Arlington Public Schools
Procurement Office
2110 Washington Blvd., Arlington, VA 22204 · Phone: (703) 228-7643 · Fax: (703) 841-0681
www.apsva.us

Agreement

Contract Title: Health Care Services for Arlington Public Schools

This Contract 56FY23, for the provision of Health Care Services for Arlington Public Schools for the Self-Insured Preferred Provider Organization Plan (SI-PPO) and the Self-Insured Exclusive Provider Organization Plan (SI-EPO) ("the Work") is entered into as of the date the Procurement Agent signs this Agreement, this 17th day of July, 2023; by and between CareFirst BlueCross BlueShield, located at 3060 Williams Drive, Suite 200, Fairfax VA 22031 , hereinafter called "Contractor" and Arlington County School Board, operating as Arlington Public School hereinafter called "APS" or "Owner".

In consideration of the mutual stipulations, agreements and covenants contained herein, the parties herby agree as follows:

Contract Term

The initial term of this Contract shall commence on the date the Contract is fully executed by the Procurement Director/ Procurement Agent and expiring on December 31, 2026 ('Initial Contract Term'), unless otherwise stated as provided in the Contract Documents. Work under this Contract shall commence January 1, 2024.

This Contract may be renewed for a term not to exceed twelve (12) months ('Renewal Contract Term') by written notice given by APS at any time prior to thirty (30) Days after expiration of the preceding Initial Contract Term or Renewal Contract Term. No representative of APS has any authority to order, direct, or request work after expiration of the Initial Contract Term or Renewal Contract Term and prior to a Renewal Contract Term in strict compliance with the renewal terms herein APS, at its sole discretion, has the right, but is under no obligation, to exercise this right to renewal not to exceed three (3) additional one-year periods at the same terms and conditions.

Unless directed otherwise by APS, any Work in progress at the time of expiration of a Contract term may continue and be completed under the terms of the Contract in existence at the time the Purchase Order for the Work was issued, but must be completed no later than six (6) months following expiration of the Contract term in which the Purchase Order was issued.

Contract Price

APS will pay the Contractor in accordance with the terms of the Payment section below and of Attachment B - Pricing Schedule for the Contractor's completion of the Work as required by the Contract Documents. The Contractor will complete the Work for the total amount specified in this section ("Contract Amount").

Scope of Services

The Contractor agrees to perform the services described in the Contract Documents (hereinafter the "Work"). The primary purpose of the Work is to obtain the services of a qualified Contractor to provide and implement the Work. The Work is more fully described in Attachment A. The Contract Documents set forth the minimum work estimated by APS and the Contractor to be necessary to complete the Work. It shall be the Contractor's responsibility, at the Contractor's sole cost, to provide the specific services set forth in the Contract Documents and sufficient services to fulfill the purposes of the Work. Nothing in the Contract Documents shall be construed to limit the Contractor's responsibility to manage the details and execution of its Work. The Contractor shall be responsible for providing the Work.

Contract Amount

APS will pay the Contractor in accordance with the firm fixed price(s) shown in Attachment B – Pricing Schedule. The firm fixed price shall include all of the Contractor's fees in performance of the Work under this Contract, including but not limited to, travel, overhead and profit. The firm fixed price(s) shall not be subject to change during the Contract Term.

Contract Documents

The Contract consists of the following documents: all of which are incorporated into and are part of the Contract, and which, in the event of a conflict, shall be given precedence in the order listed, with any Amendment or Modification having precedence over preceding provisions. In the event of a conflict within a Contract Document at the same level of precedence, that provision requiring the higher quality of performance or quantity shall prevail. In the event of a conflict which is not resolved by the foregoing, the Owner shall determine the provision having precedence.

1 Agreement #56FY23 and all modifications properly incorporated into the Agreement
2 Attachment A – Scope of Work
3 Attachment B – Pricing Schedule
4 Attachment C – Contractor Certification Regarding Criminal Convictions
5 Attachment D – Non-Disclosure and Data Security Agreements
6 Attachment E – Business Associate Agreement
7 Attachment F – Contract Terms and Conditions
8 Attachment G – Certificate(s) of Insurance
9 Attachment H – Sample Purchase Order
10 Attachment I – Administrative Services Agreement

The following are incorporated by reference:

11 The Request for Proposal (RFP) documents, and
12 The Proposal Response from the Contractor

Where the terms and provisions of the Agreement vary from the terms and provisions of the other Contract Documents, the terms and provisions of the Agreement shall prevail over the other Contract Documents.

The Contract Documents set forth the entire Contract between APS and the Contractor. APS and the Contractor agree that no representative or agent of either of them has made any representation or promise with respect to this Contract which is not contained in the Contract Documents. The Contract Documents are referred to herein below as the "Contract."

Definitions

All words and terms shall have the meanings and terms assigned to them in the Contract Documents, unless a different meaning is clear from the context.

Right to Terminate Contract

APS has the right to terminate this Contract for convenience at any time, or for default, all pursuant to the provisions of the Terms and Conditions.

Payment Procedures:
Payment is on a deliverable basis. Contractor will be paid upon Acceptance of the applicable Deliverables upon its submission of a complete invoice satisfactory to the Project Officer that meets the requirements of this section and other applicable provisions of the Contract. APS will pay the Contractor within thirty (30) calendar days after the date of receipt of a correct (as determined by the Project Officer) invoice approved by the APS Project Officer. The number of the Purchase Order shall appear on all invoices.

Assignments
This Contract is not assignable by Contractor without the express written consent of APS, and APS shall be under no obligation to grant such consent. Sale, assignment or transfer of a controlling interest in the Contractor shall be deemed an assignment for purposes of this provision and shall be grounds for termination of this Contract if consent of APS is not obtained. It is understood by APS that Contractor may use Subcontractors for performance of parts of the Work. However, it is expected that Contractor will be performing the Work, and subcontracting of all or substantially all of the Work under any Purchase Order shall be deemed an assignment subject to the restrictions of this Section.

Notices
Unless otherwise provided herein, all notices and other communications hereunder shall be deemed to have been given when made in writing and either (a) delivered in person, (b) delivered to an agent, such as an overnight or similar delivery service, or (c) deposited in the United States mail, postage prepaid, certified or registered, or (d) emailed, addressed as follows:

To the Contractor:

Sue Yenyo
Sales Consultant, National Accounts
CareFirst BlueCross BlueShield
3060 Williams Drive, Suite 200
Fairfax VA 22031
sue.yenyo@carefirst.com

To APS:

Brianna Cobbins
Executive Director, HR and Operation
Department of Human Resources
Arlington Public Schools
2110 Washington Blvd.
Arlington, Virginia 22204
brianna.cobbins@apsva.us

And

David J. Webb, C.P.M.
Procurement Director / Procurement Agent
Arlington Public Schools
2110 Washington Blvd.
Arlington, Virginia 22204
david.webb@apsva.us

Binding Agreement
The Owner and the Contractor each binds itself, its successors and assigns to the other, its successors and assigns, in respect of all covenants, terms, conditions and obligations contained in each of the Contract Documents.

The Work shall be performed in accordance with the above-referenced Contract Documents and is the complete agreement between APS and the Contractor and may not be altered except by written amendment signed by APS and the Contractor in compliance with the requirements of the Contact Documents.

The signatures of APS and the Contractor, or their authorized representatives, are set out below in acknowledgment and acceptance of this Contract.

IN WITNESS WHEREOF, APS and Contractor have executed this Agreement as of the date written above.

Acceptance:

Arlington Public Schools		**CareFirst BlueCross BlueShield**	
Authorized Signature:	David J. Webb	Authorized Signature:	
Printed Name	David J. Webb, C.P.M.	Printed Name:	Joseph Scibilia
Title:	Director/Procurement Agent	Title:	Vice President, Public & Labor
Date:	July 17, 2023	Date:	July 13, 2023

Attachments:

1 Attachment A – Scope of Work
2 Attachment B – Pricing Schedule
3 Attachment C – Contractor Certification Regarding Criminal Convictions
4 Attachment D – Non-Disclosure and Data Security Agreements
5 Attachment E – Business Associate Agreement
6 Attachment F – Contract Terms and Conditions
7 Attachment G – Certificate(s) of Insurance
8 Attachment H – Sample Purchase Order
9 Attachment I – Administrative Services Agreement

Attachment A

Scope of Work

The Scope of Work consists of the provision of:

1. Group Self-Insured- Preferred Provider Organization (SI-PPO) Plan

1.1 Group Medical Coverage through a Group Self-Insured-Preferred Provider Organization (SI-PPO) Plan

1.1.1 Administration, management, and all related services are to be included, and as a minimum not be limited to the following:

1.1.1.1 Implementation of Plan Services

1.1.1.2 Account and Data Management

a. Billing

b. Timely and accurate adjudication of claims

c. Reporting/ Analysis

1.1.1.3 Enrollment (open season and ongoing) including onsite meetings with employee groups.

a. Implementation of Plan Services

1.1.1.4 Communications

a. Develop and distribute member handbooks which contain evidence of coverage, enrollee's responsibilities, and plan's responsibilities.

b. Design, develop, produce and distribute educational, open enrollment and marketing materials.

c. Administer and distribute all required communications.

1.1.1.5 Customer Service

a. Provide a toll-free customer service number which shall provide general information on the plan, claims status and counseling to members.

b. Respond correctly and timely to inquiries received by telephone, by mail, by email or in person.

c. Claims resolution: coordination of review, processing

1.1.2 Guidelines

1.1.2.1 Plans must be insurer-filed and have state and federal approval.

1.1.2.2 Plans must be in compliance with state and federal healthcare laws.

1.1.2.3 The proposed plan(s) must provide benefits that are as good or better than current benefit levels.

1.1.2.4 Coverage must be guaranteed issue and guaranteed renewable for each participant.

1.2 Prescription Drug Coverage

1.2.1 Administration, management, and all related services are to be included, and as a minimum not be limited to the following:

1.2.1.1 Implementation of Plan Services

1.2.1.2 Account and Data Management

a. Billing
b. Timely and accurate adjudication of claims
c. Reporting/ Analysis
d. Comply with potential external audits to ensure correct adjudication of claims.
e. Timely and accurate payment of rebates.
f. Execute all agreed upon formulary management programs.

1.2.1.3 Enrollment (open season and ongoing) including onsite meetings with employee groups.

a. Implementation of Plan Services

1.2.1.4 Communications

a. Develop and distribute member handbooks which contain evidence of coverage, enrollee's responsibilities and plan's responsibilities.
b. Design, develop, produce and distribute educational, open enrollment and marketing materials.
c. Administer and distribute all required communications.

1.2.1.5 Customer Service

a. Provide a toll-free customer service number which shall provide general information on the plan, claims status and counseling to members.
b. Respond correctly and timely to inquiries received by telephone, by mail, by email or in person.
c. Claims resolution: coordination of review, processing

1.3 Vision coverage

1.3.1 Administration, management, and all related services are to be included, and as a minimum not be limited to the following:

1.3.1.1 Implementation of Plan Services

1.3.1.2 Account and Data Management

a. Billing
b. Timely and accurate adjudication of claims
c. Reporting/ Analysis

1.3.1.3 Enrollment (open season and ongoing) including onsite meetings with employee groups

a. Implementation of Plan Services

1.3.1.4 Communications

a. Develop and distribute member handbooks which contain evidence of coverage, enrollee's responsibilities and plan's responsibilities.

b. Design, develop, produce and distribute educational, open enrollment and marketing materials.

c. Administer and distribute all required communications.

1.3.1.5 Customer Service

a. Provide a toll-free customer service number which shall provide general information on the plan, claims status and counseling to members.

b. Respond correctly and timely to inquiries received by telephone, by mail, by email or in person.

c. Claims resolution: coordination of review, processing

1.3.2 Guidelines

1.3.2.1 Plan must be insurer-filed and have state and federal approval.

1.3.2.2 The proposed plan must provide benefits that are as good or better than current benefit levels.

1.3.2.3 Coverage must be guaranteed issue and guaranteed renewable for each participant.

1.4 Onsite Nurse Practitioner

1.4.1 Manage, promote, and staff on-site office with the expectation of six hours per day, five days per week.

1.4.2 Ensure compliance functions associated with on-site care management.

1.4.3 Access to health services shall be available to all APS employees.

1.4.4 Offer free visits by appointment for non-emergency, non-work related illnesses and musculoskeletal injuries, limited lab services, and treatment of illnesses, including prescriptions

1.4.5 Be staffed by a team of nurse practitioners, registered nurses and/or support staff who can provide referrals and write prescriptions.

1.5 Employee Assistance Program (EAP)

1.5.1 Available to all full-time and part-time APS employees and members of their households.

1.5.2 Offer standard EAP services including, but not limited to: emotional, mental, psychological health and substance abuse counseling and referral; and intervention and disciplinary diversion.

1.5.3 Services to include, but not be limited to, psychotherapists, social workers, family counselors, other medical and/or health practitioners, 24-hour crisis telephone response and onsite sessions, substance abuse expertise/ counseling and credit and financial counseling.

1.5.4 Safety sensitive substance abuse support. Serve as the Substance Abuse Professional (SAP) as required under the Federal Highway Administration’s alcohol and controlled substance testing program requirements of commercial motor vehicle drivers and assist APS in ensuring compliance with the Drug Free Workplace Act of 1988.

1.5.5 Provide Critical Incident Stress Management and acute crisis management.

1.5.6 Offer a broad range of concierge and convenience services.

1.5.7 Offer managerial and supervisor support and training.

1.5.8 Offer a robust catalog of both in-person and online educational opportunities.

1.5.9 Partner with existing APS wellness programs.

1.5.10 Promote and market the EAP to drive awareness.

1.5.11 Maintain a computerized tracking system to provide statistical information and requested reports necessary to evaluate the EAP.

