3) additional one-year extensions, exercised individually or combined, as mutually agreed by the parties and approved by the Governor and Executive Council (G&C). The implementation period shall commence within seven days of G&C approval. The services outlined in this Agreement shall commence on January 1, 2027. Payments for contractual services shall commence January 1, 2027, and shall not be made during the implementation period.

SECTION A – MA/PDP PLAN

ARTICLE A1 - PURPOSE

State has requested Humana to provide health insurance coverage to its eligible retirees and other eligible individuals as described in this Exhibit. Humana's standard operating procedures, as they may be amended from time to time, will be used in the performance of services specified in this Exhibit and the provision of benefits described in the Evidence of Coverage. In the event of a conflict between the standard operating procedures and the Agreement, the Agreement shall control.

Humana shall administer this MA/PDP Plan consistent with applicable State law and eligibility guidelines, subject to the provisions of Article A15, paragraph L below. The MA/PDP Plan will be administered as a "Passive PPO" with integrated prescription drug coverage, as defined below.

ARTICLE A2 - DEFINITIONS

In this Exhibit, the following terms will have the meanings set forth below. Capitalized terms used in this Exhibit that are not defined below are defined in the Evidence of Coverage.

Application. Any mutually agreed upon enrollment mechanism, including, without limitation, paper applications provided by Members or State and spreadsheets or electronic enrollment files.

Confidential Information. Confidential information means any information disclosed by a party to the other party that should reasonably be considered to be of a confidential nature, including without limitation, business plans, financial information, pricing, rates, technology, know-how, trade secrets and proprietary information.

Covered Service. Any hospital, medical, prescription or other health care service rendered to Members for which benefits are provided pursuant to the Evidence of Coverage.

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Creditable Coverage. Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines.

Eligible Person. Eligible Person means a retiree of the State or his or her eligible spouse, surviving spouse, or dependent who is:

(1) not otherwise covered under a group health plan where Medicare pays primary,
(2) Medicare eligible for both Parts A and B if the Plan is an MA or MA/PDP plan or Medicare eligible for Parts A and/or B if the Plan is a PDP,
(3) eligible to participate in the State's post-retirement health benefits program under State law and eligibility guidelines, and
(4) eligible to enroll in a plan offered by Contractor pursuant to applicable Laws.

Enrolled Member
"Enrolled member" means an Eligible Person who has elected to enroll in a Plan offered by Contractor made available through State's enrollment process and whose enrollment has been confirmed by Contractor.

Evidence of Coverage. The Evidence of Coverage document (hereinafter "EOC") means the document issued annually to each Enrolled Member that outlines benefits and coverage under the Enrolled Member's particular Plan. The Evidence of Coverage is subject to CMS approval and will be provided to State when it becomes available prior to the Plan Effective Date and on an annual basis thereafter for any Renewal Plan Years. The Evidence of Coverage documents are applicable to all Enrolled Members, as may be amended, are hereby incorporated by reference and made part of this Agreement. The Evidence of Coverage also defines the rights and responsibilities of the Member and the Plan.

Late Enrollment Penalty. A penalty amount imposed by CMS and added to a Member's monthly premium if the Member has gone without Medicare Part D Prescription Drug Coverage or other Creditable Coverage for a continuous period of 63 days or more before enrolling in the Part D Plan.

Law. Law means any federal, state, or local law, statute, regulation, ordinance, code, rule, order, or other similar requirement enacted, adopted, or enforced by a government authority, including, without limitation, Medicare laws and CMS regulations and requirements, including CMS manuals, CMS payment methodology, and other directives.

Low-Income Subsidy. A Medicare subsidy program to assist Eligible Individuals with limited income and resources to pay Medicare prescription drug program costs.

Mandates. Mandates means applicable laws, regulations and government requirements in effect during the terms of the Agreement including, without limitation, applicable Medicare laws, regulations and CMS requirements (including CMS manuals, memo guidance and other directives).

Medicare Passive PPO. A Medicare Passive PPO Plan is a type of Medicare Advantage Plan (Medicare Part C) offered by a private insurance company in which the plan design is the same for both in and out-of-network providers. As long as the provider accepts Medicare, a member will receive the same level of coverage regardless of whether the provider participates in the Plan's network.

Member. A Medicare beneficiary who (i) who is eligible to receive Covered Services, (ii) who has enrolled in the MA/PDP Plan, and (iii) whose enrollment has been confirmed by CMS.

Prescription Drug Coverage. Prescription drug benefits offered through the MA/PDP Plan that provide Medicare Part D Prescription Drug Coverage, which helps pay for certain outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B, combined with non-Medicare prescription drug coverage that supplements the Part D coverage.

Provider. A duly licensed physician, health professional, hospital, pharmacy or other individual, organization and/or facility that provides health services or supplies within the scope of an applicable license and/or certification and meets any other requirements set forth in the Evidence of Coverage.

ARTICLE A3 - IMPLEMENTATION

3.A Implementation services will commence upon the Effective Date of the Agreement. However, payment under the Agreement shall not commence until January 1, 2027. Parties agree to collaborate and establish protocols and processes for managing MA/PDP Plan services.

3.B Humana will develop a detailed implementation plan that will contain tasks to be completed by Humana and/or State and a timeframe for completion of each task. The implementation plan will encompass all required implementation steps to include both the medical and pharmacy benefits. The implementation plan will also contain measurement periods specific to each task. The implementation plan shall be modified as necessary, as mutually agreed by the Parties.

3.C The implementation plan shall include a process for the Parties to mutually agree to all administrative forms including those related to enrollment, changes and terminations, to the extent allowed under CMS regulations.

3.D Humana agrees to provide a total allowance of $150,000 to be used for both implementation and pre/post implementation audit allowances. The stipulations of these allowances are included in Exhibit C – Pricing and Payment Terms of this contract.

ARTICLE A4 - ELIGIBILITY AND ENROLLMENT

4.A Only Eligible Individuals may be enrolled in the MA/PDP Plan, per specified eligibility rules established by the State. The MA/PDP Plan shall cover all eligible current and future individuals, including disabled members under age 65 and members with end-stage renal disease (ESRD), that would be covered under the current Medicare retiree medical and prescription drug benefit plans, subject to CMS guidelines.

4.B Enrollment. The State shall offer enrollment in the MA/PDP Plan in compliance with all applicable Mandates as follows:

i The State shall enable all eligible individuals to enroll in the MA/PDP Plan within 31 days of becoming eligible to receive coverage under the MA/PDP Plan.

ii If an eligible member does not elect to enroll upon initial eligibility, they retain the right to participate at any time during the year upon completion of enrollment process.

All eligible individuals and dependents not enrolled in the MA/PDP Plan(s) within 31 days of becoming eligible may be enrolled at any time during the year upon completion of appropriate

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enrollment forms and proof of Medicare Part A and B enrollment. Coverage under the MA/PDP Plan(s) will not become effective until confirmed by Humana.

4.C Enrollment/Disenrollment Processing. The Parties shall agree in advance who shall bear responsibility for enrollment and disenrollment transactions. The Party bearing responsibility for enrollment/ disenrollment transactions shall perform the function in accordance with all applicable Mandates, including Mandates relating to timeframes for processing and submission of such transactions. All processing by Humana will be in accordance with the guidelines established by CMS and augmented by the State where applicable. All of the enrollment and disenrollment requirements described in this Exhibit also apply to any third-party administrator retained by the State to accept enrollment/disenrollment requests on its behalf.

The State must notify Humana of the date in which a Member's eligibility ceases for the purpose of termination of coverage under the Agreement.

4.D Eligibility Data. Humana agrees 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 mutually agreed upon by the State and Humana.

Humana agrees to accept and process an Interface file from the State twice per week, on dates agreed upon by the State and Humana, to ensure timely subscriber eligibility and enrollments. Upon acceptance of the file by Humana, Humana agrees to process each file within 24 hours of receipt of file.

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 Humana 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, contractors are required to retrieve eligibility and enrollment data, from this server. In addition, contractors and/or subcontractors will be required to use this method for sending/receiving any other agreed upon data files to the State.

Humana shall provide the State with a Transaction Reply Report (TRR) after each interface file is received and uploaded.

4.E Any retroactive disenrollments must be submitted by Humana to CMS for approval. The State or its designee shall be responsible for providing Humana with applicable data or information required to substantiate Humana's request to CMS for such retroactive disenrollment.

ARTICLE A5 - OBLIGATIONS OF HUMANA

5.A Humana will file all the necessary documents with governmental agencies as appropriate in order to file as an Employer Group Waiver Plan matching the current level of benefits provided by the State.

5.B Humana shall provide Plan services to Enrolled Members, as described in this Agreement and the applicable Evidence of Coverage ("Services"). However, in no event will Humana provide benefits for

services rendered prior to the Effective Date or after the termination of the Agreement, or for any period for which full premium payment has not been paid to Humana, except as otherwise provided in the Evidence of Coverage and/or applicable CMS requirements.

5.C Humana shall furnish or make available an identification card, Evidence of Coverage and all other CMS-required documents for each Member enrolled in the MA/PDP Plan(s) covered by the Agreement.

5.D Humana shall furnish appropriate Application forms and related material necessary and appropriate for the enrollment of Members, and shall provide such assistance to the State or its designee as may be reasonably necessary for enrollment purposes. Humana shall maintain current eligibility status records in accordance with the Eligibility Notice(s) submitted by the State or its designee for the purpose of administering the Agreement.

5.E Humana shall send a Creditable Coverage attestation form to applicable Members in accordance with CMS guidelines regarding the administration of any Late Enrollment Penalty that may be imposed by CMS.

5.F Any Late Enrollment Penalty assessed as a result of a lapse or other gap in Creditable Coverage, may be paid by State on behalf of its membership. If the State chooses not to pay such Late Enrollment Penalties for its Members, Humana will bill the applicable Member directly for any Late Enrollment Penalty assessed by CMS.

5.G Per CMS requirements, the Evidence of Coverage provided by Humana includes information on programs to help Members with limited resources pay for their prescription drugs.

5.H Humana is responsible for pursuing recoveries of claim payments as appropriate and as required or allowed by law. Humana shall determine which recoveries it will pursue in its discretion. However, Humana may not pursue a recovery if the cost of collection is likely to exceed the recovery amount, or if the recovery is prohibited by law or by an agreement with a Provider or other vendor.

5.I Humana will review, investigate, process and pay claims according to the terms and conditions of the Agreement, the Evidence of Coverage, and Humana's contracts with Providers or other vendors. Humana may make benefit payments to either Providers or Members as described in the Evidence of Coverage, and will coordinate benefits with other payors as required by law. Humana will give notice in writing to the Member when a claim for benefits has been denied. The notice will provide the reasons for the denial and the right to an appeal of the denial in accordance with the procedures set forth in the Evidence of Coverage.

5.J Each Party is accountable for its subcontractors', affiliates', and subsidiaries' performance. Such performance is held to the same performance standards as the Party and subcontractor's failure to perform places the accountable Party at risk. Humana shall be responsible for all performance guarantee penalties that may result from underperformance of any Humana subcontractor, affiliate, or subsidiary.

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5.K Subsidiaries, Affiliates, Partner Networks, and Subcontractors. Humana shall notify the State of any service provider or system change whether the new provider is, or the new system is run by, a subcontractor, subsidiary, affiliate, Humana, or another entity. Such notification shall be required during implementation and throughout the term of the Agreement. Humana 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 entity. (See Appendix V for list).

ARTICLE A6 - OBLIGATIONS OF STATE

6.A The State or its designee shall keep such records and furnish to Humana such notification and other information as may be reasonably required by Humana for the purpose enrolling and disenrolling Members, processing terminations, or for any other purpose reasonably related to the administration of the Agreement. The State or its designee will give notification of eligibility to each Member who is or will become eligible for enrollment, and will submit to Humana the appropriate information necessary to enroll the member.