1.5.12 Ensure client confidentiality.

1.5.13 Integrate with medical plan where possible.

1.6 Administration of FSAs and COBRA

1.6.1 Available to all APS employees scheduled to work 15 or more hours per week in a benefits-eligible position.

1.6.2 Provide pro-active support and flexible program alternatives to help meet objective of educating employees on the advantages of FSAs.

1.6.3 Communicate available FSA benefits with the goal of maximizing program enrollment.

1.6.4 Provide solid operational performance, demonstrated by exemplary claims handling, experience in offering debit card features and validation of purchases, and reliable information on participants' accounts.

1.6.5 Provide excellent customer service demonstrated by professional, courteous, and highly competent member services.

1.6.6 Provide access to a user-friendly secure website including web enrollment services, efficient automated tools, member account information electronic claims submission and online notifications.

1.6.7 Distribute notifications, election packets, correspondence.

1.6.8 COBRA (Consolidated Omnibus Budget Reconciliation Act) to include termination notices as required by law.

1.6.9 Process election forms and carefully tracking all key dates to ensure accurate and timely responses to COBRA requirements.

1.6.10 View health plan information, rates and payment information.

1.6.11 Maintain qualifying events and HIPAA loss-of-coverage data online.

1.6.12 Accept and process COBRA notification data bai Electronic Data Transfer (EDT) file format.

1.6.13 Mail the appropriate COBRA election packet, HIPAA Certificate of Creditable Coverage or the COBRA rights notification forms when files are received.

1.6.14 FSAs to include: Health Care; Dependent Care; Parking; and Transit.

2. <u>Self-Insured-Exclusive Provider Organization (SI-EPO) Plan.</u>

2.1. Group Medical Coverage through a Self-Insured Exclusive Provider Organization (SI-EPO) Plan.

2.1.1. Administration, management, and all related services are to be included, and as a minimum not be limited to the following:

2.1.1.1. Implementation of Plan Services

2.1.1.2. Account and Data Management

a. Billing

b. Timely and accurate adjudication of claims

c. Reporting/ Analysis

2.1.1.3 Enrollment (open season and ongoing) including onsite meetings with employee groups.

a. Implementation of Plan Services

2.1.1.4 Communications

a. Develop and distribute member handbooks which contain evidence of coverage, enrollee's responsibilities, and plan's responsibilities.

b. Design, develop, produce and distribute educational, open enrollment and marketing materials.

c. Administer and distribute all required communications.

2.1.1.5 Customer Service

a. Provide a toll-free customer service number which shall provide general information on the plan, claims status and counseling to members.

b. Respond correctly and timely to inquiries received by telephone, by mail, by email or in person.

c. Claims resolution: coordination of review, processing

2.1.2 Guidelines

2.1.2.1 Plans must be insurer-filed and have state and federal approval.

2.1.2.2 Plans must be in compliance with state and federal healthcare laws.

2.1.2.3 The proposed plan(s) must provide benefits that are as good or better than current benefit levels.

2.1.2.4 Coverage must be guaranteed issue and guaranteed renewable for each participant.

2.2 Prescription Drug Coverage

1.2.1 Administration, management, and all related services are to be included, and as a minimum not be limited to the following:

2.2.2.1 Implementation of Plan Services

2.2.2.2 Account and Data Management

a. Billing

b. Timely and accurate adjudication of claims

c. Reporting/ Analysis

d. Comply with potential external audits to ensure correct adjudication of claims.

e. Timely and accurate payment of rebates.

f. Execute all agreed upon formulary management programs.

2.2.2.3 Enrollment (open season and ongoing) including onsite meetings with employee groups

a. Implementation of Plan Services

2.2.2.4 Communications

a. Develop and distribute member handbooks which contain evidence of coverage, enrollee's responsibilities and plan's responsibilities.

b. Design, develop, produce and distribute educational, open enrollment and marketing materials.

c. Administer and distribute all required communications.

2.2.2.5 Customer Service

a. Provide a toll-free customer service number which shall provide general information on the plan, claims status and counseling to members.

b. Respond correctly and timely to inquiries received by telephone, by mail, by email or in person.

c. Claims resolution: coordination of review, processing

End of Scope of Work

Attachment B

Pricing Schedule

1. Self-Insured-Preferred Provider Organization (SI-PPO) Plan:

	TOTAL
OAP Low	**1115**
OAP High	**766**
Total	**1881**

Self-Insured	PPO			
Fees	**2024**	**2025**	**2026**	**Comments**
Medical Plans PEPM	$29.75	$29.75	$29.75	
Network Access Fee	See comments	See comments	See comments	Included fee is based as a % of claims. Under the proposed BlueCard program, a Host BCBS plan may withhold an access fee of up to [redacted] (but not to exceed [redacted] for any claim) of the provider discount the plan has obtained from its participating providers.
Utilization Review Fees	Included	Included	Included	
Claims Fiduciary	$0.96	$0.96	$0.96	Fiduciary Option 4 is included in our proposal.
Nurse Line	Included	Included	Included	
MHSA Network and Non-Claims Admin.	Included	Included	Included	
MHSA Claims Administration	Included	Included	Included	
OON Claim Management	Included	Included	Included	CareFirst will negotiate out-of-network claims on APS's behalf and reprice non-contracted claims through a vendor-partner. When successful, a 40% fee is applied to the savings generated.
Total Admin. Fee	**$30.71**	**$30.71**	**$30.71**	

Additional Services included in the above Administrative Fee		
Additional Services	**Response**	**Explanation**
Non-Standard Service Hours	Not included	
Standard Reports	Included	
Ad hoc Reports	Included	Any applicable fee will be dependent on timing and difficulty.
800 Telephone Links	Included	
Reporting On-Demand Access	Included	
Large Case Management	Included	
On-site APS-dedicated nurse practitioner	Included	As requested, this is provided as a separate line item and includes up to a $300,000 budget.
Implementation Fees	Included	CareFirst is providing APS with an annual Wellness Fund of $125,000 and $100,000 General Fund as outlined in the caveats of our proposal.
Fees for Monthly Data Feeds to Data Warehouse vendor	Included	
Stop Loss Interface Fees	Not included	Not applicable since APS does not currently have stop loss.
Integration with PBM fees	Not included	Our proposal assumes pharmacy will be placed with CareFirst.
Fees for Monthly Data Feeds to Data Warehouse vendor		
Rate Guarantee	Included	
Rate Cap Admin Fees:	Included	CareFirst is offering 3 year flat fees with 2% increase in years 4 and 5. CareFirst has also provided APS with a 1st year only 9 month fee holiday as outlined in the caveats of our proposal.
Second Year	0%	
Third Year	0%	

1.2. Prescription Drug Coverage:

Administrative Fees	2024	2025	2026
Per member per month	**$0.00**	**$0.00**	**$0.00**

Financial Offer- Network (Primary financial offer)			
Confirmation if the following are included or excluded in the guaranteed/estimated discount from AWP.			
Network Inclusion/Exclusions	**Mail Channel**	**Retail Channel**	**Specialty Channel**
U&C	Included	Included	Included
OTCs	Excluded	Excluded	Excluded
Compounds	Excluded	Excluded	Excluded
Vaccines	Excluded	Excluded	Excluded
Specialty Drugs	Included	Included	Included
LDD	Included	Included	Included
Bio-Similar	Included	Included	Included
Authorized Generics	Included	Included	Included
ZBC (Using calculated Ingredient Cost; not 100% discount)	Included	Included	Included
COBs	Excluded	Excluded	Excluded
DMRs	Excluded	Excluded	Excluded
Home Infusion	Included	Included	Included
LTC	Included	Included	Included
I/T/U (Indian/Tribal Health Providers)	Included	Included	Included
Military/ VA	Excluded	Excluded	Excluded
Non-Formulary Drugs	Excluded	Excluded	Excluded
Formulary Excluded Drugs	Excluded	Excluded	Excluded
Out-of-Network/Non-Contracted	Excluded	Excluded	Excluded
Claims with Ancillary Charges (if excluded, please define in comment section)	Included	Included	Included
Claims with Copay Assistance (if excluded, please define in comment section)	Excluded	Excluded	Excluded
Claims with an Override	Included	Included	Included
Subrogation Claims	Excluded	Excluded	Excluded
DAW 5 Claims	Excluded	Excluded	Excluded
Repackaged NDCs	Excluded	Excluded	Excluded
Unit dose/Unit of Use NDCs	Included	Included	Included
Rural Pharmacies	Included	Included	Included

List all other exclusions not listed in the table above		
List all other exclusions not listed in the table above:	COVID Anti-Virals and COVID test kits	
If Rural Pharmacies are excluded, please define and provide a current list.	Not Applicable	
APS guarantees are measured and reconciled on a dollar-for-dollar basis with 100% of any shortfalls recouped by APS.	Accept	
APS prefer each distinct pricing guarantee to be measured and reconciled individually. Please confirm agreement.	Do not accept	Discount and Dispensing fees are measured in aggregate, however surpluses in one guarantee (for

		example, Discount guarantee) will not be used to offset shortages in another guarantee (for example, Dispensing Fee or Rebate Guarantee). Rebates are reconciled in aggregate but are not used to offset outside the Rebate channel.
Please describe any limitations to the Pricing Guarantees (Network, Specialty, Rebates, etc.), if any.	Please refer to explanations throughout the questionnaire.	
Network name & type for Retail 30:	Broad Network	
Which Retail 30 network are you proposing? Please provide a description in the comment section below.	Extensive broad network of retail pharmacies comprised of all major chains and local retail locations.	
Are the "Financial Offer Retail 30" rates estimates or guarantees?	Guarantees	

Retail 30 standard drugs (Non-Specialty Drugs)			
Financial Offer Retail 30	**2024**	**2025**	**2026**
Generic AWP Discount	84.00%	84.25%	84.50%
Generic Dispensing Fee	$0.35	$0.35	$0.35
Brand AWP Discount	19.00%	19.10%	19.20%
Brand Dispensing Fee	$0.35	$0.35	$0.35
Network name & type for Retail 90:		Mail at Retail Network	
Which Retail 90 network are you proposing? Please provide a description in the comment section below.		Retail 90 assumes CVS Voluntary Maintenance Choice.	
Are the "Financial Offer Retail 90" rates estimates or guarantees?		Guarantees	
Retail 90 standard drugs (Non-Specialty Drugs)			
Financial Offer Retail 90	**2024**	**2025**	**2026**
Generic AWP Discount	86.50%	86.60%	86.70%
Generic Dispensing Fee	$0.00	$0.00	$0.00
Brand AWP Discount	25.00%	25.00%	25.00%
Brand Dispensing Fee	$0.00	$0.00	$0.00
Describe as Mandatory, Maintenance/Choice/Smart 90, etc. for Mail network.		Voluntary Maintenance Choice	
Which Mail network are you proposing? Please provide a description in the comment section below.		Exclusive	With Voluntary Maintenance Choice, members have the option of having their maintenance medications filled at any CVS retail pharmacy or through the CVS Caremark Mail Service Pharmacy.

Are the "Financial Offer Mail Service" rates estimates or guarantees?		Guarantees	

Mail standard drugs (Non-Specialty Drugs)			
Financial Offer Mail Service	**2024**	**2025**	**2026**
Generic AWP Discount	86.50%	86.60%	86.70%
Generic Dispensing Fee	$0.00	$0.00	$0.00
Brand AWP Discount	25.00%	25.00%	25.00%
Brand Dispensing Fee	$0.00	$0.00	$0.00

Additional Information		
Please list any limitations including Days Supply, if applicable. (Mail)	Mail Day supply is 84 days or greater.	
Which specialty network are you proposing? Please provide a description in the comment section below.	Exclusive	CVS Specialty Pharmacies only.
Are the "Financial Offer Specialty Drugs at Retail" rates estimates or guarantees?	Guarantees	

Specialty drugs filled at Retail			
Financial Offer Specialty Drugs at Retail	**2024**	**2025**	**2026**
Generic AWP Discount	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy
Generic Dispensing Fee	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy
Brand AWP Discount	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy
Brand Dispensing Fee	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy
New to Market Brand AWP Discount	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy
New to Market Brand Dispensing Fee	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy
LDD AWP Discount	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy
LDD Dispensing Fee	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy
Biosimilar AWP Discount	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy
Biosimilar Dispensing Fee	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy	Included in Specialty Drug at Specialty Pharmacy

Additional Information		
Are the "Financial Offer Specialty Drugs at Mail/Specialty" rates estimates or guarantees?	Guarantees	

Specialty drugs filled at Mail/Specialty Pharmacy:			
Financial Offer Specialty Drugs at Mail/Specialty	**2024**	**2025**	**2026**
Generic AWP Discount	20.00% combined overall specialty discount	20.10% combined overall specialty discount	20.20% combined overall specialty discount
Generic Dispensing Fee	Retail: $0.35 combined brand/generic Mail: $0.00 combined brand/generic	Retail: $0.35 combined brand/generic Mail: $0.00 combined brand/generic	Retail: $0.35 combined brand/generic Mail: $0.00 combined brand/generic
Brand AWP Discount	20.00% combined overall specialty discount	20.10% combined overall specialty discount	20.20% combined overall specialty discount
Brand Dispensing Fee	Retail: $0.35 combined brand/generic Mail: $0.00 combined brand/generic	Retail: $0.35 combined brand/generic Mail: $0.00 combined brand/generic	Retail: $0.35 combined brand/generic Mail: $0.00 combined brand/generic
New to Market Brand AWP Discount	Included in combined overall Specialty Discount	Included in combined overall Specialty Discount	Included in combined overall Specialty Discount
New to Market Brand Dispensing Fee	Included in combined Dispensing Fee	Included in combined Dispensing Fee	Included in combined Dispensing Fee
LDD AWP Discount	Included in combined overall Specialty Discount	Included in combined overall Specialty Discount	Included in combined overall Specialty Discount
LDD Dispensing Fee	Included in combined Dispensing Fee	Included in combined Dispensing Fee	Included in combined Dispensing Fee
Biosimilar AWP Discount	Included in combined overall Specialty Discount	Included in combined overall Specialty Discount	Included in combined overall Specialty Discount
Biosimilar Dispensing Fee	Included in combined Dispensing Fee	Included in combined Dispensing Fee	Included in combined Dispensing Fee