6.B The State or its designee will timely distribute to Members notices of premium changes and termination of the Agreement. Notice by Humana to the State shall be deemed to constitute notice to all Members in order to effectuate any such change or termination; provided, however, that Humana reserves the right to provide any such notice(s) to Members if Humana deems it appropriate, contingent upon State approval. State or its designee shall comply with all applicable laws and regulations relating to the distribution of notices and information to Members.

6.C State hereby acknowledges, agrees and certifies its compliance during the term of the Agreement with the following requirements as they relate to State's MA/PDP Plan(s).

Premium – State hereby agrees and certifies, as to Member premium, if any, that:

(i) Different amounts can be subsidized by State for different classes of Members in an MA/PDP Plan, provided such classes are reasonable and based upon objective business criteria (i.e., years of service, business location, job category, nature of compensation). Different classes cannot be based on eligibility for the Part D Low Income Subsidy. Accordingly, State hereby certifies that such classes (if any) are reasonable and based upon objective business criteria.

(ii) The premium within a given class does not vary by Member;

(iii) With regard to the Part D premium, Members cannot be charged for prescription drug coverage provided under the MA/PDP Plan more than the sum of his or her monthly premium attributable to basic prescription drug coverage and 100% of the monthly premium attributable to his or her non-Medicare Part D benefits (if any); and

(iv) State must pass through any direct subsidy payments received from CMS to reduce the amount that the Member pays (or in those instances where the Member in the State's MA/PDP Plan pays premiums on behalf of a Medicare-eligible spouse or dependent, the amount the Member pays).

ARTICLE A7 - NOTICES

The State shall notify all Members of the termination of the Agreement. In the case of changes to the Evidence of Coverage, Humana shall provide notice to all members, as required by CMS. Any such notice shall be subject to review by the State.

ARTICLE A8 - CHANGES IN THE AGREEMENT

Subject to Section 18 of the P-37, Humana may change the benefit provisions and the terms and conditions thereof as a result of changes in benefit provisions or other requirements mandated by CMS or federal law, or changes in benefit provisions agreed to by the Parties in writing. Humana will provide written notice to the State not less than 60 days before the effective date of any such change (other than mutually agreed changes) or such shorter notice as may be required to comply with CMS or federal laws changes. State can also propose changes to the benefit provisions at any time by giving 45 days advance written notice of any such requested change to Humana. The effective date of such requested changes, if agreed to by Humana, shall be agreed to by the Parties.

ARTICLE A9 - TERMINATION AND/OR SUSPENSION OF PERFORMANCE

Upon termination of the Agreement, Humana shall cease to have any liability for benefits or claims incurred after the effective date of termination (except as may be otherwise provided in the Evidence of Coverage), and shall have no liability to offer continuation or conversion coverage to Members. In the event of a future change in contractor to provide similar services to State, Humana shall provide the necessary services and claims data to avoid disruption to members at no cost to the State.

ARTICLE A10 - TERMINATION OF COVERED PERSONS

In addition to Humana's termination and cancellation rights described in the Evidence of Coverage, Humana reserves the right to cancel or rescind any health care benefits provided hereunder to any Member who, in Humana's determination, engages in misrepresentation and/or fraudulent conduct in relation to any Application for coverage or any claims made for coverage or under the Agreement.

ARTICLE A11 - DATA REPORTS

11.A Humana will provide State the Part C Medicare Membership Reports (MMR) upon request, once per year after the risk score updates in January and July, including all fields as received from CMS.

11.B Humana will provide State the Part C Model Output Reports (MOR) upon request, no more often than once annually and within thirty days of request, including all fields as received from CMS.

Additionally, the PlanCompass report containing clinical utilization information will be produced annually after the completion of the Initial Plan Year and will be provided within five months of the end of each Renewal Plan Year.

11.C Humana agrees to provide the State and/or designated health care consultant all CMS revenue reports (e.g., CMS direct subsidy; Federal reinsurance payments, Manufacturer coverage gap discounts, Low-income subsidies) and pharmacy rebates and other manufacturer revenue on a quarterly basis by the 25th

of the month following the end of the quarter.

11.D Humana agrees to provide such additional reports as mutually agreed to in writing by Humana and the State. Standard reports are existing reports that Humana can run by changing report parameters. Ad-hoc requests include non-standard reports, or reports entailing actuarial or underwriting analysis. Such reports shall be provided by Humana within seven (7) business days unless otherwise mutually agreed and may be subject to an additional charge depending on complexity, and within a mutually agreeable timeframe.

11.E Subject to the requirements and limitations of applicable privacy laws, including, without limitation, HIPAA, Humana will provide State and other third parties as directed by the State with claim line detail for all claims including, but not limited to, financial and diagnoses information upon request at no additional cost. Claim line detail is not included for pharmacy claims. If Ingredient Cost and Dispense Fee are provided in separate fields, the Pharmacy NPI and Pharmacy Type will not be included. If Pharmacy NPI and Pharmacy Type are required, the Ingredient Cost and Dispense Fee will be blended into one field.

11.F The provisions of reports by Humana to the State shall be subject at all times to the requirements and limitations of applicable privacy laws, including, without limitation, HIPAA.

ARTICLE A12 –MEDICARE ADVANTAGE PROGRAM FOR PPO

12.A Medicare Advantage Passive PPO Plan.

Humana shall provide a Medicare PPO plan with a nationwide network for retirees residing within the 50 United States, its territories, and District of Columbia. Humana shall maintain reciprocity between the Medicare PPO, local, and regional networks. Non-participating provider claims shall be allowed at 100% of the Medicare fee schedule based on the provider's location and be processed based at the member's non-par benefit. Humana shall also provide a passive PPO plan where members have the same benefit level for any provider (participating or nonparticipating) that accepts Medicare and the Medicare Advantage plan's payment terms.

12.B Member Liability Calculation. When a Member receives Covered Services outside of the MA/PDP Plan service area from a Medicare Advantage PPO network provider, the cost of the service, on which Member liability (copayment/coinsurance) is based will be either:

i. The Medicare allowable amount for Covered Services; or
ii. The amount Humana negotiates with its provider on behalf of MA/PDP Plan Members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

12. C Out-of-Country Travel. Emergency or urgently needed care is covered while traveling outside the United States during a temporary absence of less than six months. Medically necessary emergency and urgently needed outpatient care and inpatient care (60 days per lifetime) is covered. This coverage is worldwide and limited to what is allowed under the Medicare fee schedule for the services received in the United States. Members may also access online and via telephonic services Humana offers.

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ARTICLE A13 - AGREEMENT ADMINISTRATION

13. A Humana has the authority to determine eligibility for benefits under the Agreement. Humana also has the authority to resolve all questions arising under the Evidence of Coverage and to establish and amend the policies and procedures with regard to the administration of benefits under the Evidence of Coverage. Humana's authority to determine eligibility for benefits shall be exercised consistently with the provisions of the Agreement, the Evidence of Coverage, applicable Provider agreements, and applicable law.

13. B Humana shall furnish a draft Evidence of Coverage to the State. The Parties shall agree upon any changes to the Evidence of Coverage that may be necessary and/or in the best interest of Members. In the event changes to the provisions of the Evidence of Coverage are mandated as a result of a change to any applicable State or federal law, the Parties shall meet and determine the best manner to change the terms of the Evidence of Coverage to conform to such law. In the event of material changes to the Evidence of Coverage, the Humana will provide timely notice of such changes to Members. No change to the Evidence of Coverage shall be effective unless and until approved in writing by an authorized representative of each Party. Notwithstanding the foregoing, the Parties acknowledge and agree that only those portions of the Evidence of Coverage to which CMS allows modifications may be modified by the foregoing procedures, and then only in accordance with CMS requirements.

13. C Humana may waive or modify any referral, authorization, or certification requirements, benefit limits, or other processes contained in the Evidence of Coverage if such waiver is in the best interest of a Member or will facilitate effective and efficient administration of claims.

13. D Humana may, from time to time, institute pilot or test programs regarding disease management, utilization management, case management and/or wellness initiatives. Such initiatives may impact some, but not all Members. Humana reserves the right to discontinue a pilot or test program at any time without notice.

13. E Humana will have sole responsibility for resolving appeals from claim decisions, consistent with applicable law.

13. F All statements made by State and any Member will be considered representations and not warranties.

ARTICLE A14 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

14. A All capitalized terms used but not defined in this Article have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

14. B Humana may disclose Summary Health Information to State for purposes of obtaining premium bids from other carriers or third-party payers, or for amending or terminating the MA/PDP Plan or as is required by the State under Article A11 -Data Reports.

14. C Humana may disclose Protected Health Information ("PHI") to State for it to carry out Plan administration functions, but such disclosure may occur only after receipt of written certification from State that: (1) State's MA/PDP Plan documents and operations comply with the privacy requirements of HIPAA; (2) State has provided notice to affected individuals as required by HIPAA; and (3) PHI will not be used for the

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purpose of employment-related actions or other actions not related to administration of benefits under the MA/PDP Plan or permitted by law.

14. D Humana will comply with any additional disclosure restrictions required by applicable state and federal law.

ARTICLE A15 - MISCELLANEOUS

15. A Humana hereby notifies State that Humana or its vendors may have reimbursement contracts with certain providers for the provision of and payment for health care services and supplies provided to, among others, Members under the Agreement. Under some of these contracts, there may be settlements which require Humana to pay the providers or vendors additional money (which may or may not be solely funded by Humana) or which require the providers or vendors to return a portion of volume discounts, rebates, or excess money paid. Such providers or vendors may include entities affiliated with Humana. Under many provider or vendor contracts, the negotiated reimbursement does not contemplate any type of settlement between Humana and the provider or vendor. State has no responsibility for additional payment to vendors nor any right to discounts, rebates, or excess money received from vendors.

15. B All Members enrolled under the Agreement shall have only the rights and benefits, and shall be subject to the terms and conditions, set forth in the Agreement and in the Evidence of Coverage, and as granted by applicable State and federal law, and subject further to the provisions of Article A15, paragraph L below.

15. C Humana agrees to treat all proprietary information about State's operations and its MA/PDP Plan in a confidential manner. State agrees to treat all information about Humana's business operations, rate and discount information, and other proprietary data or information in a confidential manner, subject to applicable state disclosure laws which may require disclosure. Neither Party will disclose proprietary information to any other person without the prior written consent of the Party to whom the information pertains. However, either Party may disclose such information to its regulators, legal advisors, lenders, business advisors, and other third parties for purposes related to the subject matter of the Agreement, or for research purposes. Humana may also make such disclosures as required or appropriate under applicable securities laws. If a Party is required by law to make a disclosure of any proprietary information, the disclosing Party will immediately provide written notice to the other Party detailing the circumstances and extent of the disclosure. Humana agrees that all provisions of this Agreement are subject to the State's requirement to comply with RSA Chapter 91-A, the State's right-to-know law. Humana further agrees that the Agreement and its Appendices constitute a public document and will be posted on the State's website in its entirety.

15. D The Parties acknowledge that Humana is not engaged in the practice of medicine; it merely makes decisions regarding the coverage of services. Providers participating in MA/PDP Plan's networks are not restricted from exercising independent medical judgment regarding the treatment of their patients, regardless of Humana's coverage determinations.

15. E Care Management Programs. Humana will offer programs that are designed to improve member quality of care, ensure access to Covered Benefits or coordinate care delivered to members under the MA/PDP Plan ("Care Management Programs").

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15. F Humana will administer Care Management Programs consistent with any applicable mandates. The State acknowledges that Humana may alter or discontinue the Disease and Care Management Programs offered to members at any time, consistent with all mandates. Humana will provide the State timely notice of any additions or deletions to the Care Management Program.

15. G Incontestability. Except as to a fraudulent misstatement, or issues concerning Premiums due: No statement made by the State, or any member shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.

15. H Compliance with Mandates. The State and Humana shall comply with all Mandates applicable to the performance of their obligations under the Agreement. The Parties shall comply with the applicable provisions of the CMS/Regulatory Addendum, which is designed to ensure the State's and Humana's compliance with specific Mandates.

15. I Clerical Errors. Clerical errors or delays by either Party in keeping or reporting data relative to coverage will not reduce or invalidate a member's coverage. Upon discovery of an error or delay, an adjustment of Premium shall be made. Humana may also modify or replace an EOC or other document issued to member in error.

15. J Medicare Secondary Payer Requirements. Humana agrees to comply with all Medicare Secondary Payer ("MSP") mandates that apply to the State, MA/PDP Plan and Humana.

15. K Parties agree and understand that the Agreement is the controlling document for all legal purposes. The terms of the Agreement may not be altered or changed without the advance written agreement of both Parties, and subject to Section 18 of the P-37.

15. L Reference is made to the provisions of 42 C.F.R. §422.402, as supplemented by Chapter 10 of the Medicare Managed Care Manual, regarding federal preemption of state laws with respect to Medicare Advantage plans, including Employer State Waiver Plans, offered by Medicare Advantage organizations. Such plans are required to abide by all applicable federal laws, regulations and CMS or other federal agency rules, guidance or other requirements promulgated with respect to such plans (collectively, "Medicare Laws"). Any obligations of Humana in any agreement to which this Exhibit is attached or made a part of to comply with or based upon the requirements of state or local law, regulations or guidance, including, without limitation, regulations or guidance issued by state or local governmental agencies, shall not be binding on the MA/PDP Plan, which shall comply with applicable Medicare Laws in all aspects of MA/PDP Plan governance and operations.

ARTICLE A16 – MEMBER COMMUNICATIONS

16. A CMS determines whether material sent to Member relating to the MA/PDP Plan ("Member Materials") may be modified. In some cases, CMS mandates the content of Member Materials and permits no modifications. The State reserves the right to review all CMS mandated member materials prior to distribution.

16. B To the extent permitted by CMS and consistent with Mandates, Humana's Account Team and professional Marketing Team will work closely with the State to draft, review and finalize Member Materials and obtain the State's approval prior to sending to Members. As of the Effective Date of the Agreement, CMS will allow the State to modify and approve the following Member Materials, whether in written or electronic form, prior to sending to Members:

- Announcement Letter
- Info Packet cover letter
- Enrollment kit brochure (client logo/cobranded)
- Meeting Invite Mailer
- State of New Hampshire-specific Retiree Health Educational PowerPoint Deck (web-based)
- ID Card (client logo/ select benefit cost shares)
- Evidence of Coverage (EOC) (State review and co-branding only)
- And any pre-enrollment documents that relate to Services and/or the State's MA/PDP Plan.

16. C The EOC is made available online on an annual basis or Members may request a printed copy by calling Humana's member services team. Humana will provide State with the EOC at least 90 days prior to the beginning of each plan year, dependent upon the State's confirmation of required paperwork.

16. D Upon the State's request, Humana will share samples of post-enrollment standard Member correspondence and will work with the State to provide notice of upcoming planned Member mailings. The State acknowledges that operational notices (including, but not limited to, clinical program notifications, preventive reminders, and Explanations of Benefits) mandated by CMS cannot be altered by the State ("Operational Notices"); therefore, Humana will not obtain the State's approval of such Operational Notices prior to mailing. Humana will share sample materials during the implementation process, unless the material is new after the implementation process.

16. E Humana confirms that the State will be provided an opportunity to review and approve all communication materials that are not Operational Notices (including letters, brochures, electronic, website, etc.) prior to being sent to members.

16. F Humana shall issue member ID cards and, if applicable, other mutually agreed upon materials to Enrolled Members. Unless otherwise stated or mutually agreed to by the parties, all costs associated with new ID cards, replacement cards, Enrolled Member communications, or marketing materials, including production, will be the responsibility of Humana.

Humana will mail, via surface mail, a member ID card to all members at least fifteen (15) business days before the "go-live" date based on the information confirmation from CMS. Humana will mail ID cards to newly enrolled members within fifteen (15) business days of receiving acceptance from CMS. Humana will re-issue the member ID card within five (5) business days of notice if a member reports a lost card or for any reason that results in a change to the information disclosed on the member ID card. Humana will issue new member ID cards as required by the State, at its expense.

16. G The State and Humana will work together to develop a Member outreach process through which the State and Humana attempt to confirm a Member's residential street address. Upon confirming the

Member's residential street address, Humana will update the Member's records and submit the updated address to CMS and provide to the State in a mutually agreed upon format and process.

16. H Humana will discuss with the State and have them approve any additional Member Materials that may be sent to Members at the option of the State.

16. I For any Member Materials that the State determines may cause Member confusion, Humana will draft talking points for the State's member services department upon the State's request.

16. J Humana's member website shall be available to members 24 hours per day, 7 days per week, 365 days per year. In the event of a system downtime, advanced notice shall be provided to members with minimal interruption. The Humana agrees to no interruptions or blackout periods to the member website, except for scheduled maintenance. Functionalities should include at a minimum:

- Provider directory and provider search (physician, hospital, pharmacy, and ancillary providers) for Providers that accept Medicare assignment)
- Directions to provider's office provided by Map Quest or other mapping/direction applications
- Ability to review claims payment status online
- Ability to review a history of claims payments (medical and pharmacy), including deductible status, and out-of-pocket maximum status
- Ability to see a summary of the State's MA/PDP Plan design and review the EOC
- Ability to print ID cards and request replacement cards
- Ability to contact Member Services online
- Star Ratings
- Information about diseases and conditions
- Contact information for the State, its other vendors, and links to their websites
- Online access to forms
- Ability to review/select incentives (i.e., gift cards) when they are available to the member.

ARTICLE A17 – MEMBER SERVICES

17. A Humana, at its own expense, will provide toll-free telephone access to Customer Service representatives to assist State and Enrolled Members with benefit issues, locating participating providers and pharmacies, and other related Enrolled Member concerns. This service will be available Monday - Friday 8:00 a.m. – 9:00 p.m. Eastern Time.

17. B Humana should describe the member services center servicing the State, where is it located, hours or operation and the process for member to follow when they call in and go through IVR and process for after-hours support.

17. C Humana will have special telephone features for the hearing impaired.

17. D Humana will provide resources will be available to assist non-English speaking callers through a translation service.

17. E Humana will warm or soft transfer members to other service areas or vendors including the State, if necessary.

17. F Humana confirms members will be able to opt out of the Interactive Voice Response (IVR) to speak with a live MSR.

17. G Humana confirms all calls will be recorded and kept for 24 months and made available for the State's review upon request.

17. H Humana agrees to document 100% of the State's member service calls through call recordings and call notes, except during periods of routine system maintenance, updates, and unplanned outages. Subject to HIPAA requirements, the State may listen to calls on-site at Humana.

17. I Humana will handle all initial internal and external appeals in accordance with CMS requirements and guidelines.

17. J Humana will handle any and all grievances in accordance with CMS requirements and guidelines.

17. K Humana shall provide member access to an on-line member website that will provide access to provider directory and provider search (physician, facility, pharmacy and ancillary providers) as well as the ability to access a summary of the State's MA/PDP Plan design and review/download the EOC.

17. L Humana agrees to provide access to designated State representatives to an on-line Employer Portal, which will provide access to various resources and member information, including:

- Member enrollment status
- Member effective dates and termination dates
- Summary information and coverage details
- Eligibility rosters
- Ability to download and print plan documents and forms
- Retiree contact information
- Ability to view, print and request ID cards
- Other helpful contact and resource information

ARTICLE A18 – ACCOUNT MANAGEMENT

18. A Humana shall designate an MA/PDP Plan Account Manager who shall participate in the State's Integrated Account Management Model to manage the State Account ("Account Manager"). The Account Manager shall be responsible for coordinating the services provided by Humana to help ensure efficient and effective operations.

18. B If statewide educational sessions are required by the State, the Humana shall host said sessions for the State's Medicare-eligible retirees and Medicare-eligible dependents of retirees prior to the initial term of

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the Agreement. Humana shall conduct these meetings in all regions of the state on mutually agreeable dates as well as prepare and mail the communications announcing the sessions, at no additional cost. If limitations beyond the control of either Party prevent in person sessions, i.e., state of emergency, Humana shall provide alternative methods of education.

18. C Humana agrees to, at minimum, biweekly calls to review aggregate member or MA/PDP Plan service issues. Humana agrees to allow the State to review these service quality issues to the resolution endpoint.

18. D Humana agrees to provide appeal reports upon request, in accordance with their data release policy, which will include the volume of appeals received and closed, and the percentage of overturned appeals.

18. E Humana agrees to a minimum of one annual meeting with call center executives to discuss services regarding enrollment and member issues and/or complaints.

18. F Humana agrees to designate a dedicated member services lead for direct contact by the State team to escalate/resolve day to day individual member coverage issues, with established channel(s) for communication.

18. G Humana shall provide an annual scorecard to the State so that the State can assess the performance of the account team assigned to the State. The State and Humana will determine a mutually agreed upon scorecard.

18. H Humana confirms that all Member Service Representatives (MSR), clinical staff and other applicable team members are appropriately licensed or certified in the state in which they are employed.

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SECTION B – PART D PRESCRIPTION DRUG PLAN (PDP)

ARTICLE B1 – PURPOSE

Humana shall provide Part D prescription drug plan (PDP) coverage, utilizing Humana's Group Plus formulary to eligible retirees or other individuals in accordance with the terms of this Section B of Exhibit B to the Agreement. The Part D PDP is designed to supplement the standard Part D prescription drug coverage.

Humana's standard policies and procedures, as they may be amended from time to time, will be used in the performance of services specified in this Section B and the provision of benefits contained in the -Evidence of Coverage (EOC) (as defined below). In the event of a conflict between such policies and procedures and the Agreement, the Agreement shall control.

ARTICLE B2 – DEFINITIONS

Capitalized terms used in this Section B that are not defined in the Agreement above are defined in the Certificate of Coverage that describes the prescription drug benefits and services provided by Humana, including any amendments or schedules ("Evidence of Coverage (EOC)").

ARTICLE B3 – OBLIGATIONS OF HUMANA

A. Humana will provide non-Medicare supplemental prescription drug benefits under the terms of the Agreement and the EOC). Humana will not provide benefits hereunder: (1) before a Member's first day of coverage under the Agreement; (2) after the termination of coverage; or (3) during any period that full premium has not been paid, except as required by law.

B. Humana will provide either electronic or paper copy of materials such as EOC, ID cards and provider directories, as permitted under applicable law. State will assist in the distribution of materials if requested by Humana. Humana will provide paper copies of electronic materials, upon Member request.

C. Humana will process the enrollment of eligible individuals, subject to the terms of the Agreement, and Humana will maintain current Member eligibility information submitted by State.

D. Humana will process claims, including investigating and reviewing the claims to determine what amount, if any, is due and payable according to the terms and conditions of the Agreement and the EOC. Humana has the right to make benefit payments to either Providers or Members as described in the EOC. Humana will coordinate benefits with other payors. Humana will give notice in writing when a claim for benefits has been denied. The notice will provide the reasons for the denial and the right to an appeal of the denial under the terms of the EOC.

E. Humana is responsible for pursuing recoveries of claim payments as appropriate. Humana shall determine which recoveries it will pursue. However, Humana will not pursue a recovery if the cost of collection is likely to exceed the recovery amount, or if the recovery is prohibited by law or an agreement with a Provider or other vendor.

F. Humana shall not: (1) adjust premiums based on genetic information; (2) request genetic testing, except to determine medical appropriateness; (3) collect genetic information from a Member in connection with enrollment; or (4) collect genetic information for any other underwriting purpose.

G. Humana shall provide members access to the open formulary called the Group Plus formulary that covers most CMS allowable medications. Some medications may have clinical Utilization Management criteria requirements for prior authorization, step therapy, or quantity limits as determined by Humana and in accordance with CMS guidelines.