Additional Information		
Please list any limitations including Days Supply, if applicable. (Specialty)	The maximum days' supply coverage for specialty drugs is 30 days.	
Please list any additional Specialty Drug exclusions not otherwise included above.	Not Applicable	
Specialty network guarantees will include a separate overall discount guarantee for Specialty Brands and Specialty Generics.	Disagree	The Specialty discount guarantee of AWP-20.00% (Year 1) applies to both brand and generic Specialty drugs.
Specialty pricing will be guaranteed on the individual drug (NDC or GPI) level, overall Discount, or both?	Overall discount	The Specialty discount guarantee of AWP-20.00% (Year 1) applies to both brand and generic Specialty drugs.
In addition to the aggregate specialty guarantee, does the Bidder agree to provide individual specialty drug guarantees? (If Contractor selects "Aggregate and Individual Specialty Drug Guarantees," please ensure the specialty list	Disagree	

includes discounts or upload a guaranteed price list in Section 16: Optional Attachments)		
Are you willing to offer an overall PMPM guarantee? If offering a PMPM guarantee please upload details including exclusions in the Optional Attachments section.	No	

1.2.1. Credits and Allowances:

Credits and Allowances					
Type	**One time**	**2024**	**2025**	**2026**	**Comment**
Implementation	$57,500.00	$0.00	$0.00	$0.00	Implementation credit is a one-time credit that will be invoiced in full within the first 90 days of 1/1/2024 .
Other	Pharmacy Management Fund and a Pharmacy Loyalty Credit	$50,000.00	$50,000.00 $10,000.00	$50,000.00 $10,000.00	We are providing a Pharmacy Management Fund for the 2024, 2025, and 2026 contract years; invoices are required. The loyalty credit will be provided within the 1st 90 days of the 1st quarter as outlined in the caveats.

1.2.2. Rebates

Financial Offer- Rebates	Response	Explanation
Name of proposed formulary	Formulary 2	Formulary 2 is our standard formulary which includes the Advanced Control Specialty Formulary (ACSF).
Please attach a list of all drugs excluded from proposed formulary, if any.	Attached	Please refer to attachment labeled, "CareFirst 2023 Formulary 2 - Exclusions" and "Drug Exclusion Plan Design List." List is subject to change.
Copay/Co-insurance requirements:	In order to qualify for three-tier qualifying Rebates, Members under this Agreement must be covered under a three-tier qualifying plan design. A three-tier qualifying plan design consists of a plan design with the first tier comprised of Generic Drugs, the second tier comprised of Preferred Brand Drugs, and the third tier comprised of Non-Preferred Brand Drugs, with at least a $15.00 co-payment differential between Preferred and Non-Preferred Brand Drugs, at least a $15.00 differential in the minimum Copayment, or a differential of Coinsurance 1.5 times or 50 percentage points between the Preferred and Non-Preferred Brand Drug (for example, if Preferred Brand Drug Coinsurance was 20%, the Non-Preferred Brand Drug Coinsurance would need to be 30% to qualify).	

Financial Offer- Rebates	Response	Explanation
Does the Rebate offer apply to the current plan benefit design and formulary type (Open, Exclusionary)	Yes	Our Formulary 2 is an open formulary with drug exclusions.

Additional Category Included/ excluded from Rebate proposal		
Category	**Standard Brand Drugs**	**Specialty Drugs**
U&C	Included	Included
Compounds	Excluded	Excluded
LDD	Excluded	Excluded
Bio-Similar	Excluded	Excluded
ZBC (Using calculated Ingredient Cost; not 100% discount)	Included	Included
Multisource Brands	Included	Included
Diabetic test strips and OTC insulins	Excluded	Excluded
All OTCs (Not including Diabetic test strips and OTC insulins)	Excluded	Excluded
Non-rebatable Specialty NDCs (If excluded, please provide a list of NDCs)	Included	Included
Non-rebatable Brand NDCs (If excluded, please provide a list of NDCs)	Included	Included
Home Infusion	Excluded	Excluded
LTC	Included	Included
Vaccines	Excluded	Excluded
Military/ VA	Excluded	Excluded
Out-of-Network/Non-Contracted Pharmacies	Excluded	Excluded
Rural Pharmacies (If excluded, please define.)	Included	Included
COBs	Excluded	Excluded
DMRs	Excluded	Excluded
Claims with Ancillary Charges (if excluded, please define in comment section)	Included	Included
Claims with Copay Assistance (if excluded, please define in comment section)	Excluded	Excluded
Discount Card Claims	Excluded	Excluded
Claims with an Override	Included	Included
Subrogation Claims	Excluded	Excluded
DAW 5 Claims	Excluded	Excluded
Repackaged NDCs	Excluded	Excluded
Unit dose	Included	Included
Unit of Use NDCs	Included	Included
Claims for beauty aids and cosmetics	Included	Included
Multi-Source Generic Claims	Excluded	Excluded
Single-Source Generic Claims	Excluded	Excluded
Claims where after meeting the deductible the Member's Cost Share under the applicable Benefit Design is greater than or equal to 50%	Included	Included

Other exclusions not listed above		
other exclusions not listed above.	COVID Anti-Virals and COVID Test Kits	
Contractor agrees to pass-through 100% of their received Manufacturer Derived Revenue.	Partial Agree	CareFirst retains MAF
Contractor agrees to pass-through 100% of Manufacturer Derived Revenue whether directly paid to Contractor or Contractor's affiliate, subsidiary, or subcontractor (Such as GPO or Rebate Aggregator), less any bona fide service fees.	Partial Agree	CareFirst retains MAF.
Contractor will disclose all Manufacturer derived revenue directly paid to Contractor or Contractor's affiliate, subsidiary, or subcontractor (Such as GPO or Rebate Aggregator).	Disagree	.

% of Manufacturer Derived Revenue (whether directly paid to Contractor or Contractor's affiliate, subsidiary, or subcontractor) passed through to APS.		
Category	**Standard Brand Drugs - enter % passed through to plan**	**Specialty Drugs- enter % passed through to plan**
Rebates	Provided to client based on proposed rebate guarantees.	Provided to client based on proposed rebate guarantees.
Incentive rebates categorized as mail-order purchase discounts	Provided to client based on proposed rebate guarantees.	Provided to client based on proposed rebate guarantees.
Credits	N/A	N/A
Market Share Incentives	Provided to client based on proposed rebate guarantees.	Provided to client based on proposed rebate guarantees.
Promotional Allowances	N/A	N/A
Commissions	N/A	N/A
Market Share Utilization	Provided to client based on proposed rebate guarantees.	Provided to client based on proposed rebate guarantees.
Drug pull-through programs	N/A	N/A
Implementation Allowances	N/A	N/A
Rebate Submission Fees	N/A	N/A
Formulary Placement Fees	N/A	N/A
Administrative Fees	Not included under the definition of rebates.	Not included under the definition of rebates.
Inflation Caps/Pricing Protection	Provided to client based on proposed rebate guarantees.	Provided to client based on proposed rebate guarantees.
Price Concessions	N/A	N/A
Performance-based Incentives	N/A	N/A
Data Fees	N/A	N/A
Volume-based Incentives	N/A	N/A
Other	N/A	N/A

Expected total rebate dollar amount the client will receive during the three-year term of the contract. Provide estimated rebate amount for Biosimilars, LDD, and any ancillary claims in the "All Other" bucket.				
Estimated Rebate Amounts	**2024**	**2025**	**2026**	**Total**
Standard Brands filled at Retail	$467,443	$481,462	$495,903	$1,444,807
Standard Brands filled at Mail	$1,172,492	$1,207,667	$1,243,902	$3,624,061
Standard Brands filled at Specialty	N/A	N/A	N/A	N/A
Specialty Brands filled at Retail	N/A	N/A	N/A	N/A
Specialty Brands filled at Mail	N/A	N/A	N/A	N/A
Specialty Brands filled at Specialty	$893,200	$919,996	$947,590	$2,760,786

Rebates Guarantees		
Description	**Response**	**Explanation**
For the following table, "Financial Offer Rebates," are you willing to provide estimates or guarantees?	Guarantees	We are providing a fixed per brand script rebate guarantee.

Financial Offer Rebates	2024	2025	2026
Retail/30 per brand claim	$276.43	$284.72	$293.26
Retail/90 per brand claim	$719.32	$740.90	$763.13
Mail per brand claim	$719.32	$740.90	$763.13
Specialty Drugs at Specialty/Mail per brand claim	$2,800.00	$2,884.00	$2,970.50
Specialty Drugs at Retail per brand claim	Included In Specialty Drugs at Specialty	Included In Specialty Drugs at Specialty	Included In Specialty Drugs at Specialty
Please provide any comments on your entries in the above table:	text	Retail 90 assumes Voluntary Maintenance Choice	

Included Services			
Services (Eligibility)	**Please indicate Included or Excluded**	**Additional Cost**	**Comment**
Administration of eligibility submitted in a Contractor/PBM-standard digital format.	Included	Dollars. $0.00	Text
Eligibility maintenance.	Included	Dollars. $0.00	Text
Hard copy eligibility submission.	Included	Dollars. $0.00	Text
Please list any eligibility services that aren't included in the bid below and provide cost.	All eligibility services are included in our bid, there are no additional costs.		
Services (Support)			
APS is allowed access to PBM's systems to support coverage, eligibility & authorization activities.	Excluded	Dollars. N/A	
Connectivity charges to customer and provider support system.	Included	Dollars. $0.00	
Please list any support services that aren't included in the bid below and provide cost.			We have noted any services that are available at an additional cost.
Services (Claim Adjudication)			

Administration of PBM standard plan designs including tiered (3 and greater) co-payments, coinsurance, maximum limits, out-of-pocket limits, and deductibles.	Included	Dollars. $0.00	
In-network claims adjudication via on-line claims adjudication system.	Included	Dollars. $0.00	
Direct reimbursement/out-of-network claims adjudication (including check and EOB)	Excluded	Dollars. $1.50 per paid claim	
On-line claims history retention more than 12 months.	Included	Dollars. $0.00	
Transfer of claims to medical carrier and consultants.	Included	Dollars. $0.00	Since we have integrated medical and pharmacy claims, there is no need to transfer claims. CareFirst will provide monthly files to APS and your consultant at no additional cost.
Compound Claim Adjudication	Included	Dollars. $0.00	Included in overall pricing of compound claim adjudication.
Vaccine Claim Adjudication	Included	Dollars. $0.00	Included in overall pricing of vaccine claim adjudication.
Please list any claim adjudication services that aren't included in the bid below and provide cost.			We have noted any services that are available at an additional cost.
Services (Retail Pharmacy Network)			
Establish, maintain, credential and contract an adequate panel of participating network pharmacies.	Included	Dollars. $0.00	
Develop & distribute communication materials to participating pharmacies regarding the program.	Included	Dollars. $0.00	
Toll-free access to Help Desk for eligibility/claims processing assistance.	Included	Dollars. $0.00	
Toll-free access to PBM pharmacists to obtain DUR assistance.	Included	Dollars. $0.00	
Monitor network pharmacy performance and compliance, including generic substitution rates, formulary program conformance, and DUR intervention conformance through retail network management initiatives and reporting.	Included	Dollars. $0.00	
Standard pharmacy audit program (including desktop, member survey, and onsite pharmacy audits).	Included	Dollars. $0.00	
Enhanced audit program (please describe).	Excluded	Dollars. N.A	We do not offer an enhanced audit program at this time.
Please list any retail pharmacy network services that aren't included in the bid below and provide cost.			We have noted any services that are available at an additional cost.
Services (Clinical Programs)			
Point of Sale Edits.	Included	Dollars. $0.00	
Dose/Quantity Duration Edits.	Included	Dollars. $0.00	

Step Therapy Edits.	Included	Dollars. $0.00	
Dispensing Quantity Edits.	Included	Dollars. $0.00	
Physician prescribing summaries.	Included	Dollars. $0.00	
High utilization management.	Included	Dollars. $0.00	
Patient-specific notifications to physicians regarding drug therapy problems (i.e. non-compliance, early discontinuation, suboptimal therapy) based on integrated prescription, medical, and laboratory data.	Included	Dollars. $0.00	
Please list any clinical program services that aren't included in the bid below and provide cost.	text	Pharmacy Advisor - $0.50 PMPM Safety and Monitoring - $0.06 PMPM Drug Savings Review - $0.30 PMPM	
Services (Reviews and Appeals Management)			
Prior Authorization - Clinical	Excluded	Dollars. $30.00 Per Review	
Prior Authorization - Administrative	Included	Dollars. $0.00	
First Level Appeals	Excluded	Dollars. $100.00 Per Request	
Higher Level Appeals	Excluded	Dollars. $500.00 Per Request	
Clinical - conditions of coverage reported by physician	Excluded	Dollars. $30.00 Per Review	
Please list any review and appeal management services that aren't included in the bid below and provide cost.			We have noted any services that are available at an additional cost.
Services (Reporting)			
Standard management reports.	Included	Dollars. $0.00	
Daily or weekly claims detail file (sent to APS and/or consultants).	Included	Dollars. $0.00	
Quarterly or annual claims detail electronic file (sent to APS and/or consultants).	Included	Dollars. $0.00	
Web-based online, decision support tool allowing APS access to reports and ad hoc query capabilities.	Included	Dollars. $0.00	
Additional ad hoc/custom report production, reprogramming and testing of non-standard requirements for APS.	Included	Dollars. $0.00	
Up to 10 programming hours to support specialized reporting or benefit design.	Included	Dollars. $0.00	
Please list any reporting services that aren't included in the bid below and provide cost.			We have noted any services that are available at an additional cost.
Services (Member Services)			