H. Humana agrees to comply with the State's plan design as it pertains to copayment for each drug tier.

I. Humana agrees to cover some therapeutic classes excluded or limited by CMS as an enhanced coverage option to minimize disruption between the State's current formulary and Humana's Group Plus formulary. Those included are Cosmetics, Cough/Cold, Dental products, Enhanced Erectile Dysfunction, Senior Care, Vitamins/Minerals, and Basic Weight Loss medications subject to certain limitations.

J. Humana, as another enhanced coverage option, agrees to provide the $0 Stars Medication Adherence Benefit to reduce member cost share and remove financial barriers for select generic medications from the three CMS Stars drug classes for Medication Adherence (Diabetes, High Blood Pressure, and High Cholesterol).

ARTICLE B4 – OBLIGATIONS OF STATE

A. State will provide initial eligibility information in the format agreed to by the Parties, as well as notice of additions, deletions, and changes to enrollment. State will also provide any information reasonably required by Humana to administer the Agreement, including information regarding: (1) eligibility for enrollment and termination of Members; (2) changes due to Medicare eligibility; or (3) participation levels.

B. State will notify each Individual as the Individual becomes eligible for enrollment and will collect and submit to Humana enrollment information.

C. All information provided by State to Humana will be true, accurate and complete to the best of its knowledge. In order to facilitate the distribution of materials, State will assist, where possible, with the collection of Member email addresses and Member consents to electronic transaction/communication in accordance with applicable State or Federal electronic transaction laws.

D. State will timely notify Humana of any Member termination or loss of eligibility for coverage. Any retroactive disenrollments from the MA/PDP Plan must be submitted by Humana to the Centers for Medicare & Medicaid Services ("CMS") for approval. The State shall be responsible for providing

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Humana with applicable data or information required to substantiate Humana's request to CMS for such retroactive disenrollment.

E. State must comply with Humana's participation levels, and other applicable underwriting rules that are consistent with applicable laws.

F. State will promptly notify Humana if there is a change in State's status as either a large group or small group, as defined under applicable law. In such event, State will provide all information requested by Humana about its status.

G. State agrees to distribute and deliver to its retirees and dependents, the Summary of Benefits and Coverage ("SBC") provided by Humana as required by federal law. The SBC must be provided with open enrollment materials or, if State does not hold an open enrollment, at least 30 days prior to the new plan year renewal date. An updated SBC provided by Humana will be posted by the State if the benefits change between the time of original distribution and the effective date of coverage. SBCs must also be provided to new enrollees and special enrollees. The State may distribute the SBC either electronically or by paper, subject to the requirements of applicable law. If requested by Humana, State will certify its compliance with the SBC distribution requirements.

H. State will timely notify Humana of requested benefit changes prior to the new plan year renewal date. A request for benefit changes after the new plan year renewal date may delay the effective date of the benefit changes by at least 60 days and require a notice of material modification.

I. State is responsible for all applicable requirements pertaining to COBRA administration, unless otherwise agreed to in writing by Humana. If Humana has agreed to perform any COBRA administration duties on behalf of State, such arrangement will be described in a separate agreement.

ARTICLE B5 – CHANGES TO BENEFIT PLAN OR EVIDENCE OF COVERAGE

The benefit coverage shall remain the same throughout the applicable plan year except as changes may be required by Law. If such changes are necessary, the Contractor will notify the State in writing as soon as reasonably practicable upon becoming aware of a pending change. Nothing in this paragraph shall be deemed to prohibit the enhancement of benefit coverage during the current plan year if mutually agreed to by Contractor and State.

Humana may modify the terms of the EOC by giving at least 60 days advanced written notice prior to the new plan year renewal date. State can also propose changes to the terms of the EOC at any time by giving written notice of any such requested change to Humana. The effective date of such changes requested to the EOC shall be agreed to by the Parties.

ARTICLE B6 – TERMINATION

A. State will promptly notify Members that the Agreement is or will be terminated and will provide any notice regarding a Member's right to other coverage. Humana will not provide benefits coverage for

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services rendered after the effective date of termination, except as otherwise provided in the EOC or required by law.

B. Termination of the Agreement for any reason shall automatically terminate the State's MA/PDPMA/PDP Plan. In addition, termination of the State's MA/PDP Plan for any reason shall automatically terminate the Agreement.

ARTICLE B7 – NOTICES

If requested by Humana, State will distribute notices and other communications to Members. State will notify all Members of the termination of the Agreement.

ARTICLE B8 – AGREEMENT ADMINISTRATION

A. Humana has the discretionary authority to determine eligibility for benefits under the Agreement. Humana also has the discretionary authority to resolve all questions arising under the EOC and to establish and amend the policies and procedures with regard to the administration of benefits under the EOC. In addition, Humana has all powers necessary or appropriate to carry out its duties in connection with the performance of services under the Agreement. Humana's authority to determine eligibility for benefits shall be exercised consistently with the provisions of the Agreement, the EOC, provider agreements, and applicable law.

B. Humana may waive or modify any authorization or certification requirements, benefit limits, or other processes contained in the EOC if such waiver is in the best interest of the Member or will facilitate effective and efficient claims administration.

C. Humana will have sole responsibility for resolving appeals from claim decisions, consistent with state and federal law. If State receives a question or complaint regarding benefits provided under the Agreement, State will advise the Member to contact Humana.

D. All statements made by State and any Member will be considered representations and not warranties. Additionally, no statement will be used to contest the validity of coverage after the Agreement has been in force for two years.

E. Humana assumes only those responsibilities that are expressly stated in the Agreement. Nothing contained in the Agreement will be construed to deem Humana as Plan Sponsor, Plan Administrator, or a Named Fiduciary for purposes of ERISA.

ARTICLE B9 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

A. All capitalized terms used in this Article have the same meaning as defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

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B. Humana may disclose Summary Health Information to State for purposes of obtaining premium bids from other carriers or third party payers or amending or terminating the Plan.

C. Humana may disclose Personal Health Information ("PHI") to State for it to carry out Plan administration functions, but such disclosure may occur only after receipt of certification from State that: (1) State's Plan documents comply with the privacy requirements of HIPAA; (2) State has provided notice to affected individuals as required by HIPAA; and (3) PHI will not be used for the purpose of employment-related actions or other actions not related to administration of benefits under the Plan.

D. Humana will comply with any additional disclosure restrictions required by applicable state and federal law.

ARTICLE B10 – MISCELLANEOUS

A. Humana agrees to treat all proprietary information about State's operations and its Plan in a confidential manner. The State agrees to treat all information about Humana's business operations, discount information, and other proprietary data in a confidential manner, subject to applicable state disclosure laws which may require disclosure. Neither Party will disclose proprietary information to any other person without the prior written consent of the Party to whom the information pertains. However, either Party may disclose such information to its legal advisors, lenders, business advisors, and other third parties for or research purposes. Humana may also make such disclosures as required or appropriate under applicable securities laws. If a Party is required by law to make a disclosure of any proprietary information, the disclosing Party will immediately provide written notice to the other Party detailing the circumstances of and extent of the disclosure. Humana agrees that all provisions of this Article 16 are subject to the State's requirement to comply with RSA Chapter 91-A, the State's right-to-know law. Humana further agrees that the Agreement and its Appendices constitute a public document and will be posted on the State's website in its entirety.

B. By performing the services under the Agreement, Humana is not engaged in the practice of medicine; it merely makes decisions regarding the coverage of services. Providers participating in Humana networks are not restricted from exercising independent medical judgment regarding the treatment of their patients, regardless of Humana's coverage determinations.

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EXHIBIT C – PRICING AND PAYMENT TERMS

This Exhibit C defines the payment terms, pricing, and pricing conditions for the services outlined in 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.

A. CONTRACT PRICE

Humana hereby agrees to provide Medicare Advantage with Prescription Drug coverage for State of New Hampshire Medicare-eligible Retirees and eligible dependents in compliance with the terms and conditions specified in this Agreement for an amount not to exceed the price limitation reflected in the Form P-37, Box 1.8 totaling $215,227,000.

B. TERMS OF PAYMENT

The State shall pay monthly premiums due to the Contractor on a Per Member Per Month (PMPM) basis for each member covered under the State's Plan in accordance with the Contractor's enrollment records at the PMPM rates set forth below.

The Total Per Member Per Month (PMPM) Premium Rates represents the full cost of all services including hourly rates, staffing, administration costs, travel costs and any other applicable costs in performing this contract unless otherwise agreed to by the State. The State shall not pay broker commissions for services rendered under this contract and any premium charged to the State shall be void of an agency fee or commission.

The State is not responsible for any fee or expense not outlined in this Exhibit C. In addition, all fees charged to the State shall be reported to the State upon request.

1. PMPM Premium rates are based on the data provided by the State, consistent with applicable laws.

2. Humana shall provide an invoice in a mutually agreed to format, which includes the PMPM price and the membership/enrollment counts. The Contractor shall included additional invoice support/detail with each invoice.

3. Humana does not have an obligation to accept a partial premium payment. State must make payments regardless of any contributions to those payments by Members.

4. The full invoice amount is due and payable on the 1st of each month during the term of the Agreement. The State is entitled to a 30-day period following the due date (the "Grace Period"), for the payment of any premium and/or other amounts due.

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C. INVOICING AND PREMIUM PAYMENTS

Humana shall invoice the State on a monthly basis for the Total PMPM Premium fees. The State will pay Humana upon acceptance of the invoice by check or ACH within 30 days from the date of the State's receipt of each invoice. If ACH, Humana shall set up the ACH payment option through the New Hampshire Department of Treasury.

Invoices shall be mailed or electronically submitted to the State's addresses below:

The State of New Hampshire Department of Administrative Services
Division of Risk & Benefits
25 Capitol Street
Concord, NH 03301

Electronic submission can be sent to: riskfinancebureau@das.nh.gov

The State reserves the right to request a membership listing upon request.

D. PER MEMBER PER MONTH (PMPM) PREMIUM RATES

State of New Hampshire – PPO- Non-Integrated, Sole Carrier Offering (NISCO)

Plan Names:	Humana Medicare Group Plan Passive PPO Custom Medical with Custom PDP Passive Waiver Custom Medical with Custom PDP
Rx Formulary	Group Plus Formulary - 27800
Additional Medication Buy-Ups:	Cosmetics, Coughs and Colds, Vitamins, Weight Loss Agents Standard, EDs Enhanced, Dental, Senior Care
Additional Services Included:	Hearing, Vision

	Plan Year	MA Only Rate	PDP Only Rate	Total PMPM Rate
Plan Year 1	1/1/2027 – 12/31/2027	$163.67	$242.64	$406.31
Plan Year 2	1/1/2028 – 12/31/2028	$199.52	$279.50	$479.02
Plan Year 3	1/1/2029 – 12/31/2029	$232.05	$319.88	$551.93

1. The MA Only Rate and PDP Only Rates are displayed for informational purposes only and are not available as standalone offerings. Both Rates are combined as the Total PMPM Rate and must be purchased concurrently in accordance with the Non-Integrated, Sole Carrier Offering (NISCO).

2. Humana develops rates by evaluating available claims experience, actual enrollment demographics, applicable risk adjustment, retention factors, trend projections, and CMS reimbursement levels. Renewal rates are established using actuarially sound methodologies and the best available information at the time rates are developed.

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3. The Total PMPM Rate for Plan Year 1 is a Guaranteed Rate for the full plan year. Going forward, the Contractor shall notify the State on or about May 1st prior to the new Plan Year of the need to adjust the rate with an explanation of the reason for the adjustment. The Contractor shall propose the adjusted premium rates with all supporting rate development no later than May 15th or a different timeframe that is mutually agreed upon.

4. If the renewal calculations for Plan Year 2 and/or Plan Year 3 result in a Total PMPM rate that is lower than the Total PMPM Rate reflected in the chart above, the lower rate shall apply. If the renewal calculations for Plan Year 2 and/or Plan Year 3 result in a Total PMPM rate that is higher than the Total PMPM Rate reflected in the chart above, Humana shall honor the above Total PMPM Rates as rate maximums.