Toll-free telephone access to customer service for the program for use by plan members, benefits personnel, and physicians.	Included	Dollars. $0.00	
Toll-free telephone access to voice response unit for location of network pharmacies in zip code area.	Included	Dollars. $0.00	
24-hour access to a Contractor pharmacist via toll-free telephone service.	Included	Dollars. $0.00	
Contractor enrollment package for new members, including announcement letter, descriptive brochure, & mail-service envelope.	Included	Dollars. $0.00	
Distribution of customized materials, except as described elsewhere.	Included	Dollars. $0.00	CareFirst will include any customized materials within a mailing, upon request. There are additional costs involved for customized materials.
Optional Explanation of Benefits (OEOB) to describing the application of deductibles and coinsurance.	Included	Dollars. $0.00	All Explanation of Benefits are available through our CareFirst website.
Customized, targeted member mailings for supporting formulary initiatives.	Included	Dollars. $0.00	In some circumstances, we may create materials that meet APS's branding needs. When designing branded materials for an account, CareFirst requires a camera-ready proof of the logo and identification of all colors by Pantone Matching System number. Additionally, as a part of the Blue Cross Blue Shield Association, CareFirst must abide by the brand guidelines set forth by the Association and regulators to ensure CareFirst's brand compliance. Should APS wish to customize communication materials, we are happy to work with you to do so. Additional costs, are dependent on the level of customization required.
Please list any member services that aren't included in the bid below and provide cost.			We have noted any services that are available at an additional cost.
Services (Contractor Website)			
Standard member website capabilities including online prescription ordering and status, coverage and benefit information, health information, and assessment resources.	Included	Dollars. $0.00	

Online drug cost comparison tool including formulary status and average cost per prescription.	Included	Dollars. $0.00	
Please list any Contractor website services that aren't included in the bid below and provide cost.			We have noted any services that are available at an additional cost.
Services (Account Management)			
APS clinical and plan consulting, analysis and cost projections.	Included	Dollars. $0.00	
Annual analysis of program utilization and impact of plan design and managed care interventions.	Included	Dollars. $0.00	
Please list any account management services that aren't included in the bid below and provide cost.			We have noted any services that are available at an additional cost.
Services (Mail Pharmacy Services)			
Processing of prescriptions received via Internet, fax, phone or mail.	Included	Dollars. $0.00	
Refill orders received by phone or Internet 24 hours a day, 7 days a week.	Included	Dollars. $0.00	
Handling and postage expense of home delivery prescriptions.	Included	Dollars. $0.00	
Expedited delivery.	Included	Dollars. $0.00	
Braille prescription labels for visually impaired.	Included	Dollars. $0.00	
Communication/educational materials included in medication packages including benefit summary statement, drug information leaflet, mail-service envelope, and refill forms (as needed).	Included	Dollars. $0.00	
General communications regarding utilization of home delivery including brochures, table tent cards, posters, content for general e-mail messaging to members, newsletter content.	Included	Dollars. $0.00	
Please list any Mail pharmacy services that aren't included in the bid below and provide cost.			We have noted any services that are available at an additional cost.

1.3. Vision coverage:

Enrollment (Current Population)	
Employee Only	1248
Employee + Spouse	234
Employee + Child(ren)	221
Employee + Family	300
Total Subscribers:	2003

Vision	2024	2025	2026
Employee Only	$8.40	$8.40	$8.40
Employee + Spouse	$16.80	$16.80	$16.80
Employee + Child(ren)	$17.64	$17.64	$17.64
Employee + Family	$24.62	$24.62	$24.62

1.4. Onsite Nurse Practitioner:

Onsite Nurse	2024	2025	2026
Implementation/Startup Fee	$0	$0	$0
Ongoing Fee (PEPM)	$6.84	$6.84	$6.84

1.5. Employee Assistance Program (EAP):

EAP	3 Session Model	6 Session Model	10 Session Model	Comments
One-time implementation/start-up fee	N/A	N/A	N/A	There are no implementation fees.
Annual renewal/maintenance fee	N/A	N/A	N/A	There are no annual renewal/maintenance fees.
Fee per participant per month	$1.00 PEPM	$1.30 PEPM	$1.63 PEPM	

1.6. Administration of FSAs and COBRA

Administration of FSAs and COBRA	Health FSA	Dependent FSA	COBRA Services/HIPAA	Comments
One-time implementation/start-up fee	$250		Waived with multiple products	
Annual renewal/maintenance fee	$0	$0	$150	We've provided the Commuter pricing in the COBRA & Commuter fee review.
Take over charge/rollover from prior vendor	$0	$0	$10.00 per continuant	
Fee per participant per month	$2.93	$2.93		
Discrimination testing	One round included annually additional test $600 per test.	One round included annually additional test $600 per test.		
FSA debit card	Included	Not applicable		

Administration of FSAs and COBRA	Health FSA	Dependent FSA	COBRA Services/HIPAA	Comments
Eligibility feeds in excess of 52 per year	Included	Included		
Amount of Imprest balance required	Not applicable	Not applicable		
Minimum check amount	$5	Not applicable		
Plan document	Included, changes additional fee	Included, changes additional fee		
SPD development & printing	Information provided to APS electronically	Information provided to APS electronically		
Communication materials	Welcome kit and standard communications included	Welcome kit and standard communications included		
Open enrollment meetings	Included, with number of meetings to be mutually agreed upon	Included with number of meetings to be mutually agreed upon		
Fees for ad hoc reports	To be determined based on complexity and available data.	To be determined based on complexity and available data.		
Other services and fees associated, please describe	Refer to the attached fee review.	Refer to the attached fee review.		Refer to the attached fee review.
			Per Event Basis:	**Comments**
Per continuant per month charge			$0.40 Per Employee Per Month (PEPM).	We are not proposing event-based COBRA admin.
Outside carrier elig feeds and premium remittance (per carrier per month)			$25.00 per carrier per month	
COBRA Qual. Event Notice (including distribution and processing)			Included	
COBRA/HIPAA Initial Notice			Included	
WHCRA Notices			$2.25 per notice (optional)	
CHIPRA Notices			Not included	
PPACA Notices			Not included	
State Continuation Notices			Available in California, Texas,	

Administration of FSAs and COBRA	Health FSA	Dependent FSA	COBRA Services/HIPAA	Comments
			New York, Iowa, and South Dakota for additional PEPM.	
Past Due Notices			Included in participant's monthly statement	
Direct Billing (per retiree per month)			**Optional**	
Retro COBRA/HIPAA Initial Notices			$3.00 per retro COBRA special rights notice (optional) $2.00 per retro OE notice (optional)	
Post-COBRA HIPAA Cert of Cov			HIPAA Certificates of Creditable Coverage are no longer required effective December 31, 2014 based upon Department of Health and Human Services and the Centers for Medicare & Medicaid Services final regulations.	
Medicare Part D Notices			Not included	
HIPAA Privacy Notices			$2.60 per HIPAA special enrollment notice	
Open Enrollment Service (packaging and distribution)			Standard Open enrollment packets: $15.00*	
Assumptions:	**Indicate agreement or provide additional detail:**			
Mailing costs included	Yes for Welcome Kit	Yes for Welcome Kit	Standard Open enrollment packets: $15.00*	
Standard FSA reports include:				
Monthly executive summary report	Yes	Yes		
Monthly member detail report	Yes	Yes		
Monthly utilization report	Yes	Yes		

Administration of FSAs and COBRA	Health FSA	Dependent FSA	COBRA Services/HIPAA	Comments
Monthly Member Health Statements included	Member account information is available online.	Member account information is available online.	COBRA information for the participant is available on the member portal.	
Other assumptions	Refer to the attached fee review.	Refer to the attached fee review.	Refer to the attached fee review.	

2. Self-Insured - Exclusive Provider Organization (SI-EPO) Plan:

	TOTAL
OAP Low	**1115**
OAP High	**766**
Total	**1881**

Self-Insured	**Self-Insured-Exclusive Provider Organization (SI-EPO)**			
Fees	**2024**	**2025**	**2026**	**Comments**
Medical Plans PEPM	$29.75	$29.75	$29.75	
Network Access Fee	See comments	See comments	See comments	Included fee is based as a % of claims. Under the proposed BlueCard program, a Host BCBS plan may withhold an access fee of up to [redacted]% (but not to exceed $[redacted] for any claim) of the provider discount the plan has obtained from its participating providers. Please refer to the caveats section of our proposal for a complete detailed description.
Utilization Review Fees	Included	Included	Included	
Claims Fiduciary	$0.96	$0.96	$0.96	Fiduciary Option 4 is included in our proposal.
Nurse Line	Included	Included	Included	
MHSA Network and Non Claims Admin.	Included	Included	Included	
MHSA Claims Administration	Included	Included	Included	
OON Claim Management	Included	Included	Included	CareFirst will negotiate out-of-network claims on APS's behalf and reprice non-contracted claims through a vendor-partner. When successful, a 40% fee is applied to the savings generated.
Total Admin. Fee	**$30.71**	**$30.71**	**$30.71**	

End of Pricing Schedule

Attachment C

Contractor Certification Regarding Criminal Convictions

The completed form from the Contractor is a condition precedent to the award of the Contract.

As the official authorized to enter into this Contract on behalf of my organization, I certify that the Contractor, its employees, its sub-contractor(s) and their employees, who will have direct contact with students either on or off school property either during regular school hours or during school-sponsored activities during the performance of this Contract, has not been convicted of:

1. A felony or of any offense involving the sexual molestation, physical or sexual abuse, or rape of a child;
2. A sexually violent offense as defined in Va. Code Ann. § 9.1-902;
3. Any of the offense listed below occurring on or after July 1, 2006 in which the offender was more than three years older than the victim, when the offense was done in the commission of, or as a part of the same course of conduct of, or as part of a common scheme or plan to commit, (i) abduction or kidnaping in violation of Va. Code Ann. § 18.2-47 or § 18.2-48, (ii) burglary in violation of Va. Code Ann. § 18.2-89, (iii) entering a dwelling house with intent to commit crimes in violation of Va. Code Ann. § 18.2-90 or Va. Code Ann. § 18.2-91, or (iv) aggravated malicious wounding in violation of Va. Code Ann. § 18.2-51.2., or (v) any similar offense under the laws of any foreign country or any political subdivision thereof, or the United States or any political subdivision thereof:

   a. Rape of a child under 13 in violation of Va. Code Ann. § 18.2-61;
   b. Forcible sodomy with a child under 13 in violation of Va. Code Ann. § 18.2-67.1; or
   c. Object sexual penetration with a child under 13 in violation of Va. Code Ann. § 18.2-67.2;.or
4. A conviction for a crime of moral turpitude.

I understand that a materially false statement regarding this certification is a Class 1 misdemeanor and that conviction of such misdemeanor shall result in the revocation of this Contract and of any related license that I may hold. I declare under penalty of perjury that the foregoing statements are true and correct.

This form must be completed by an authorized official for any organization contracting to provide services under a contract with the Arlington Public Schools or any of its schools or departments, or any subcontractor under such contractor.

CareFirst BlueCross BlueShield (business name of Group Hospitalization and Medical Services, Inc.)
Name of Offeror

[signature]
Signature

3060 Williams Drive, Suite 200
Fairfax, VA 22031
1501 S. Clinton Street
Baltimore, MD 21224
Address of Offeror

Reggie White, Senior Vice President, Commercial Market and CFA
Name and Title (please type or print)

(703) 489-8395
Telephone

February 3, 2023
Date

End of Contractor Certification Regarding Criminal Convictions

Attachment D

Non-Disclosure and Data Security Agreements

The undersigned, an authorized agent of the Contractor and on behalf of CareFirst BlueCross BlueShield (Contractor) hereby agree that the Contractor will hold Arlington Public Schools (APS) provided information, documents, data, images, records and the like (hereafter "Information") confidential and secure and to protect it against loss, misuse, alteration, destruction or disclosure. This includes but is not limited to the Information of the APS, its employees, contractors, residents, clients, patients, taxpayers and property as well as Information that the APS shares with Contractor for testing, support, conversion or other services provided under APS (the "Work" or "APS Contract" as applicable) or which may be accessed through other APS owned or controlled databases (all of the above collectively referred to herein as "Information" or "APS Information").

In addition to the Data Security obligations set in the APS Contract, the Contractor agrees that it will maintain the privacy and security of the APS Information, control and limit internal access and authorization for access to such Information and not divulge or allow or facilitate access to APS Information for any purpose or by anyone unless expressly authorized. This includes but is not limited to Information that in any manner describes, locates or indexes anything about an individual including, but not limited to, his/her (hereinafter "his") Personal Health Information, treatment, disability , services eligibility, services provided, investigations, real or personal property holdings, and his education, financial transactions, medical history, ancestry, religion, political ideology, criminal or employment record, social security number, tax status or payments, date of birth, address, phone number or that affords a basis of inferring personal characteristics, such as finger and voice prints, photographs, or things done by or to such individual, and the record of his presence, registration, or membership in an organization or activity, or admission to an institution (also collectively referred to herein as "Information" or "APS Information").