5. Future renewal rates for Year 2 and Year 3 remain subject to the Assumptions and Conditions and Multi-Year Stipulations outlined below. Any rates exceeding what is provided above require prior approval from the Governor and Executive Council.

6. If there are any disputes associated with the proposed renewal rates by either Party, the Parties agree to meet and confer in good faith for a period of up to thirty (30) days from the initial notification, or a different timeframe that is mutually agreed upon. If at the end of this timeframe the Parties remain in dispute about the proposed renewal rates, either Party may terminate this Agreement.

7. The State may terminate this Agreement in accordance with Section 9.1 of the P-37. The Contractor may terminate this Agreement upon two hundred ten (210) days' prior written notice or a different timeframe that is mutually agreed upon notice to the State in accordance with Section 9.3 of the P-37 as amended in Exhibit A.

E. ASSUMPTIONS AND CONDITIONS

For members with End Stage Renal Disease (ESRD), the Humana Group Medicare Advantage Plan is only offered to eligible members who are diagnosed and enrolled in a manner that is consistent with applicable Medicare secondary payer laws, and the rules and regulations set forth by CMS.

The rates provided do not reflect any potential premium adjustments provided by Center for Medicare and Medicaid Services (CMS) or federal regulations based on a Medicare beneficiary's income.

Humana shall have the right to adjust the premium rates set forth in this rate sheet if:

i. a change in or clarification to Law affects Medicare Part C or D program costs or revenue;
ii. a natural disaster, pandemic, act of God or other cause beyond the reasonable control of Humana affects Medicare Part C or D programs costs or revenue;
iii. highly utilized specialty or high-cost drugs are introduced, or additional indications are added to such a drug resulting in an increase in the pharmacy allowed per member per month; or
iv. Humana determines that data provided and relied upon by Humana in development of the premium rates was inaccurate, incomplete, biased, misleading, or otherwise contributed to Humana underestimating actual plan expenses or revenue incurred by the State.

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For purposes of this agreement, "Law" shall mean, "any federal, state, or local law, statute, regulation, ordinance, code, rule, order, or other similar requirement enacted, adopted, or enforced by a government authority, including, without limitation, Medicare laws and CMS regulations and requirements, including CMS manuals, CMS payment methodology, and other directives.

Humana will hold the contracted rates, assuming all of the information provided is accurate, and could be subject to change should any of the following differ:

- All members are retired and enrolled in Medicare Part A and Part B
- A minimum average employer contribution level of 75% of the premium for the plan.
- A majority of members' (51% or more) primary residence is in an adequate Humana Medicare Advantage network service area. Humana will monitor network adequacy throughout the year to confirm standards are met.
- Enrolled membership should not change from current, or differ from the information provided, by more than 10% per year. This rate assumes 11,046 currently enrolled members.
- Humana's Medicare Advantage plan is the only plan offered. Additionally, there is no secondary plan wrapping around, coordinating with, or offered in conjunction with this plan for all current and future Medicare eligible retirees.
- Part D, administered by Humana Pharmacy Solutions, will utilize Humana's Group Plus formulary and include utilization management programs such as: quantity limits, prior authorization, and step therapy. Humana continually updates its drug list and quantity limits, and ensures these updates are in accordance with CMS regulations.
- Benefits, deductibles, maximum out of pocket accumulators, and any applicable pharmacy accumulators will be reset on January 1 each year and in accordance with the State's plan design.
- Humana assumes all information provided by the State is accurate with the understanding if there is a material change from the provided information, including the offering environment, Humana has a right to revise the rate, subject to Governor and Executive Council approval as necessary.

F. MULTI-YEAR STIPULATIONS

Humana's multi-year rates (Plan Year 2 and Plan Year 3) outlined in the chart above are subject to the same assumptions and conditions listed above.

G. IMPLEMENTATION ALLOWANCE STIPULATIONS

Humana agrees to provide a total allowance of $150,000 to be used for both implementation and pre/post implementation audit allowances.

To qualify for the Implementation Allowance, a minimum enrollment of 9,000 is required. Upon submission and execution of proper documentation from the State, Humana will pay the associated eligible implementation costs directly to the appropriate vendor(s) or the State up to the maximum allowance of $150,000.

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Eligible transition expenses include costs associated with the move to a Humana Medicare Advantage product such as, but not limited to, client produced presentation and/or flyer development, production and mailing costs; travel/lodging expenses for client personnel to attend enrollment meetings; etc.

Non-eligible expenses include employee payroll, costs incurred to administer an RFP, or other expenses that would have been incurred if no change of plan sponsor had occurred.

Request for reimbursement under this agreement must be submitted with proper invoices/receipts to your Humana Account Manager no later than 6 months following the plan effective date. Any unused amounts will expire after that time, unless mutually agreed to by the Contractor and the State.

H. GAIN SHARE SUMMARY

Humana agrees to a three (3) year gain sharing arrangement based on the projected Medical Expense Ratio (MER) for Medicare Advantage enrollees. For this agreement to be in effect, an average monthly enrollment of 9,000 must be maintained for the entire plan year.

Plan Years:
1/1/2027 – 12/31/2027
1/1/2028 – 12/31/2028
1/1/2029 – 12/31/2029

If MER greater to or equal to 92.00% = $0
If MER is less than 92.00% - 50% of the difference between a 92.00% MER and the actual MER multiplied by Total Premium revenue

Calculation of MER
MER is defined as Total Incurred Claims and Other Costs divided by the Total Premium Revenue

Total Premium Revenue equals the premium paid by the State and enrolled members, adjusted for any provided premium credit or reallocation, plus CMS Revenue, minus any applicable health insurer fees/taxes.

Other Costs are the actual incurred costs for programs and services such as Clinical and Care Management programs that improve health outcomes and Provider Incentives. Items included in other costs are recorded in accordance with US GAAP and are consistent with the reporting in Humana's audited financial statements. For these items, reasonable assumptions will be used to allocate appropriate amounts to the group level.

Settlement Procedure
Revenue and claims incurred in each of the calendar years will be calculated based on a six-month run-out period with a residual incurred-but-not-reported (IBNR) factor applied to claims. The three plan years' total incurred claims and total premium revenue will be aggregated to calculate the final expected payout, if applicable. The final MER will be calculated based on the sum of revenue and claims for the all plan years in

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the contract period. The final reconciliation settlement will be calculated within 60 days after the end of the final six-month run-out period.

For both the medical (MA) and prescription drug (Part D) coverage - offered as either MA/PDP or non-integrated sole carrier offering (MA + PDP Only), the claims and revenue components of the gain share calculation will include the applicable amounts from both the medical and prescription drug coverage and settled in aggregate.

Sole Use of Premium Refunds
In order to be eligible for premium refund, the State must maintain the minimum membership requirement during the plan year above and be an active group in good standing with Humana at the time of the Gain Share reconciliation. Reconciliation is completed retrospectively, with settlement statements provided up to 8 months after the end of the plan year. Cancellation or non-renewal would result in forfeiture of up to one year of Gain Share Settlement, where applicable.

This agreement requires that Gain Share funds shall be used for the benefit of the retirees covered in accordance with Medicare Regulations and State and Federal Laws.

I. PERFORMANCE GUARANTEES

1. General Conditions

a) Humana shall conduct an analysis of the data necessary to calculate any one of the Performance Guarantees within the timeframes provided in the charts below. In addition, any calculation of Performance Guarantees, reports provided, or analysis performed by Humana shall be based on Humana's then current measurement and calculation methodology and shall be available to the State upon request.

b) Humana shall develop and both parties shall mutually agree with a Performance Report Card as a means to measure compliance on a quarterly basis. Humana shall provide the quarterly performance report card in a manner acceptable to the State, within 45 days following the reporting quarter. Supporting documentation used to calculate the performance guarantees shall be provided with the Performance Report Card. The Performance Report Card shall include cumulative data over the life of the contract.

c) The performance guarantees may be subject to verification by audit. Any audits performed by Humana to test compliance with any of the Performance Guarantees shall be based on a statistically valid sample size with a 95% confidence level.

d) The measurement of the Performance Guarantee shall be based on: (1) the performance of any service team, business unit, or measurement group assigned by Humana to the activity to which the specific Performance Guarantee being measured relates; and (2) data that is maintained and stored by Humana or its Vendors.

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e) Humana shall be accountable for the performance of all subsidiaries, affiliates, and/or subcontractors and agrees such performance is held to the same performance standards as Humana and any subsidiary, affiliate or subcontractor's failure to perform shall place Humana at risk. Humana shall be responsible for payment of any performance guarantee penalty that may result from underperformance of any Humana subcontractor, affiliate or subsidiary. (See Appendix V for a list of subcontractors, affiliates, and/or subsidiaries.

f) Parties agree to reassess any of the Performance Guarantees and/or the amounts at risk upon the occurrence of any of the following:

(1) A change to the plan benefits or the administration of the plan initiated by State that results in a substantial change in the services to be performed by Humana or the measurement of a Performance Guarantee; or

(2) Humana does not receive information or other support from State that would allow Humana to meet the Guarantee; or

(3) Changes in law

g) If any Performance Guarantees are tied to a particular program and its components, such Performance Guarantees are only valid if the State participates in the program and such components for the entirety of the assessment period associated with the Performance Guarantee.

h) All Performance Guarantees may be revisited and may potentially be impacted due to a cause beyond the reasonable control of a Party such as a pandemic (an outbreak of disease that affects an exceptionally high proportion of members) being declared by the Centers for Disease Control or if a Force Majeure event (meaning an act of God, civil or military disruption, terrorism, fire, strike, flood, riot or war) occurs during the Measurement Period that impacts a meaningful portion of the State's population.

i) Performance Guarantees apply when there are 9,000 or more enrolled members on the Effective Date and throughout the assessment period. Should membership fall below 9,000 or more enrolled members, Humana and the State will revisit and renegotiate the Performance Guarantees.

2. Payment:

a. If Humana fails to meet any of the obligations specifically described in a Performance Guarantee, Humana shall pay the State the applicable amount set forth in the Performance Guarantee. Payment shall be in the form of a check, or wire transfer to the State which will occur annually unless otherwise stated in the Performance Guarantee.

b. Humana shall not be obligated to make payment under a Performance Guarantee if State's or State's vendor's action or inaction adversely impacts Humana's ability to meet any of its obligations related to such Performance Guarantee.

c) Waiver of Performance Guarantee: The State, in its sole discretion, may elect to waive payment for a performance guarantee in instances in which the State believes it is reasonable and appropriate to do so.

J. PERFORMANCE GUARANTEE CHARTS

IMPLEMENTATION (I) PERFORMANCE GUARANTEES

Ref #	Service/Task	Service Level Target	Measurement	Reporting & Assessment Intervals	Annual Fees at Risk
I1	Implementation Readiness - Contract Year 1	100% of services will take effect and be fully operational on the 'go live' date(s) as specified in the Contract, and 99% of members will be mailed accurate ID cards at least fifteen (15) business days prior to the beginning of the plan year. The State understands Humana must receive a Transaction Reply Report (TRR) acceptance from CMS and will work to develop a mutually agreeable implementation plan to ensure this.	Measured by Contractor's report of initial 'go-live' readiness, reported no later than 5 business days prior to the initial 'go-live' date; and the State's service experience during the month following the 'go-live' date.	One-time assessment, reported no later than one month after the initial 'go-live' date	$100,000 for the first day and $10,000 for each subsequent calendar day the deadline that services are not fully operational.
I2	Annual 'go-live' Readiness - Contract Years 2 & 3 and any optional renewal years	100% of services will take effect and be fully operational on the 'go live' date(s) as specified in the contract for each plan year, and 99% of members will be mailed accurate ID cards at least fifteen (15) business days prior to the beginning of the plan year. The State understands Humana must receive a Transaction Reply Report (TRR) acceptance from CMS and will work to develop a mutually agreeable implementation plan to ensure this.	Measured by Contractor's report of service readiness, reported no later than 5 business days prior to each subsequent annual plan-year effective date; and the State's service experience during the month following each subsequent annual plan-year effective date.	Reported and assessed annually, in subsequent years of the contract no later than the end of January after the effective date.	$75,000 for the first day and $5,000 for each subsequent calendar day the deadline that plan is not fully operational.