Contractor also agrees that a claims administrator may use and/or disclose PHI or other claims data for the following purposes, provided all such disclosure is consistent with HIPAA Privacy standards: (i) internal exchange and study between and among the claim administrator and its affiliates for purposes of utilization studies, cost analyses or modeling initiatives, quality assurance, provider profiling, credentialing and network management, fraud and abuse monitoring or investigation, administrative or process improvement and cost comparison studies and reports for actuarial analyses; and (ii) unless prohibited by APS, administrator may release claims information in a de-identified format to a third party data aggregation service or data warehouse for purposes of utilization studies, cost analyses or modeling initiatives, quality assurance, provider profiling, credentialing and network management, fraud and abuse monitoring or investigation, administrative or process improvement, cost comparison studies and reports for actuarial analyses and/or other commercial purposes.

The Contractor agrees that it will not divulge or otherwise facilitate the disclosure, dissemination or access to or by any unauthorized person, for any purpose, of any Information obtained directly, or indirectly, as a result of its work on the Work. Contractor shall coordinate closely with the APS Project Officer to ensure that its authorization to its employees or approved subcontractors is appropriate, tightly controlled and that such person/s also maintain the security and privacy of Information and the integrity of APS networked resources.

Contractor agrees to take strict security measures to ensure that Information is kept secure, properly stored, that if stored that it is encrypted as appropriate, stored in accordance with industry best practices and otherwise protected from retrieval or access by unauthorized persons or unauthorized purpose. Any device or media on which Information is stored, even temporarily, will have strict security and access control. Any Information that is accessible will not leave the Contractor's work site or the APS' physical facility, if working onsite, without written authorization of the APS Project Officer. If remote access or other media storage is authorized, Contractor is responsible for the security of such storage device or paper files.

Contractor will ensure that any laptops, PDAs, netbooks, tablets, thumb drives or other media storage devices, as approved by the APS, and connected to the APS network are secure and free of all computer viruses or running the latest version of an industry standard virus protection program. Contractor will ensure that all passwords used by its employees or subcontractors are robust, protected and not shared. No Information may be downloaded expect as

agreed to by the parties and then only onto an APS approved device. Downloading onto a personally owned device is prohibited. Contractor agrees that it will notify the APS Project Officer immediately upon discovery, becoming aware or suspicious of any unauthorized disclosure of Information, security breach, hacking or other breach of this Non-Disclosure and Data Security Agreement, the APS Contract, APS policy, Contractor's security policies, or any other breach of Work protocols. The Contractor will fully cooperate with the APS to regain possession of any Information and to prevent its further disclosure, use or dissemination. The Contractor also agrees, if requested, to promptly notify others of a suspected or actual breach.

Contractor agrees that all duties and obligations enumerated in this Non-Disclosure and Data Security Agreement also extend to its employees, agents or subcontractors who are given access to APS Information. Breach of any of the above conditions by Contractor's employees, agents or subcontractors shall be treated as a breach by Contractor. Contractor agrees that it shall take all reasonable measures to ensure its employees, agents and subcontractors are aware of and abide by the terms and conditions of this Non-Disclosure and Data Security Agreement and related data security provisions in the APS Contract.

It is the intent of this Non-Disclosure and Data Security Agreement to ensure that the Contractor has the highest level of administrative safeguards, disaster recovery and best practices are in place to ensure confidentiality, protection, privacy and security of APS Information and APS networked resources and to ensure compliance with all applicable local, state and federal law or regulatory requirements. Therefore, to the extent that this Non-Disclosure and Data Security Agreement conflicts with the APS Contract or with any applicable local, state, or federal law, regulation or provision, the more stringent APS Contract requirement, law, regulation or provision shall control.

At the conclusion of the Work, Contractor agrees to return all APS Information to the APS Project Officer. These obligations remain in full force and effect throughout the Work and shall survive any termination of the APS Contract.

Authorized Signature: Regg[signature] ____________________

Printed Name and Title: Reggie White, Senior Vice President, Commercial Market and CFA

Date: February 3, 2023

End of Non-Disclosure and Data Security Agreement

Attachment E

Business Associate Agreement

This Business Associate Agreement is hereby entered into between CareFirst BlueCross BlueShield (hereafter referred to as "Business Associate") and Arlington Public Schools (hereafter referred to as "Covered Entity" or "APS") (collectively "the parties") and is hereby made a part of any Underlying Agreement for goods or services entered into between the parties.

Recitals

APS provides services to its residents and employees which may cause it or others under its direction or control to serve as covered entities for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

APS, in its capacity as a covered entity, may provide Business Associate with certain information that may include Protected Health Information (PHI), so that Business Associate may perform its responsibilities pursuant to its Underlying Agreement(s) with and on behalf of APS.

Covered Entity and Business Associate intend to protect the privacy of PHI and provide for the security of any electronic PHI received by Business Associate from Covered Entity, or created or received by Business Associate on behalf of Covered Entity in compliance with HIPAA; in compliance with regulations promulgated pursuant to HIPAA, at 45 CFR Parts 160 and Part 164; and in compliance with applicable provisions of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and any applicable regulations and/or guidance issued by the U.S. Department of Health and Human Services ("DHHS") with respect to the HITECH Act (collectively "federal law").

WHEREAS, federal law and the specific regulations promulgated pursuant to HIPAA at 45 CFR § 164.314, 45 CFR § 164-502(e) and 45 CFR § 164.504(e) require a Covered Entity to enter into written agreements with all Business Associates (hereinafter "Business Associate Agreement");

WHEREAS, the parties desire to comply with HIPAA and desire to secure and protect such PHI from unauthorized disclosure;

THEREFORE, **Business Associate** and **Covered Entity,** intending to be legally bound**,** agree as follows. The obligations, responsibilities and definitions may be changed from time to time as determined by federal law and such changes are incorporated herein as if set forth in full text:

1) Definitions

The capitalized terms used in this Business Associate Agreement shall have the meaning set out below:

a) **Accounting**. "Accounting" means a record of disclosures of protected health information made by the Business Associate.

b) **Breach.** "Breach" means the acquisition, access, use, or disclosure of protected health information in a manner not permitted by this Business Associate Agreement and/or by HIPAA which compromises the security or privacy of the protected health information. For purposes of this Business Associate Agreement, any unauthorized acquisition, access, use, or disclosure of protected health information shall be presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a HIPAA risk assessment.

c) **Business Associate**. "Business Associate" means a person who creates, receives, maintains, or on behalf of a Covered Entity to accomplish a task regulated by HIPAA and not as a member of the Covered Entity's workforce. A Business Associate shall include, but is not limited to, a non-workforce person/entity who performs data processing/analysis/transmission, billing, benefit management, quality assurance, legal, actuarial, accounting, administrative and/or financial services on behalf of the Covered Entity involving protected health information. A Business Associate also includes a subcontractor.

d) **Covered Entity**. "Covered Entity" means a health plan, a health care clearinghouse, and/or a health care provider who transmits any health information in electronic form in connections with an activity regulated by HIPAA.

e) **Data Aggregation**. "Data Aggregation" means, with respect to PHI created or received by Business Associate in its capacity as the Business Associate of Covered Entity, the combining of such PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a Business Associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

f) **Designated Record Set.** "Designated Record Set" means all records, including medical, enrollment, billing, payment, claims, and/or case management maintained by and/or for a Covered Entity.

g) **Discovery**. "Discovery" shall mean the first day an unauthorized use or disclosure is known or reasonably should have been known by Business Associate, including when it is or should have been known by any person other than the person who engaged in the unauthorized use/disclosure who is an employee, officer, or agent of Business Associate.

h) **Electronic Protected Health Information**. "Electronic Protected Health Information" means individually identifiable health information that is transmitted by or maintained in electronic media.

i) **HIPAA.** "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 as in effect and/or as amended.

j) **HITECH Act**. "HITECH Act" means the portions of the Health Information Technology for Economic and Clinical Health Act which serve as amendments to HIPAA. HITECH is included within the definition of HIPAA unless stated separately.

k) **Individual.** "Individual" means the person who is the subject of protected health information and/or a person who would qualify as a personal representative of the person who is the subject of protected health information.

l) **Protected Health Information.** "Protected Health Information" or "PHI" means individually identifiable health information transmitted and/or maintained in any form.

m) **Remuneration**. "Remuneration" means direct or indirect payment from or on behalf of a third party.

n) **Required By Law.** "Required By Law" means an activity which Business Associate is required to do or perform based on the provisions of state and/or federal law.

o) **Secretary.** "Secretary" means the Secretary of the Department of Health and Human Services or the Secretary's designee.

p) **Security Incident.** "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with the system operations in an information system.

q) **Underlying Agreement**. "Underlying Agreement" means APS contract for goods or services made through APS's procurement office which the parties have entered into and which APS has determined requires the execution of this Business Associate Agreement.

r) **Unsecured Protected Health Information**. "Unsecured Protected Health Information" means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology approved by the Secretary.

2) Obligations and Activities of Business Associate

a) Business Associate acknowledges and agrees that it is obligated by law (or upon the effective date of any portion thereof shall be obligated) to meet the applicable provisions of HIPAA and such provisions are incorporated herein and made a part of this Business Associate Agreement. Covered Entity and Business Associate agree that any regulations and/or guidance issued by DHHS with respect to HIPAA that relate to the obligations of business associates shall be deemed incorporated into and made a part of this Business Associate Agreement.

b) In accordance with 45 CFR §164.502(a)(3), Business Associate agrees not to use or disclose PHI other than as permitted or required by this Business Associate Agreement or as Required by Law.

c) Business Associate agrees to develop, implement, maintain and use appropriate administrative, technical, and physical safeguards that reasonably prevent the use or disclosure of PHI other than as provided for by this Business Associate Agreement, in accordance with 45 CFR §§164.306, 310 and 312. Business Associate agrees to develop, implement, maintain and use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI, in accordance with 45 CFR §§164.306, 308, 310, and 312. In accordance with 45 CFR §164.316, Business Associate shall also develop and implement policies and procedures and meet the documentation requirements as and at such time as may be required by HIPAA.

d) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate, of a use or disclosure of PHI by Business Associate in violation of the requirements of this Business Associate Agreement.

e) In accordance with 45 CFR §§164.308, 314 and 502, Business Associate will ensure that any workforce member or agent, including a vendor or subcontractor, whom Business Associate engages to create, receive, maintain, or transmit PHI on Business Associates' behalf agrees to the same, or substantially similar but not less restrictive restrictions and conditions that apply through this Business Associate Agreement to Business Associate with respect to such information, including minimum necessary limitations. Business Associate will ensure that any workforce member or agent, including a vendor or subcontractor, whom Business Associate engages to create, receive, maintain, or transmit PHI on Business Associates' behalf, agrees to implement reasonable and appropriate safeguards to ensure the confidentiality, integrity, and availability of the PHI.

f) At the request of Covered Entity, Business Associate will provide Covered Entity, or as directed by Covered Entity, an Individual, access to PHI maintained in a Designated Record Set in a time and manner that is sufficient to meet the requirements of 45 CFR § 164.524, and, where required by

HIPAA, shall make such information available in an electronic format where directed by the Covered Entity.

g) At the written request of Covered Entity, (or if so directed by Covered Entity, at the written request of an Individual), Business Associate agrees to make any amendment to PHI in a Designated Record Set, in a time and manner that is sufficient to meet the requirements of 45 CFR § 164.526.

h) In accordance with 45 CFR §164.504(e)(2), Business Associate agrees to make its internal practices, books, and records, including policies and procedures, and any PHI, relating to the use and disclosure of PHI, available to Covered Entity or to the Secretary for purposes of determining compliance with applicable law. To the extent permitted by law, said disclosures shall be held in strictest confidence by the Covered Entity. Business Associate will provide such access in a time and manner that is sufficient to meet any applicable requirements of applicable law.

i) Business Associate agrees to document and maintain a record of disclosures of PHI and information related to such disclosures, including the date, recipient and purpose of such disclosures, in a manner that is sufficient for Covered Entity or Business Associate to respond to a request by Covered Entity or an Individual for an Accounting of disclosures of PHI and in accordance with 45 CFR § 164.528. Business Associate further shall provide any additional information where required by HIPAA and any implementing regulations. Unless otherwise provided under HIPAA, Business Associate will maintain the Accounting with respect to each disclosure for at least six years following the date of the disclosure.

j) Business Associate agrees to provide to Covered Entity upon written request, or, as directed by Covered Entity, to an Individual, an Accounting of disclosures in a time and manner that is sufficient to meet the requirements of HIPAA, in accordance with 45 CFR §164.528. In addition, where Business Associate is contacted directly by an Individual based upon information provided to the Individual by Covered Entity and where so required by HIPAA and/or any implementing regulations, Business Associate shall make such Accounting available directly to the Individual.

k) In accordance with 45 CFR §164.502(b), Business Associate agrees to make reasonable efforts to limit use, disclosure, and/or requests for PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. Where required by HIPAA, Business Associate shall determine (in its reasonable judgment) what constitutes the minimum necessary to accomplish the intended purpose of a disclosure.

l) In accordance with 45 CFR §502(a)(5), Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual, except with the express written pre-approval of Covered Entity.

m) To the extent Business Associate is to carry out one or more of the Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s).

n) In accordance with 45 CFR §164.314(a)(1)(i)(C), Business Associate agrees to promptly report to Covered Entity any Security Incident of which Business Associate becomes aware.

o) In accordance with 45 CFR §164.410 and the provisions of this Business Associate Agreement, Business Associate will report to Covered Entity, following Discovery and without unreasonable delay, but in no event later than ten business days following Discovery, any Breach of Unsecured Protected Health Information. Business Associate shall cooperate with Covered Entity in investigating the Breach and in meeting Covered Entity's obligations under HIPAA and any other applicable security breach notification laws, including but not limited to providing Covered Entity with such information in addition to Business Associate's report as Covered Entity may reasonably request, e.g., for purposes of Covered Entity making an assessment as to whether/what Breach Notification is required.

Business Associate's report under this subsection shall, to the extent available at the time the initial report is required, or as promptly thereafter as such information becomes available but no later than 30 days from discovery, include:

1. The identification (if known) of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach;
2. A description of the nature of the unauthorized acquisition, access, use, or disclosure, including the date of the Breach and the date of discovery of the Breach;
3. A description of the type of Unsecured PHI acquired, accessed, used or disclosed in the Breach (e.g., full name, Social Security number, date of birth, etc.);
4. The identity of the individual(s) who made and who received the unauthorized acquisition, access, use or disclosure;
5. A description of what Business Associate is doing to investigate the Breach, to mitigate losses, and to protect against any further breaches; and
6. Contact information for Business Associate's representatives knowledgeable about the Breach.

p) Business Associate shall maintain for a period of six years all information required to be reported under paragraph "o". This records retention requirement does not in any manner change the obligation to timely disclose all required information relating to a non-permitted acquisition, access, use or disclosure of Protected Health Information to APS Privacy Officer and APS Project Officer or designee ten business days following Discovery.

3) <u>Permitted Uses and Disclosures by Business Associate</u>

Except as otherwise limited in this Business Associate Agreement, Business Associate may use or disclose PHI, consistent with HIPAA, as follows:

a) Business Associate may use or disclose PHI as necessary to perform functions, activities, or services to or on behalf of Covered Entity under any service agreement(s) with Covered Entity, including Data Aggregation services related to the health care operations of Covered Entity, if called for in the Underlying Agreement, if Business Associate's use or disclosure of PHI would not violate HIPAA if done by Covered Entity.

b) Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

c) Business Associate may disclose PHI for the proper management and administration of Business Associate if:

1. Disclosure is Required By Law;

2. Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential, and will be used or further disclosed only as Required By Law or for the purpose for which it was disclosed, and the person agrees to promptly notify Business Associate of any known breaches of the PHI's confidentiality; or

3. Disclosure is pursuant to an order of a Court or Agency having jurisdiction over said information.

d) Business Associate may use de-identified data to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

4) **Obligations of Covered Entity**

a) Covered Entity will notify Business Associate of any limitations on uses or disclosures described in its notice of privacy practices (NOPP).

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

c) Covered Entity will notify Business Associate of any restriction of the use or disclosure of PHI, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

d) Covered Entity will notify Business Associate of any alternative means or locations for receipt of communications by an Individual which must be accommodated or permitted by Covered Entity, to the extent that such alternative means or locations may affect Business Associate's use or disclosure of PHI.

e) Except as otherwise provided in this Business Associate Agreement, Covered Entity will not ask Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA if such use and/or disclosure was made by Covered Entity.

5) Term, Termination and Breach

a) This Business Associate Agreement is effective when fully executed and will terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, including any material provided to subcontractors. If it is infeasible to return or destroy all PHI, protections are extended to such information, in accordance with the Section 5(d) and 5(e) below.

b) Upon Covered Entity's determination that Business Associate has committed a violation or material breach of this Business Associate Agreement, and in Covered Entity's sole discretion, Covered Entity may take any one or more of the following steps:

1. Provide an opportunity for Business Associate to cure the breach or end the violation, and if Business Associate does not cure the Breach or end the violation within a reasonable time specified by Covered Entity, terminate this Business Associate Agreement;

2. Immediately terminate this Business Associate Agreement if Business Associate has committed a material breach of this Business Associate Agreement and cure of the material breach is not feasible; or,

3. If neither termination nor cure is feasible, elect to continue this Business Associate Agreement and report the violation or material breach to the Secretary.

c) If Business Associate believes Covered Entity has failed to fulfill any of its duties under this Business Associate Agreement, Business Associate will promptly notify Covered Entity as to same and Covered Entity shall promptly address the matter with Business Associate.

d) Except as provided in Section 5(e) upon termination of this Business Associate Agreement for any reason, and subject to applicable law, Business Associate will return or destroy, at the discretion of Covered Entity, all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision will also apply to PHI that is in the possession of workforce members, subcontractors, or agents of Business Associate. Neither Business Associate, nor any workforce member, subcontractor, or agent of Business Associate, will retain copies of the PHI.

e) If Business Associate determines that returning or destroying all or part of the PHI received or created by and/or on behalf of Covered Entity is not feasible, Business Associate will notify Covered Entity of the circumstances making return or destruction infeasible. If Covered Entity agrees that return or destruction is infeasible, then Business Associate will extend the protections of this Business Associate Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. Business Associate further agrees to retain the minimum necessary PHI to accomplish those tasks/responsibilities which make return and/or destruction infeasible.

6) **Miscellaneous**

a) Covered Entity and Business Associate agree to take any action necessary to amend this Business Associate Agreement from time to time as may be necessary for Covered Entity or Business Associate to comply with the requirements of HIPAA, and/or any other implementing regulations or guidance.

b) Notwithstanding the expiration or termination of this Business Associate Agreement or any Underlying Agreement, it is acknowledged and agreed that those rights and obligations of Business Associate which by their nature are intended to survive such expiration or termination shall survive, including but not limited to Sections 5(d) and 5(e) herein.

c) In the event the terms of this Business Associate Agreement conflict with the terms of any other agreement between Covered Entity and Business Associate or the Underlying Agreement, then the terms of this Business Associate Agreement shall control.

d) Notices and requests provided for under this Business Associate Agreement will be made in writing to Covered Entity, delivered by hand-delivery, overnight mail or first-class mail, postage prepaid at:

(1) Michael Hodge
Assistant Superintendent, Human Resources

Arlington Public Schools Privacy Officer
2110 Washington Blvd.
Arlington, Virginia 22204

(2) Kenneth M. Golski
Assistant Division Counsel
Arlington Public Schools
2110 Washington Blvd.
Arlington, Virginia 22204

(3) Brianna Cobbins
Executive Director, HR and Operations
Arlington Public Schools
2110 Washington Blvd.
Arlington, Virginia 22204

Notice and requests provided for under this Business Associate Agreement will be made in writing in the manner described above to Business Associate at:

Sue Yenyo
Sales Consultant, National Accounts
CareFirst BlueCross BlueShield
3060 Williams Drive, Suite 200
Fairfax VA 22031
sue.yenyo@carefirst.com

e) No more than once annually, unless Covered Entity claims additional needed for just cause, covered Entity will have the right to inspect any records of Business Associate or to audit Business Associate to determine whether Business Associate is in compliance with the terms of this Business Associate Agreement. However, this provision does not create any obligation on the part of Covered Entity to conduct any inspection or audit.

f) Nothing in this Business Associate Agreement shall be construed to create a partnership, joint venture, or other joint business relationship between the parties or any of their affiliates, or a relationship of employer and employee between the parties. Rather, it is the intention of the parties that Business Associate shall be an independent contractor.

g) Nothing in this Business Associate Agreement provides or is intended to provide any benefit to any third party.

h) The Business Associate will indemnify and hold harmless Arlington Public Schools, its elected officials, officers, directors, employees and/or agents from and against any employee, federal administrative action or third party claim or liability, including attorney's fees and costs, arising out of or in connection with the Business Associate's violation (or alleged violation) and/or any violation and/or alleged violation by Business Associate's workforce, agent/s, or subcontractor/s of the terms of this Business Associate Agreement, federal law, HIPAA, the HITECH Act, and/or other implementing regulations or guidance or any associated audit or investigation.

The obligation to provide indemnification under this Business Associate Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with written notice of any claim for which indemnification is sought. Any limitation of liability provisions contained in the

Underlying Agreement do not supersede, pre-empt, or nullify this provision or the Business Associate Agreement generally.

This indemnification shall survive the expiration or termination of this Business Associate Agreement or the Underlying Agreement.

i) Any ambiguity in this Business Associate Agreement shall be resolved to permit the parties to comply with HIPAA, its implementing regulations, and associated guidance. The sections, paragraphs, sentences, clauses and phrases of this Business Associate agreement are severable. If any phrase, clause, sentence, paragraph or section of this Business Associate Agreement is declared invalid by a court of competent jurisdiction, such invalidity shall not affect any of the remaining phrases, clauses, sentences and sections of this Business Associate Agreement.

j) If any dispute or claim arises between the parties with respect to this Business Associate Agreement, the parties will make a good faith effort to resolve such matters informally, it being the intention of the parties to reasonably cooperate with each other in the performance of the obligations set forth in this Business Associate Agreement. The Dispute Resolution clause of the Underlying Agreement ultimately governs if good faith efforts are unsuccessful.

k) A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any other right or remedy as to any subsequent events.

l) Neither party may assign any of its rights or obligations under this Business Associate Agreement without the prior written consent of the other party.

m) This Business Associate Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced with, and shall be governed by, the laws of the Commonwealth of Virginia and the United States of America.

n) This Business Associate Agreement shall remain in effect for the duration of the Underlying Agreement between the parties, any renewals, extension or continuations thereof, and until such time as all PHI in the possession or control of the Business Associate has been returned to the Covered Entity and/or destroyed. If such return or destruction is not feasible, the Business Associate shall use such PHI only for such limited purposes that make such return or destruction not feasible and the provision of this Business Associate Agreement shall survive with respect to such PHI.

o) The Business Associate shall be deemed to be in violation of this Business Associate Agreement if it knew of, or with the exercise of reasonable diligence or oversight should have known of, a pattern of activity or practice of any subcontractor, subsidiary, affiliate, agent or workforce member that constitutes a material violation of that entity's obligations in regard to PHI unless the Business Associate took prompt and reasonable steps to cure the breach or end the violation, as applicable, and if such steps were unsuccessful, terminated the contract or arrangement with such entity, if feasible.

p) Upon the enactment of any law or regulation affecting the use or disclosure of PHI, or any change in applicable federal law including revisions to HIPAA; upon publication of any decision of a court of the United States or of the Commonwealth of Virginia, relating to PHI or applicable federal law; upon the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of PHI disclosures or applicable federal law, APS reserves the right, upon written notice to the Business Associate, to amend this Business Associate Agreement as APS determines is necessary to comply with such change, law or regulation. If the Business Associate disagrees with any such amendment, it shall so notify APS in writing within thirty (30) days of APS's notice. In case of disagreement, the parties agree to negotiate in good faith the appropriate amendment(s) to give effect to such revised obligation. In APS's discretion, the failure to enter into an amendment shall be deemed to be a default and good cause for termination of the Underlying Agreement.

q) APS makes no warranty or representation that compliance by the Business Associate with this Business Associate Agreement, HIPAA, the HITECH Act, federal law or the regulations promulgated thereunder will be adequate or satisfactory for the Business Associate's own purposes or to ensure its compliance with the above. The Business Associate is solely responsible for all decisions made by it, its workforce members, agents, employees, subsidiaries and subcontractors regarding the safeguarding of PHI and compliance with federal law.

r) The Business Associate agrees that its workforce members, agents, employees, subsidiaries and subcontractors shall be bound by the confidentiality requirements herein and the provisions of this Business Associate Agreement shall be incorporated into any training or contracts with the same.

s) This Business Associate Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same document.

t) This Business Associate Agreement shall replace and supersede any prior Business Associate Agreement entered between the parties.

IN WITNESS WHEREOF, each party hereto has executed this Business Associate Agreement in duplicate on the date below written:

ARLINGTON PUBLIC SCHOOLS			
Authorized Signature:	David J. Webb	Authorized Signature:	[signature]
Printed Name	David J. Webb, C.P.M.	Printed Name:	Reggie White
Title:	Director/Procurement Agent	Title:	Senior Vice President, Commercial Market and CFA
Date:	July 17, 2023	Date:	February 3, 2023

End of Business Associate Agreement

Attachment F

Contract Terms and Conditions

1. Standard of Care
   In the performance or furnishing of services hereunder, the Contractor and all its agents, shall exercise the highest degree of skill and care normally accepted as practices and procedures by members of the same profession for provision of the Work.

2. Responsibility of the Contractor
   The Contractor shall be responsible for the quality, technical accuracy, and the coordination of all deliverables and other services furnished by the Contractor under this Contract. The Contractor shall, without additional compensation, correct, or revise any errors or deficiencies that significantly affect the production environment, as determined by the Project Officer, which are discovered within a twelve-month period of final completion of Work.

3. Responsibility for Claims and Liabilities
   APS' review, approval, or acceptance of, or payment for, any services or deliverables required under this Contract shall not be construed to operate as a waiver by APS of any rights or of any cause of action arising out of the Contract. The Contractor shall be and remains liable to APS for the accuracy and competency of deliverables, plans, specifications, or other documents.

4. Payment
   The Parties agree to a payment arrangement using a portal with administrative fees invoiced and paid monthly. Claims payments made by Contractor shall be invoiced and reimbursed on a weekly basis using the portal.

5. Project Officer
   The performance of the Contractor is subject to the review and approval of the APS Project Officer ("Project Officer") who shall be appointed by the Director of the Arlington APS department requesting the Work under this Contract. However, it shall be the responsibility of the Contractor to manage the details of the execution and performance of its work under the Contract Documents.