I3	Implementation Readiness - In the event of a significant claims system upgrade or platform change before or during contract period	100% of services will take effect and be fully operational on the system 'go live' effective date(s) as specified in the contract and, if applicable, 99% of members will be mailed accurate ID cards at least fifteen (15) business days prior to the beginning of the plan year. The State understands Humana must receive a Transaction Reply Report (TRR) acceptance from CMS and will work to develop a mutually agreeable implementation plan to ensure this.	Measured by Contractor's report of system 'go-live' readiness, reported no later than 5 business days prior to the system 'go-live' date; and the State's service experience during the month following the system 'go-live' date.	Reported and assessed within 30 days of the system "go-live" date falls.	$25,000 for the first day and $5,000 for each subsequent calendar day the deadline that plan is not fully operational
I4	Medical Prior Authorizations and Medical Pre-certifications	100% of existing Medical Prior Authorizations and Medical Pre-certifications for any new members and age-ins will be honored without disruption to the member.	Contractor confirms that new members and/or age-ins will have existing Medical Prior Authorizations and Medical Pre-certifications honored and processed without disruption. All Prior Authorizations and Pre-certifications should process within 7 calendar days of receipt.	Reported quarterly, assessed quarterly	$20,000 for each percentage below the threshold.
I5	Prescription Drug Prior Authorizations	100% of valid (defined as the Prior Authorization (PA)) that has not expired or does not expire prior to the new plan year start date. Humana will not extend authorizations that have or will expire prior to the start date. Also note, while Humana	Contractor confirms a one-time load for existing retiree members that enter the plan. Existing Prior Authorizations will be considered for transfer or re-issue and process (be entered into Humana's system and in place prior to plan start) without disruption. All	Reported annually, assessed annually	$20,000 for each percentage below the threshold.

		will load all valid PA's, PA's will not apply to any drugs that are non-formulary. Members would need to switch to a formulary alternative or request a non-formulary exception. Prior Authorizations for formulary medications for members transferring from the State's Retiree Plan will be considered for transfer or re-issue and process without disruption to the member, if applicable. Prior Authorizations will be honored through the effective end date, not to exceed the end of the plan year.	Prior Authorizations should be considered for transfer or re-issue and processed prior to the plan start date, if applicable. PA loads are contingent upon receipt of the claims file and authorization data from the previous MAPD plan within the required timeline during the initial implementation process. Multiple files are acceptable but in order to load prior to 1/1, we need the previous PBM to send by late November at the latest. Subsequent files need to be sent by mid to late January for timely loading.		

ADMINISTRATION (A) PERFORMANCE GUARANTEES

Ref #	Service/Task	Service Level Target	Measurement	Reporting & Assessment Intervals	Annual Fees at Risk
A1	Reporting of Retiree and Dependents enrolled in the plan who Drop Part B	Report 100% of plan enrollees who drop their Medicare Part B coverage identified on a weekly basis so that their Part B cancellation may be reinstated timely and they do not experience any gap in coverage.	100% of Medicare-eligible retirees and their Medicare-eligible dependents who are enrolled in plan and are identified as having dropped their Medicare Part B will be reported to the State as identified on a weekly basis.	Reported monthly, assessed quarterly	$5,000 per day for each plan enrollee who is identified to have dropped their Medicare Part B coverage and is not reported to the State as identified on a weekly basis resulting in lack of timely reinstatement

					and therefore experiencing a gap in coverage.
A2	System Downtime	At least 99.5% access to its systems by all the retail pharmacies in Contractor's network 24 hours a day, 7 days a week, 365 days a year.	Total 'live' time, divided by the difference of total time less maintenance time. The standard must be maintained each month.	Reported monthly, assessed annually	$25,000 for each percentage below the threshold.
A3	Retail Pharmacy Turnover	Less than 5% of retail pharmacies will leave the retail network.	Based upon Contractor's reporting of changes to their in network retail pharmacies.	Reported quarterly, assessed annually	$10,000 for each percentage point equal to or above the 5% threshold.

MEMBER (M) SERVICES PERFORMANCE GUARANTEES

Ref #	Service/Task	Service Level Target	Measurement	Reporting & Assessment Intervals	Annual Fees at Risk
M1	Average Speed of Answer (ASA)	100% of all inbound he State-specific member calls selecting the IVR will be answered within 10 seconds or less on average, and 30 seconds for member calls selecting a live Member Service Representative (MSR). This excludes calls abandoned before answering.	The total time for all calls to be answered, divided by the total number of calls. Measured by Contractor's standard internal call reports produced by Contractor's automated phone system for all of the State's member calls.	Reported monthly, assessed quarterly	$10,000 for each percentage point below the threshold for a month, measured separately for IVR and live MSR inbound calls. $100,000 maximum.
M2	Telephone Abandonment Rate	Average call abandonment rate will be less than 3%.	The number of calls accepted into the telephone system, compared to those that are abandoned. Measured by Contractor's standard internal call reports for the State-specific calls produced by Contractor's automated	Reported monthly, assessed quarterly	$10,000 for each percentage point above the threshold, measured monthly. $50,000 maximum.

			phone system for all member calls.		
M3	The Contractor's website for the State's members will offer online, real-time access, except for scheduled maintenance.	Contractor's website for the State's members will be available and fully operational 99.5% of the time, except for scheduled maintenance.	Total 'live' operational and accessibility time, divided by the difference of total time less maintenance time.	Reported monthly for applicable months, assessed annually	$5,000 for each percentage below the standard. $25,000 maximum.

ACCOUNT (AM) MANAGEMENT PERFORMANCE GUARANTEES

Ref #	Service/Task	Service Level Target	Measurement	Reporting & Assessment Intervals	Annual Fees at Risk
AM1	Account Management Satisfaction - Annual Score Card	Minimum satisfaction rate will be a minimum of ≥ 4.0. Less than ≥ 4.0 will result in $100,000 penalty. Satisfaction rate of 4.0 to 4.49 will result in $50,000 penalty. 4.5 or greater will result in $0 penalty.	Contractor will work with the State to develop a mutually agreed upon Account Management Scorecard, for evaluation of the Account Management Team. Target is an overall account management satisfaction score of 4.0 or higher, where 1 means "very unsatisfied" and 5 means "extremely satisfied". Scores less than a 4 in any category, the client is required to supply Humana with detailed examples explaining any issues	Reported quarterly and assessed annually	$100,000 maximum annually.
AM2	Semi-Annual Meetings	Meetings will be attended by members of Contractor's Account Team who are directly accountable for the information presented/discussed. At a minimum, an Account Team member closely involved in the daily operations of the	Contractor will attend semi-annual meetings, on-site if requested by the State, to present current plan and service performance, address any recent issues/challenges encountered, suggest	Reported quarterly and assessed annually	$50,000

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		State account, a clinician (as appropriate), and an executive-level Team member with oversight responsibility must be in attendance. Reporting and information with the appropriate level of detail will be provided in advance of the call.	potential savings opportunities, and discuss other pertinent topics to be identified prior to each meeting. Attendees must be intimately familiar with the data and topics being presented/discussed, able to confidently answer questions, and able to make suggestions specifically applicable to the State's plan. The mid-year and year-end meetings are expected to provide more robust, detailed plan metrics, observations, and consultative discussion. The meetings must take place between 30 and 45 days after the end of the 6-month period.		
AM3	Tracking Log of Claim Inquiries, member Issues, and/or Complaints and Final Resolutions	100% of claim inquiries, member issues and/or complaints from either the State staff or members, acknowledged within 48 business hours and follow-up of resolution status within 2 business days of acknowledgement if not yet resolved; 24 business hours for issues clearly designated as urgent, i.e. access to care, urgent RX need and follow-up of resolution status within 2 business days of acknowledgement, if not yet resolved. The tracking log will be shared with the State on a	Actual percentage of claim inquiries, member issues and/or complaints from either the State staff or members, acknowledged within 24 business hours for issues clearly designated as urgent, and follow-up of resolution status within 2 business days of acknowledgment, if not yet resolved.	Reported quarterly, assessed annually	$25,000 for each percentage below the threshold.

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		mutually agreed upon basis. Daily reporting may be provided initially, with the ongoing reporting frequency determined collaboratively and adjusted as needed.			

CLAIMS PROCESSING (CP) PERFORMANCE GUARANTEES

Ref #	Service/Task	Service Level Target	Measurement	Reporting & Assessment Intervals	Annual Fees at Risk
CP1	Claims Processing: Accurately Implement Benefits or Program Changes, including mandated CMS updates of service codes, fee schedules, etc.	100% of these benefit or program changes will be accurately and correctly implemented and administered.	Actual percentage reported through internal claims audits and identified through the State staff or member complaints.	Ongoing/ per occurrence	Contractor will reimburse the State (including the State's retirees) 100% of the value of the error(s) if the Contractor's error results in a loss to the State or its Medicare-eligible retirees and their Medicare-eligible dependents. If the Contractor's error results in a loss to the Contractor, the State will not be responsible for making the Contractor whole for the resulting loss. Additionally, $5,000 per day will be assessed, measured from the date the benefit or

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					program change became effective until the date the error is accurately corrected in the Contractor's system(s).
CP2	Claims Processing: Accurately Implement State required benefit plan changes that have the potential to create member disruption and provider payment issues.	100% of these benefit or program changes will be accurately and correctly implemented and administered.	Actual percentage reported through internal claims audits and identified through the State staff or member complaints.	Annually	Contractor will reimburse the State (including the State's retirees) 100% of the value of the error(s) if the Contractor's error results in a loss to the State or its Medicare-eligible retirees and their Medicare-eligible dependents. If the Contractor's error results in a loss to the Contractor, the State will not be responsible for making the Contractor whole for the resulting loss. Additionally, $5,000 per day will be assessed, measured from the date the benefit or program change became effective until

					the date the error is accurately corrected in the Contractor's system(s).
CP3	Financial payment Accuracy	At least 99% of claims will be paid accurately	Calculated as the total audited "paid" dollars minus the absolute value of over and underpayments, divided by total audited paid dollars. The standard must be maintained each month.	Reported monthly, assessed quarterly	$25,000 for each percentage point below the threshold, measured on a monthly basis.
CP4	Rx Mail Turnaround - Prescriptions not requiring intervention (2 Day Clean)	At least 95% of routine home delivery prescription orders will be shipped within 2 business days.	Measured in whole business days from the date a prescription order is received by Contractor to the date the prescription order is shipped.	Reported and assessed quarterly	$50,000 for each percentage below the threshold.
CP5	Rx Mail Turnaround - Prescriptions requiring intervention All Scripts (5 day ALL)	At least 95% of all home delivery prescription orders will be shipped within 5 business days.	Measured in whole business days from the date a prescription order is received by Contractor to the date the prescription order is shipped.	Reported and assessed quarterly	$50,000 for each percentage below the threshold.