6. Adjustments for Change in Scope
   APS may order changes in the Work within the general scope of the Work consisting of additions, deletions or other revisions. No claim may be made by the Contractor that the scope of the Work or of the Contractor's services has been changed requiring adjustments to the amount of compensation due the Contractor unless such adjustments have been made by a written amendment to the Contract signed by APS and the Contractor. If the Contractor believes that any particular work is not within the scope of the Work or is a material change or otherwise will call for more compensation to the Contractor, the Contractor must immediately notify the Project Officer after the change or event occurs and within ten (10) calendar days thereafter must provide written notice to the Project Officer. The Contractor's notice must provide to the Project Officer the amount of additional compensation claimed, together with the basis therefore and supportive documentation for the amount. The Contractor will not be compensated for performing any work unless a Proposal complying with this subsection has been submitted in the time specified above and a written amendment has been signed by APS and the Contractor and an APS Purchase Order is issued covering the cost of the services to be provided under the amendment.

7. Additional Services
   The Contractor shall not be compensated for any goods or services provided except those included in the Contract Documents and included in the Contract Amount unless those goods or services are covered by a written amendment to this Contract signed by APS and the Contractor and an APS purchase order is issued covering the expected cost of such services.

APS may determine the need for additional work by the Contractor. Upon a request from APS, the Contractor shall prepare a cost Proposal for any such work. No Additional Services shall be performed unless a written amendment to this Contract has been executed by both parties.

8. Reimbursable Expenses
All expenses shall be included in the firm fixed price for provision of the Work for APS. APS shall not approve any request for reimbursement of travel-related expenses submitted by the Contractor.

9. Reimbursable Travel-Related Expenses
All travel-related expenses shall be included in the firm fixed price for provision of the Work for APS. APS shall not approve any request for reimbursement of travel-related expenses submitted by the Contractor.

Non-reimbursable Expenses: The following expenses are not allowable for reimbursement and should not be included in firm fixed price:

1. Alcoholic beverages
2. Personal phone calls
3. Self-entertainment activities (i.e. pay TV, movies, night clubs, health clubs, theaters, bowling)
4. Personal expenses (i.e. laundry, valet, haircuts)
5. Personal travel insurance (i.e. life, medical, or property insurance) for air fare or rental cars.
6. Auto repairs, maintenance and insurance costs for personal vehicles
7. Travel expenses incurred to obtain or maintain training and/or certificates that are not associated with an employee's job requirements.

10. Payment of Subcontractors*
The Contractor is obligated to take one of the two following actions within seven (7) calendar days after receipt of amounts paid to the Contractor by APS for work performed by any subcontractor under this Contract:

a. Pay the subcontractor for the proportionate share of the total payment received from APS attributable to the work performed by the subcontractor under this Contract; or

b. Notify APS and the subcontractor, in writing, of the Contractor's intention to withhold all or a part of the subcontractor's payment with the reason for nonpayment.

The Contractor is obligated to pay interest to those subcontractor(s) assigned under this Contract on all amounts owed by the Contractor that remain unpaid after seven (7) calendar days following receipt by the Contractor of payment from APS for work performed by the subcontractor under this Contract, except for amounts withheld as allowed in b., above. Unless otherwise provided under the terms of this Contract, interest shall accrue at the rate of one percent (1%) per month.

The Contractor shall include in each of its subcontracts a provision requiring each subcontractor to include or otherwise be subject to the same payment and interest requirements with respect to each lower-tier subcontractor.

The Contractor's obligation to pay an interest charge to a subcontractor pursuant to the above provisions may not be construed to be an obligation of APS. A Contract modification may not be made for the purpose of providing reimbursement for such interest charge. A cost reimbursement claim may not include any amount for reimbursement for such interest charge.

11. Non-Appropriation*

All funds for payments by APS under this Contract are subject to the availability of an annual appropriation for this purpose by Arlington County School Board (School Board). In the event of non-appropriation of funds by the School Board for the goods or services provided under this Contract, or substitutes for such goods or services which are as advanced or more advanced in their technology, APS will terminate the Contract, without termination charge or other liability to APS, on the last day of the then current fiscal year or when the appropriation made for the then current year for the services covered by this Contract is spent, whichever event occurs first. If funds are not appropriated at any time for the continuation of this Contract, cancellation will be accepted by the Contractor on thirty (30) calendar days prior written notice, but failure to give such notice shall be of no effect and APS shall not be obligated under this Contract beyond the date of termination specified in APS's written notice.

12. APS Purchase Order Requirement*

APS purchases are authorized only if an APS Purchase Order is issued in advance of the transaction, indicating that the ordering school or department has sufficient funds available to pay for the purchase. Such a Purchase Order is to be provided to the Contractor by the order agency. APS will not be liable for payment for any purchases made by its employees without appropriate purchase authorization issued by APS Procurement Agent. Contractors providing goods or services without a signed APS Purchase Order do so at their own risk and expense.

13. Replacement or Augmentation of Key Personnel and Subcontractors

The key personnel and subcontractors submitted by the Contractor in its Proposal and thereafter accepted by APS are considered essential to the Contractor's qualifications. The Contractor may not replace, substitute or augment any key personnel or subcontractor without prior written approval of APS. A request to replace or substitute any key personnel or subcontractor for any reason, shall be provided to the APS Project Officer at least fifteen (15) calendar days in advance of such proposed replacement or substitution and the request shall contain sufficient justification, including identification of the proposed replacement or substitute and their qualifications, in sufficient detail to permit evaluation by APS. Such requests shall not be unreasonably denied.

Additionally, the Contractor shall not remove or replace the approved Project Manager without written approval of APS. In cases of the approved Project Manager's prolonged illness or other extended leave of absence, Contractor shall provide an interim Project Manager whose continued work on the Work shall be subject to approval by APS.

In the event of the Project Manager's resignation or termination from the Contractor's employment, the Contractor shall replace the Project Manager with an individual with similar qualifications and experience and only with APS' prior written approval.

14. Project Staff

APS has the right of reasonable rejection and approval of staff or subcontractors assigned to the Work by the Contractor. If APS reasonably rejects staff or subcontractors, the Contractor must provide replacement staff or subcontractors satisfactory to APS in a timely manner and at no additional cost to APS. The day-to-day supervision and control of the Contractor's employees, and employees of any of its subcontractors, shall be the sole responsibility of the Contractor.

15. Supervision by Contractor

The Contractor shall at all times enforce strict discipline and good order among the workers performing under this Contract and shall only employ on the Work persons reasonably proficient in the work assigned.

16. Employment Discrimination by Contractor Prohibited*

During the performance of this Contract, the Contractor agrees as follows:

A. The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability or any other basis prohibited by state law related to discrimination in employment except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

B. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an Equal Opportunity Employer.

C. Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting the requirements of this section.

D. The Contractor will comply with the provisions of the Americans with Disabilities Act of 1990 which prohibits discrimination against individuals with disabilities in employment and mandates their full participation in both publicly and privately provided services and activities.

E. The Contractor will include the provisions of the foregoing subsections in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontract or vendor.

17. Employment of Unauthorized Aliens Prohibited*
In accordance with §2.2-4311.1 of the Virginia Code, the Contractor acknowledges that it does not, and shall not during the performance of this Contract for goods and/or services in the Commonwealth, knowingly employ an unauthorized alien as defined in the federal Immigration Reform and Control Act of 1986.

18. Drug-Free Workplace to be Maintained by Contractor*
During the performance of the Work by the Contractor's entities specifically contracted to solely support this Contract, pursuant to this Contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a Contractor by APS in accordance with the Procurement Resolution, the employees of which Contractor are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

19. Termination for Cause, Including Breach and Default; Cure
The Contract shall remain in force for the Initial Contract Term or any Renewal Contract Term(s) and until APS determines that all of the following requirements and conditions have been satisfactorily met: APS has accepted the Work, and thereafter until the Contractor has met all requirements and conditions relating to the Work under the Contract Documents, including warranty and guarantee periods. However, APS shall have the right to terminate this Contract sooner if the Contractor is in breach or default or has failed to perform satisfactorily the Work required, as determined by APS in its discretion.

If APS determines that the Contractor has failed to perform satisfactorily, then APS will give the Contractor written notice of such failure(s) and the opportunity to cure such failure(s) within at least fifteen (15) days before termination of the Contract takes effect ("Cure Period"). If the Contractor fails to cure within the Cure Period or as otherwise specified in the notice, the Contract may be terminated for the Contractor's failure to provide satisfactory Contract performance. Upon such termination, the Contractor may apply for compensation for Contract services satisfactorily performed by the Contractor, allocable to the Contract and accepted by APS prior to such termination unless otherwise barred by the Contract ("Termination Costs"). In order to be considered, such request for Termination Costs, with all supporting documentation, must be submitted to APS Project Officer within fifteen (15) calendar days after the expiration of the Cure Period. APS may accept or reject, in whole or in part, the application for Termination Costs and notify the Contractor of same within a reasonable time thereafter.

If APS terminates the Contract for default or breach of any Contract provision or condition, then the termination shall be immediate after notice from APS to the Contractor (unless APS in its discretion provides for an opportunity to cure) and the Contractor shall not be permitted to seek Termination Costs.

Upon any termination pursuant to this section, the Contractor shall be liable to APS for all costs incurred by APS after the effective date of termination, including costs required to be expended by APS to complete the Work covered by the Contract, including costs of delay in completing the Work or the cost of repairing or correcting any unsatisfactory or non-compliant work performed or provided by the Contractor or its subcontractors. Such costs shall be either deducted from any amount due the Contractor or shall be promptly paid by the Contractor to APS upon demand by APS. Additionally, and notwithstanding any provision in this Contract to the contrary, the Contactor is liable to APS, and APS shall be entitled to recover, all damages to which APS is entitled by this Contract or by law, including, and without limitation, direct damages, indirect damages, consequential damages, delay damages, replacement costs, refund of all sums paid by APS to the Contractor under the Contract and all attorney fees and costs incurred by APS to enforce any provision of this Contract.

Except as otherwise directed by APS in the notice, the Contractor shall stop work on the date of receipt of notice of the termination or other date specified in the notice, place no further orders or subcontracts for materials, services, or facilities except as are necessary for the completion of such portion of the Work not terminated, and terminate all vendors and subcontracts and settle all outstanding liabilities and claims. Any purchases after the date of termination contained in the notice shall be the sole responsibility of the Contractor.

In the event any termination for cause, default, or breach shall be found to be improper or invalid by any court of competent jurisdiction then such termination shall be deemed to have been a termination for convenience.

20. <u>Termination for the Convenience of APS</u>
The performance of work under this Contract may be terminated by the Procurement Agent in whole or in part whenever the Procurement Agent shall determine that such termination is in APS' best interest. Any such termination shall be effected by the delivery to the Contractor of a written notice of termination at least fifteen (15) calendar days before the date of termination, specifying the extent to which performance of the Work under this Contract is terminated and the date upon which such termination becomes effective. The Contractor will be entitled to receive compensation for all Contract services satisfactorily performed by the Contractor and allocable to the Contract and accepted by APS prior to such termination and any other termination costs as negotiated by the parties, but no amount shall be allowed for anticipatory profits.

After receipt of a notice of termination and except as otherwise directed, the Contractor shall stop all work on the date of receipt of the notice of termination or other date specified in the notice; place no further orders or subcontracts for materials, services or facilities except as are necessary for the completion of such portion of the work not terminated; immediately transfer all documentation and paperwork for terminated work to APS; and terminate all vendors and subcontracts and settle all outstanding liabilities and claims.

21. Indemnification* (Note: Virginia does not permit the indemnification of others; cross indemnity provisions are not acceptable). The Contractor covenants for itself, its employees, and subcontractor to save, defend, hold harmless, and indemnify APS, and all of their elected and appointed officials, officers, current and former employees, agents, departments, agencies, boards, and commissions (collectively the "APS" for purposes of this section) from and against any and all claims made by third parties or by APS for any and all losses, damages, injuries, fines, penalties, costs (including court costs and attorney's fees), charges, liability, demands or exposure, however caused, resulting from, arising out of, or in any way connected with the Contractor's acts or omissions or errors in performance or nonperformance of its work called for by the Contract Documents, whether such act or omission or error is attributable to Contractor, subcontractor, any material supplier, or anyone directly or indirectly employed by them, called for by the Contract Documents. This duty to save, defend, hold harmless and indemnify shall survive the termination of this Contract.

    If any action or proceeding relating to the indemnification required by this section is brought against APS, then upon written notice from APS to the Contractor, Contractor shall at Contractor's expense, resist or defend such action or proceeding by counsel approved by APS in writing, such approval not to be unreasonably withheld, but no approval of counsel shall be required where the cause of action is resisted or defended by counsel of any insurance carrier obligated to resist or defend same.

    If, after Notice by APS, the Contractor fails or refuses to save, defend, hold harmless and/or indemnify APS, the Contractor shall be liable for and reimburse APS for any and all expenses, including but not limited to, reasonable attorney's fees incurred and settlements or payments made. The Contractor shall pay such expenses upon demand by APS and failure to do so may result in such amounts being withheld from any amounts due to Contractor under this Contract.

    Contractor understands and agrees that it is Contractor's responsibility to provide indemnification to APS pursuant to this section. The provision of insurance, while anticipated to provide a funding source for this indemnification, is in addition to any indemnification requirements and the failure of Contractor's insurance to fully fund any indemnification shall not relieve the Contractor of any obligation assumed under this indemnification.

22. Intellectual Property Indemnification*
    The Contractor warrants and guarantees that no intellectual property rights (including, but not limited to, copyright, patent, mask rights and trademark) of third parties are infringed or in any manner involved in or related to the services provided hereunder.