REPORTING (R) PERFORMANCE GUARANTEES

Ref #	Service/Task	Service Level Target	Measurement	Reporting & Assessment Intervals	Annual Fees at Risk
R1	Humana will provide the State with a detailed monthly billing statement sent on or around the 15th of the month which includes member eligibility	Humana to provide the identified reports at the identified cadence, unless otherwise mutually agreed upon to adjust.	Measured by the State's date of receipt. Reports will be delivered on the report cadence as outlined.	Measured by the specified report receivable timeframe and assessed annually	$5,000 per day for each business day that each report is late.

	and status within 15 business days of the end of the month.				
R2	Contractor must provide MMR reports monthly	Contractor will provide accurate MMR reports monthly by the end of the corresponding month, as appropriate.	The monthly MMR shall be submitted by the end of the corresponding month, including all fields as received from CMS.	Reported and Assessed Monthly	$5,000 per day for each business day that the standard is not met. $100,000 maximum.
R3	Contractor must provide MOR reports upon request, no more often than annually	Contractor will provide accurate MOR reports upon request, no more often than annually, including all fields as received from CMS. The latest MOR will be submitted within 30 days of request.	The MOR reports shall be submitted upon request, no more often than annually, including all fields as received from CMS.	Reported and Assessed Annually	$5,000 per day for each business day that the standard is not met. $100,000 maximum.
R4	Contractor must provide claims data monthly	Contractor will provide a monthly revenue and incurred claims summary as detailed in the RFP.	The State will be able to access monthly claims reports by the 15th of the month following the subject month. Contractor reports are released on the 15th of the month, paid through the previous month, incurred 3 months prior (i.e., April report is paid through March, incurred through January).	Reported and Assessed Monthly	$5,000 per day for each business day that the standard is not met. $100,000 maximum.
R5	Contractor must report all CMS revenues and pharmacy rebates and other manufacturer revenue to the State	Contractor will report all CMS revenues (e.g., CMS direct subsidy; Federal reinsurance payments, Manufacturer coverage gap discounts, Low-income subsidies) and pharmacy rebates and other manufacturer revenue to the State on a quarterly basis.	All CMS revenues and rebates reported to the State on a quarterly basis within 45 day post the last day of the quarter Humana can provide aggregate rebate reporting on a quarterly basis. NDC level rebate reporting is not available due to stipulations in	Reported and Assessed Quarterly	$5,000 per day for each business day that the standard is not met. $100,000 maximum.

			current rebate contracts. Humana does not release detailed Part B rebate information.		

ELIGIBILITY (E) PERFORMANCE GUARANTEES

Ref #	Service/Task	Service Level Target	Measurement	Reporting & Assessment Intervals	Annual Fees at Risk
E1	Eligibility Loads (Initial Enrollment)	Initial enrollment file will be loaded within 24 hours of receipt. Files must be received by 12:00 midnight Eastern Time (ET); otherwise, written notification of the file delivery (off schedule) must be provided and receipt confirmed by Contractor. If the file is received after 12:00 midnight ET, the guarantee period commences upon file receipt.	Loaded accurately, in use, and notification transmitted to the State within 5 business days of receipt.	Reported and assessed annually	$50,000 for each business day that the standard is not met. $250,000 maximum.
E2	Eligibility updates	Twice per week eligibility update files will be loaded within 24 hours of receipt. Files must be received by 12:00 midnight ET; otherwise, written notification of the file delivery (off schedule) must be provided and receipt confirmed by Contractor. If the file is received after 12:00 midnight ET, the guarantee period commences upon file receipt.	Loaded accurately, in use, and notification transmitted to the State within 24 hours of receipt.	Reported quarterly, assessed annually	$5,000 per day for each business day the standard is not met. $50,000 maximum annually.

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COMMUNICATIONS (C) PERFORMANCE GUARANTEES

Ref #	Service/Task	Service Level Target	Measurement	Reporting & Assessment Intervals	Annual Fees at Risk
C1	Approval of State Specific, cobranded, and pre-enrollment Communications.	Submission of all State-specific, cobranded, and pre-enrollment communications (other than in response to individual inquiries) for review and approval. Additionally, in Year 1, Humana will provide sample batches of other correspondence (e.g., clinical, STARs, etc.).	Contractor will submit all State-specific, cobranded, and pre-enrollment communications (other than in response to individual inquiries) to the State for review and approval via mutually agreed upon batch process.	Reported quarterly, as applicable, and assessed annually	$75,000 per occurrence State of New Hampshire specific, cobranded, and pre-enrollment communication materials being released without the State's notification.
C2	Annual Negative Formulary Change Communication (Applicable Year 2028 Forward)	99% of members will receive notification letters of negative drug formulary changes or other changes where there is a negative impact on the member within 60 calendar days prior to effective date of change.	Contractor agrees to send notification letters within 60 calendar days for member-facing annual and negative formulary change communications sent after the Effective Date.	Reported and assessed annually	$25,000 for each percentage below the threshold.
C3	Material Medical/Pharmacy Network Provider Changes	The State must receive notice of any material medical/pharmacy provider/facility terminating from network no fewer than 30 days in advance of termination date, except where Providers do not give Humana adequate time to send notice, in which case, Humana will send notice as soon as possible.	Contractor agrees to send advance notification to the State of material medical/pharmacy network provider/facility changes.	Reported quarterly, assessed annually	$1,500 for each occurrence

HUMANA YEAR 2027 ONLY PERFORMANCE GUARANTEES

Ref #	Service/Task	Service Level Target	Measurement	Reporting & Assessment Intervals	Annual Fees at Risk
X1	Maximizing Provider Acceptance (Year 2027 Only)	Humana will actively recruit providers currently used by the State's membership, as identified in the "Network Utilization" tab of the 2027 RFP.	Humana agrees to contract, in person or via telephone, providers identified as currently utilized State providers, to educate them about the impending change in plan and seek understanding and acceptance of the State Humana Medicare Advantage Plan. To assure Humana's appropriate focus and energy will be expended to accomplish this important task, we agree to a one time $150,000 penalty should we not meet the stated target.	One-time assessment reported after the first quarter.	$150,000
X2	Minimizing Member Impact (Year 2027 Only)	Provider options provided within 72 hours	Humana will put in place a Customer Service provider acceptance escalation process which provides access to our highest level of trained staff (Humana's Account Concierge Team) regarding any provider acceptance issue where the initial Customer Services contact does not result in immediate resolution, Humana agrees to conduct additional provider outreach and education within 72	This metric will be reported quarterly and assessed following the end of the plan year. This metric only applies for the original effective year. Based upon client specific results.	$50,000

			business hours of receiving the escalation request in order to gain agreement from the provider to provide services. In any event, Humana agrees that within the 72-hour period the member will be provided with additional provider options within appropriate distance from their location to receive services. Humana agrees to a penalty of $10,000 per occurrence with an annual maximum penalty of $50,000 should we not meet the education and timeline metrics established above.		

Humana agrees to meet the performance standards as outlined above while administering the Group Medicare Advantage Plan for the State of New Hampshire. This agreement is contingent upon a minimum average enrollment of 9,000 members with Humana, with Humana being the sole Medicare Advantage option for Medicare eligible retirees.

The agreement will begin on January 1, 2027, and remain in effect for the contract period. As part of this agreement, Humana shall place an annual maximum amount at risk of $1,500,000 Year 1 and $500,000 beginning in Year 2 (January 1, 2028) based on meeting the required minimum average enrollment and performance standards.

This Performance Guarantee Agreement applies to a Medicare Advantage (MA) Only + Medicare Advantage Prescription Drug Plan (PDP) Only (Non-Integrated Sole Carrier Option (NISCO) plan.

Performance results will be reported within 45 days after the quarter, based on center results for member and claims service categories, rather than client-specific results, unless otherwise stated. Results will be assessed annually, and any penalties will be due following the end of the plan year, unless otherwise stated.

Please note that the performance standards may be subject to change due to key market or other factors, including updates to CMS rules and standards which may affect financial and processing accuracy metrics. Any PG change must be mutually agreed upon. Data is obtained through random audits based on statistically valid sampling of claims representative for payment.

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APPENDIX I – STATE'S PLAN DESIGN

Passive PPO Custom Medical and Rx Benefit Custom Overview
(In-Network Benefits match Out-of-Network Benefits

Deductible	$283 Combined (Annual Part B Deductible as determined each year*)
Inpatient Acute Hospital	$0 Copayment per Admission
Skilled Nursing Facility	$0 Copayment (days 1-100)
Physician Office Visits	$0 Copayment
Specialist Office Visits	$0 Copayment
Outpatient Surgical	$0 Copayment
Ambulance	$0 Copayment
Emergency Room	$0 Copayment
Medical Maximum Out of Pocket	*$283 Combined (Medicare Covered Services)
Prescription Drugs (Retail 30-day supply)	Custom PDP $750 MOOP; $10/$25/$40/$40 from $0 to Catastrophic

* The Annual Medicare Part B deductible is subject to change by the Centers for Medicare and Medicaid Services (CMS) and therefore the Medical Maximum Out-of-Pocket will adjust accordingly to match the CMS deductible unless otherwise directed by the State.

Contractor Initials JT
Date 07/30/2026

APPENDIX II - INCORPORATION of RFP RESPONSE

Humana's response to RFP 485-26 is hereby incorporated by reference.

Contractor Initials JT
Date 07/30/2026

APPENDIX III - INCORPORATION of EVIDENCE OF COVERAGE (EOC)

The Evidence of Coverage (EOC) is issued annually to each Enrolled Member that outlines benefits and coverage under the Enrolled Member's particular Plan. The EOC is subject to CMS approval and will be provided to State when it becomes available prior to the Plan Effective Date and on an annual basis thereafter for any Renewal Plan Years. The Evidence of Coverage documents are applicable to all Enrolled Members, as may be amended, are hereby incorporated by reference and made part of this Agreement. The Evidence of Coverage also defines the rights and responsibilities of the Member and the Plan.

Contractor Initials JT
Date 07/30/2026

APPENDIX IV – DATA PRIVACY AND SECURITY

Confidentiality and Nondisclosure

A. State and Contractor agree to maintain the confidentiality of Enrolled Member identifiable information as required by Law, including but not limited to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA").

B. State and Contractor may from time to time furnish each other with Confidential Information, written, oral or otherwise. Each party agrees it will use such Confidential Information only for the purpose of exercising its respective rights and responsibilities hereunder, and will not otherwise disclose any Confidential Information to any third party, employees, agents or representatives without the other party's written consent. Each party will use the same degree of care, but in any event no less than a reasonable degree of care, to avoid unauthorized use or disclosure of the other party's Confidential Information as that party uses to protect its own information of a similar nature.

C. 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.

D. 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.

E. 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. 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.

F. 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

Contractor Initials JT
Date 07/30/2026

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.

G. 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.

H. 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.

I. 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;
   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.

J. The confidentiality obligations set forth in this Agreement will not apply with respect to any information that: (i) the receiving party rightfully possesses at the time of disclosure by the disclosing party without a duty of confidentiality; (ii) the receiving party receives from a third party authorized to disclose such information without requirements of confidentiality; or (iii) that the receiving party develops independently of and without reference to the disclosing party's Confidential Information. In addition, the receiving party may disclose Confidential Information of the disclosing party to the extent that the receiving party is required by any applicable governmental authority to do so; provided, however, where permitted by Law, the receiving party gives the disclosing party prompt written notice of such requirement and reasonably cooperates with the disclosing party in attempting to contest or limit such required disclosures, as applicable.

K. 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

Contractor Initials JT
Date 07/30/2026

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.

L. State acknowledges and agrees that due to the unique nature of Contractor's Confidential Information, there can be no adequate remedy at law for any breach of the State's confidentiality obligations under this Agreement, that any such breach may result in harm to Contractor, and that, therefore, upon any such breach or threat thereof, Contractor will be entitled to seek appropriate equitable relief including, without limitation, injunctive relief.

M. This Attachment 3 shall survive termination or conclusion of this Agreement.

Contractor Initials JT
Date 07/30/2026

APPENDIX V – SUBCONTRACTORS, AFFILITIATES, and SUBSIDIARIES

Contractor and its affiliates perform all core services included in this contract. Contractor does not anticipate hiring any subcontractors solely for the direct support of this contract. Contractor may utilize external vendors to perform specific program and administrative services related to their Medicare Advantage and prescription drug plans. All access to information within their systems is restricted, monitored, and carefully protected and is never stored or maintained outside of the Contractor's secure firewalls. Vendors are subject to all of the same HIPAA privacy restrictions and IT security agreements as Contractor and are regularly audited. Contractor agrees to assume all financial and operational responsibility for services performed on behalf of all insured groups, regardless of whether those services are performed internally by Contractor or through an approved vendor. In addition, Contractor complies with all CMS regulations applicable to the use and oversight of contracted vendors performing services for Medicare Advantage and prescription drug plans.

Below is a list of known vendors who provide services to Group Medicare, including those who may contact members and have access to PHI:

Vendor(s)	**Service Provided**
Bayer Healthcare Pharmaceuticals, Inc.	*Enhanced clinical calls with members, prescriber fax notifications, data reporting for specific pharmaceutical families (cancer treatments)*
Burke, Inc.	*Annual employer and member surveys*
Clarest Health Company	*Nurse led clinical outreach to support members who are long overdue for a review. Leverage motivational interviewing to better understand adherence barriers and provide support to improve medication adherence.*
Conduent Commercial Solutions, LLC Conduent Business Solutions Conduent Payment Integrity Solutions	*Member Communications and System Letters; Call center support; Call center for Spanish speaking Medicare members. Go365 scanning and sorting and processing: Mail Room Services; Welcome Calls; Manages scanning correspondence for claims and paper applications* *Provides services for opening, sorting, preparing, and scanning paper claims;* *Provides auditing services on pharmacy claims*
Cotiviti	*Claims overpayment recovery and data analytics & Eliza® Robotic Calls*
Custom Health, Inc.	*Opioid Management Program*
Everlywell	*Conducts member engagement outreach to offer or directly send in-home test kits to eligible Humana members. They provide laboratory testing services for test kit samples that are returned to the lab, including notification of lab results.*
Everise, Inc.	*Call Center support: Call Center for English and Spanish speaking Medicare members*
Evolent OncoHealth	*Oncology quality management*

Contractor Initials JT
Date 07/30/2026

Vendor(s)	Service Provided
EXL Holdings Sagility	*Provide administrative cost savings by performing clinical and non-clinical support for pre and post service authorizations, claims, and provider disputes.* *HGS also provides call center support.*
Focus Health, Inc.	*Performs peer reviews of behavioral health requests for services. Review may include requests for a patient's admission, stay or other service or course of treatment (including outpatient procedures and services). Reviews can be pre-service, concurrent, post-service, initial requests, and first and second level appeals*
Healpros, LLC	*In home CDC EYE and OMW exam and gap closure vendor. Member outreach to schedule appointments and submitted supplemental data for gap closure*
Horizon	*Member satisfaction surveys when required in contract for Group Medicare clients*
Ironmark	*Print and mail services to members, providers and associates*
MedWatchers, Inc.	*Telephonic Medication Therapy Management services to retail pharmacies, physicians and/or members telephonically.*
Personify Health	*Outbound calls to members to support refilling overdue medications.*
Proprio	*Translation services*
Senture, LLC	*Customer Service Staffing*
WholeHealth Living, Inc.	*Administers leased network management, utilization management (UM) and claim payments for chiropractic, acupuncture, naturopathy and therapeutic massage services. Services vary by line of business and state.*

Contractor Initials JT
Date 07/30/2026

State of New Hampshire
Department of State

CERTIFICATE

I, David M. Scanlan, Secretary of State of the State of New Hampshire, do hereby certify that EMPHESYS INSURANCE COMPANY is a Texas Profit Corporation registered to do business in New Hampshire as EMPHESYS INSURANCE COMPANY INC. on July 13, 2026. I further certify that all fees and documents required by the Secretary of State's office have been received and is in good standing as far as this office is concerned.

Business ID: **1034107**
Certificate Number: **0007984050**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 20th day of July A.D. 2026.

David M. Scanlan
Secretary of State

SECRETARY CERTIFICATE

I, Courtney D. Durall, being the duly elected and qualified Secretary of Emphesys Insurance Company, a Corporation under the laws of the State of Texas (the "Corporation"), do hereby certify that Jill Marie Tobin is a duly elected officer of the Corporation, having the title of Senior Vice President, Group Medicare, and whose last election was April 30, 2026. I further certify that Ms. Tobin is authorized to enter into contracts or agreements on behalf of the Corporation with the State of New Hampshire and any of its agencies or departments, and is further authorized to execute any documents which may in her judgment be desirable or necessary, pursuant to such powers granted to officers in accordance with the Corporation's Bylaws.

I further certify that (i) the Corporation's Board of Directors adopted the below resolution by unanimous written consent dated April 17, 2026, concerning the election of officers of the Corporation and their authority to act under the Corporation's Bylaws, and (ii) the below resolution is in force and effect and has not been revised, revoked or rescinded.

> **RESOLVED,** that effective on April 30, 2026, each of the named persons on **Exhibit B** be, and hereby is, elected to the office of the Corporation set opposite his or her respective name to assume the duties and responsibilities fixed by the Bylaws of the Corporation, and to hold office until (a) the next annual election of the Corporation's officers at the first meeting of the Board of Directors after the 2027 Annual Meeting of Stockholders, or such other date as the Board may determine, or (b) death, resignation, or removal as provided in the Bylaws of the Corporation.

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.

Given under my hand and the Seal of the said Corporation this 30th day of July, 2026.

Courtney D. Durall

COURTNEY D. DURALL
SECRETARY

EXHIBIT B

EMPHESYS INSURANCE COMPANY

Officer	Title
John Edward Barger III	President
Celeste Marie Mellet	Chief Financial Officer
Robert Martin Marcoux, Jr.	Vice President and Treasurer
Courtney Danielle Durall	Secretary
Valerie Marie Talkers	Assistant Secretary
John-Paul William Felter	Senior Vice President, Chief Accounting Officer & Controller
Erin Fegan Banet	Senior Vice President, Chief Audit and Risk Officer
Susan Renee Crowe	Senior Vice President, Chief Compliance Officer
Jill Marie Tobin	Senior Vice President, Group Medicare
Lisa Thornell Stephens	Senior Vice President, Quality & Cost Strategy President
William Mark Preston	Vice President, Investments
John Stephen Littig	Vice President, Medicare Regional President
Frederick William Roth	Vice President, Medicare Supplement
Daniel Kevin Feld	Associate Vice President, Tax

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 07/16/2026

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 Willis Towers Watson Southeast, Inc. c/o 26 Century Blvd P.O. Box 305191 Nashville, TN 372305191 USA	CONTACT NAME: WTW Certificate Center PHONE (A/C, No, Ext): 1-877-945-7378 FAX (A/C, No): 1-888-467-2378 E-MAIL ADDRESS: certificates@wtwco.com
INSURED Emphesys Insurance Company 101 E Main St Louisville, KY 40202	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A: Columbia Casualty Company — 31127 INSURER B: Liberty Mutual Fire Insurance Company — 23035 INSURER C: Managed Care Indemnity Inc — INSURER D: LM Insurance Corporation — 33600 INSURER E: National Union Fire Ins Co of Pittsburgh — 19445 INSURER F: Aspen American Insurance Company — 43460

COVERAGES **CERTIFICATE NUMBER:** W47357349 **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. LIMITS SHOWN ARE INCLUSIVE OF AMOUNTS REQUESTED BY THE CERTIFICATE HOLDER AND MAY NOT REFLECT POLICY LIMIT AMOUNTS IN EXCESS OF THOSE REQUESTED. ***Not Applicable in WY**

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 CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC OTHER:	Y	Y	HAZ 4016061597-15	01/01/2026	01/01/2027	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 3,000,000 $ 3,000,000 $ 5,000 $ 3,000,000 $ 3,000,000 $ 3,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY			AS2-641-446221-046	01/01/2026	01/01/2027	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 5,000,000 $ $ $
C	UMBRELLA LIAB X OCCUR X EXCESS LIAB CLAIMS-MADE DED RETENTION $			MCII-EX00-2026	01/01/2026	01/01/2027	EACH OCCURRENCE AGGREGATE	$ 5,000,000 $ 5,000,000
D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		WA5-64D-446221-026	01/01/2026	01/01/2027	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 2,000,000 $ 2,000,000 $ 2,000,000
C	Professional Liability (E&O) (Claims Made)			MCII-EO-2026	01/01/2026	01/01/2027	Each Claim Aggregate	$ 5,000,000 $ 5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Blanket Additional Insured applies to General Liability only; Primary/Non-Contributory and Waiver of Subrogation apply to other lines where required by written contract and permitted by law. The Excess Liability policy is follow form over the General Liability policy, subject to the same terms, conditions, and exclusions unless otherwise stated.
SEE ATTACHED

CERTIFICATE HOLDER

State of New Hampshire
Department of Administrative Services
25 Capitol Street
Concord, NH 03301

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

Melody H. Meyer

SR ID: 30319769 BATCH: 4531650

AGENCY CUSTOMER ID: _____

LOC #: _____

ADDITIONAL REMARKS SCHEDULE

AGENCY		NAMED INSURED
Willis Towers Watson Southeast, Inc.		Emphesys Insurance Company 101 E Main St Louisville, KY 40202
POLICY NUMBER See Page 1		
CARRIER See Page 1	NAIC CODE See Page 1	EFFECTIVE DATE: See Page 1

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

Additional Insured: State of New Hampshire Department of Administrative Services

INSURER AFFORDING COVERAGE: LM Insurance Corporation NAIC#: 33600
POLICY NUMBER: WC5-641-446221-036 EFF DATE: 01/01/2026 EXP DATE: 01/01/2027

TYPE OF INSURANCE:	LIMIT DESCRIPTION:	LIMIT AMOUNT:
Workers Compensation And	Each Accident	2,000,000
Employers Liability	Disease - Pol Limit	2,000,000
Per Statute	Disease - Each Emp	2,000,000

INSURER AFFORDING COVERAGE: Liberty Mutual Fire Insurance Company NAIC#: 23035
POLICY NUMBER: EW2-64N-446221-016 EFF DATE: 01/01/2026 EXP DATE: 01/01/2027

TYPE OF INSURANCE:	LIMIT DESCRIPTION:	LIMIT AMOUNT:
Ohio Excess WC		See Below

ADDITIONAL REMARKS:
Ohio Excess Comp - Insurer's Limit of Indemnity for each accident or each employee for disease - Statutory

INSURER AFFORDING COVERAGE: Managed Care Indemnity Inc NAIC#:
POLICY NUMBER: MCII-EX01-2026 EFF DATE: 01/01/2026 EXP DATE: 01/01/2027

TYPE OF INSURANCE:	LIMIT DESCRIPTION:	LIMIT AMOUNT:
Excess General Liability	Occurence	$5,000,000 xs
and Professional Liability	Aggregate	$5,000,000

INSURER AFFORDING COVERAGE: National Union Fire Ins Co of Pittsburgh NAIC#: 19445
POLICY NUMBER: 01-708-48-52 EFF DATE: 04/01/2026 EXP DATE: 04/01/2027

TYPE OF INSURANCE:	LIMIT DESCRIPTION:	LIMIT AMOUNT:
Crime	Limit	$15,000,000

AGENCY CUSTOMER ID: _____

LOC #: _____

ADDITIONAL REMARKS SCHEDULE

AGENCY Willis Towers Watson Southeast, Inc.	NAMED INSURED Emphesys Insurance Company 101 E Main St Louisville, KY 40202
POLICY NUMBER See Page 1	
CARRIER See Page 1 / NAIC CODE See Page 1	EFFECTIVE DATE: See Page 1

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: 25 FORM TITLE: Certificate of Liability Insurance

INSURER AFFORDING COVERAGE: Aspen American Insurance Company NAIC#: 43460

POLICY NUMBER: AX00KGE26 EFF DATE: 03/31/2026 EXP DATE: 03/31/2027

TYPE OF INSURANCE:	LIMIT DESCRIPTION:	LIMIT AMOUNT:
Cyber (Claims Made)	Limit	$30,000,000

SR ID: 30319769 BATCH: 4531650 CERT: W47357349