    The Contractor further covenants for itself, its employees, and subcontractors to save, defend, hold harmless, and indemnify APS, and all of its officers, officials, departments, agencies, agents, and employees from and against any and all claims, losses, damages, injuries, fines, penalties, costs (including court costs and attorney's fees), charges, liability, or exposure, however caused, for or on account of any trademark, copyright, patented or unpatented invention, process, or article manufactured or used in the performance of this Contract, including its use by APS. If the Contractor, or any of its employees or subcontractors, uses any design, device, work, or materials covered by letters patent or copyright, it is mutually agreed and understood, without exception, that the Contract Amount includes all royalties, licensing fees, and any other costs arising from the use of such design, device, work, or materials in any way involved with the Work. This duty to save, defend, hold harmless and indemnify shall survive the termination of this Contract. If, after Notice by APS, the Contractor fails or refuses to fulfill its obligations contained in this section, the Contractor shall be liable for and reimburse APS for any and all expenses, including but not limited to, reasonable attorney's fees incurred and any settlements or payments made. The Contractor shall pay such expenses upon demand by APS and failure to do so may result in such amounts being withheld from any amounts due to Contractor under this Contract.

23. Copyright
The Contractor hereby irrevocably transfers, assigns, sets over and conveys to APS all right, title and interest, including the sole exclusive and complete copyright interest, in any and all copyrightable works created pursuant to this Contract. The Contractor further agrees to execute such documents as APS may request to affect such transfer or assignment.

Further, the Contractor agrees that the rights granted to APS by this subsSection are irrevocable. Notwithstanding anything else in this Contract, the Contractor's remedy in the event of termination of or dispute over the terms of this Contract shall not include any right to rescind, terminate or otherwise revoke or invalidate in any way the rights conferred pursuant to the provisions of this subSection. Similarly, no termination of this Contract shall have the effect of rescinding, terminating or otherwise invalidating the rights acquired pursuant to the provisions of this "Copyright" subSection.

The use of subcontractors or third parties in developing or creating input into any copyrightable materials produced as a part of this Contract is prohibited unless APS approves the use of such subcontractors or third parties in advance and such subcontractors or third parties agree to include the provisions of this subSection as part of any contract they enter into with the Contractor for work related to work pursuant to this Contract.

24. Ownership and Return of Records
This Contract confers no ownership rights to the Contractor nor any rights or interests to use or disclose APS' data or inputs.

The Contractor agrees that all drawings, specifications, blueprints, data, information, findings, memoranda, correspondence, documents or records of any type, whether written or oral or electronic, and all documents generated by the Contractor or its subcontractors as a result of APS' request for services under this Contract, are the exclusive property of APS ("Record" or "Records"), and all such Records shall be provided to and/or returned to APS upon completion, termination, or cancellation of this Contract. The Contractor shall not use, willingly allow, or cause such materials to be used for any other purpose other than performance of all obligations under the Contract without the written consent of APS. Additionally, the Contractor agrees that the Records are confidential records and neither the Records nor their contents shall be released by the Contractor, its subcontractors, or other third parties; nor shall their contents be disclosed to any person other than the Project Officer or his or her designee. The Contractor agrees that all oral or written inquiries from any person or entity regarding the status of any Record generated as a result of the existence of this Contract shall be referred to the Project Officer or his or her designee for response. At APS' request, the Contractor shall deliver all Records to the Project Officer, including "hard copies" of computer records, and at APS's request, shall destroy all computer records created as a result of APS' request for services pursuant to this Contract.

The Contractor agrees to include the provisions of this section as part of any contract or agreement the Contractor enters into with subcontractors or other third parties for work related to work pursuant to this Contract. No termination of this Contract shall have the effect of rescinding, terminating or otherwise invalidating this section of the Contract.

25. Confidential Information
The Contractor, and its employees, agents, and subcontractors, hereby agree to hold as confidential all APS information obtained as a results of its Work under this Contract. Confidential information includes, but is not limited to, nonpublic personal information, personally identifiable health information, social security numbers, proprietary systems, addresses, dates of birth, other contact information or medical information about a person's, information pertaining to products, operations, systems, customers, prospective customers, techniques, intentions, processes, plans, expertise and any information entrusted to any affiliate of the parties. The Contractor shall take reasonable measures to ensure that all of its employees, agents, and subcontractors are informed of, and abide by, this requirement.

All student data is considered to be confidential under any resulting Contract as well as under the Family Educational Rights and Privacy Act ("FERPA"), 20 U.S.C. §1232g et seq., and any other federal or state statutes or regulations pertaining to student records, and will only be released in accordance with the applicable laws and regulations. Student data shall include all metadata, forms, logs, cookies, tracking pixels, user content, and Personally Identifiable Information (PII), Education Records as defined by the Family Educational Rights and Privacy Act ("FERPA"), and other non-public information relating directly to APS students. All student data received by the Contractor shall be maintained by the Contractor in a secure location, in accordance with the Student Data Usage and Privacy Agreement.

The Contactor also agrees that it will not directly or indirectly use or facilitate the use or dissemination of student data (whether intentionally or by inadvertence, negligence or omission verbally electronically, through paper transmission or otherwise), for any purpose other than that directly associated with its officially assigned duties pursuant to any resulting Contract. Contractor is aware that unauthorized use or disclosure of student data is prohibited and, in addition, may also constitute a violation of Virginia law (e. g. the Government Data Collection and Dissemination Practice Act, formerly called the Privacy Protection Act, VA Code §2.2-3800 et seq., and the Secrecy of Information Act, VA Code §58.1-3, which may be punishable by a jail sentence of up to six (6) months and/or a fine of up to $1,000,000.).

26. <u>HIPAA Compliance</u>

The Contractor shall comply with all applicable legislative and regulatory requirements of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Pursuant to 45 C. F. R. §164.502(e) and §164.504(e), the Contractor shall be designated a Business Associate pursuant and will be required to execute an APS Business Associate Agreement. If Contractor engages a subcontractor or subcontractors in the performance of the Scope of Services under any resulting Contract, the Contractor shall enter into an agreement with each of its subcontractors pursuant to 45 C. F. R. §164.3082(b) and the Health Information Technology for Economic and Clinic Health (HITECH) Act §13401 that is appropriate and sufficient to require each subcontractor to protect the Protected Health Information (PHI) to the same extent required of Contractor under APS's Business Associate Agreement. HITECH defines PHI as individually identifiable and maintained by a covered health care provider, health plan, or health care clearinghouse. See 45 C.F.R 160.103 and 164.501. The Contractor shall ensure that its subcontractors notify the Contractor, within ten business days, of any breaches in security regarding the PHI.

The Contractor takes full responsibility for any failure to execute the appropriate agreements with its subcontractors to comply with the existing and or future regulations of HIPAA and/or HITECH, and shall indemnify APS in accordance with the Indemnification clause in this section.

27. <u>Data Security</u>

The Contractor agrees that it shall hold all APS data obtained or accessed as a result of its work under this Contract confidential in accordance with the Nondisclosure and Data Security Agreement attached hereto. If individual employees or subcontractors of the Contractor are performing work under this Contract on APS-owned property, then such individual employees or subcontractors shall be required to sign a separate Nondisclosure and Data Security Agreement, which shall be incorporated by reference into this Contract, prior to performing any work or being allowed access to APS data.

The Contractor shall hold APS Information in the strictest confidence and comply with all applicable APS security and network resources policies as well as all local, state and federal laws or regulatory requirements concerning data privacy and security. The Contractor shall develop, implement, maintain, continually monitor and use appropriate administrative, technical and physical security measures to preserve the confidentiality, privacy, integrity and availability of all electronically maintained or transmitted APS Information received from, created or maintained on behalf of APS and strictly control access to APS Information. For purposes of this provision, and as more fully described in this Contract and APS's Non-Disclosure and Data Security

Agreement (NDA), "APS Information" (also referred to as "APS Data" or "data") includes, but is not limited to, electronic information, documents, data, images, and records including, but not limited to, financial records, personally identifiable information, Personal Health Information (PHI), personnel, educational, voting, registration, tax or assessment records, information related to public safety, APS networked resources, and APS databases, software and security measures which is created, maintained, transmitted or accessed to perform the Work under this Contract.

(a) APS' Non-Disclosure and Data Security Agreement (NDA). The Contractor shall require that an authorized Contractor designee, and all key employees, agents or subcontractors working on-site at APS facilities or otherwise performing non-incidental work under this Contract, sign the NDA (attached as an Attachment D) prior to performing any work or permitting access to APS networked resources, application systems or databases under this Contract. A copy of the signed NDAs shall be available to APS Project Officer upon request.

(b) Use of Data. The Contractor shall ensure that the use, distribution, disclosure or access ("use") to APS Information and APS networked resources shall not occur in an unauthorized manner. Use of APS Information for other than as specifically outlined in this Contract is strictly prohibited, unless such other use is agreed to in writing by the parties. The Contractor will be solely responsible for any unauthorized use, reuse, distribution, transmission, manipulation, copying, modification, access or disclosure of APS Information and any non-compliance with this Data Security and Protection provision or any NDA.

(c) Data Protection. The Contractor agrees that it will protect APS Information according to standards established by the National Institute of Standards and Technology, including 201 CMR 17.00, Standards for the Protection of Personal Information of Residents of the Commonwealth and the Payment Card Industry Data Security Standard (PCI DSS), as applicable, and no less rigorously than it protects its own data, proprietary and/or confidential information. The Contractor shall provide to APS a copy of its data security policy and procedures for securing APS Information and a copy of its disaster recovery plan/s. The Contractor shall provide, if requested by APS, on an annual basis, results of an internal Information Security Risk Assessment provided by an outside firm.

(d) Data Sharing. Except as otherwise specifically provided for in this Contract, the Contractor agrees that it shall not share, disclose, sell or grant access to APS Information to any third party without the express written authorization of the APS Chief Information Security Officer or designee.

(e) Security Requirements. The Contractor shall maintain the most up to date anti-virus, industry accepted firewalls and/or other protections on its systems and networking equipment. The Contractor certifies that all systems and networking equipment that support, interact or store APS Information meet the above standards and industry best practices for physical, network and system security requirements. Printers, copiers or fax machines that store APS Data into hard drives must provide data at rest encryption. Significant deviation from these standards must be approved by the APS Chief Information Security Officer or designee, the downloading of APS information onto laptops or other portable storage medium is prohibited without the express written authorization of the APS Chief Information Security Officer or designee.

(f) Data Protection Upon Conclusion of Contract. Contractor shall retain and maintain all records and documents relating to this Contract for seven (7) years after the end of the Contractor any applicable period of time required by applicable law or judicial order, whichever is longer, and shall make these records and documents available for inspection and audit by authorized representatives of APS. All de-identified data is considered records obtained or created in the performance of the Contract will be maintained in accordance with the confidentiality requirements of all applicable federal and state laws and regulations. Upon expiration or termination of the Contract, APS may require that the data, reports and other documents developed by Contractor under the Contract may be required to be delivered to the Sponsor at no additional cost unless the manner of storage of the data or information renders the return or destruction commercially impracticable. All data is considered the mutual property of the parties. Mutual ownership is established by virtue of data aggregation. As utilization data from accounts is integrated in the Contractor's database for aggregate reporting purposes, isolation of a single account's data is not feasible with respect to destruction of any or all documentation and materials..

(g) Notification of Security Incidents. The Contractor agrees to notify the APS Chief Information Officer and APS Project Officer within five (5) Business Days of the discovery of any unintended access to, use or disclosure of APS Information.

(h) Subcontractors. To the extent the use of subcontractors is permitted under this Contract, the requirements of this entire section shall be incorporated into any subcontractor agreement entered into by the Contractor and any data sharing shall be compliant with these security and protection requirements and the NDA. In the event of data sharing, subcontractors shall provide to the Contractor a copy of their data security policy and procedures for securing APS Information and a copy of their disaster recovery plan/s.

28. Ethics in Public Contracting*

This Contract incorporates by reference Article 9 of the Procurement Resolution, as well as any state or federal law related to ethics, conflicts of interest, or bribery, including by way of illustration and not limitation, the Virginia State and Local Government Conflict of Interests Act (Code of Virginia § 2.2-3100 et seq.), the Virginia Governmental Frauds Act (Code of Virginia § 18.2-498.1 et seq., and Articles 2 and 3 of Chapter 10 of Title 18.2 of the Code of Virginia, as amended (§ 18.2-438 et seq.). The Contractor certifies that its offer is made without collusion or fraud and that it has not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer, or subcontractor and that it has not conferred on any public employee having official responsibility for this purchase any payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised unless consideration of substantially equal or greater value was exchanged.

29. APS Employees*

No employee of APS Schools, Virginia, shall be admitted to any share in any part of this Contract or to any benefit that may arise there from which is not available to the general public.

30. Force Majeure

The Contractor shall not be held responsible for failure to perform the duties and responsibilities imposed by this Contract if such failure is due to fires, riots, rebellions, natural disasters, wars, acts of terrorism, or an act of God beyond control of the Contractor, and outside and beyond the scope of the Contractor's then current, by industry standards, disaster plan, that make performance impossible or illegal, unless otherwise specified in the Contract.

APS shall not be held responsible for failure to perform its duties and responsibilities imposed by the Contract if such failure is due to fires, riots, rebellions, natural disasters, wars, acts of terrorism, or an act of God beyond control of APS that make performance impossible or illegal, unless otherwise specified in the Contract. The period hereinabove specified for the completion of his Work shall be extended by such time as shall be fixed by the Owner.

No such extension of time shall be deemed a waiver by the Owner of its right to terminate the Contract for abandonment or delay by the Contractor as herein provided or to relieve the Contractor from full responsibility for performance of his obligations hereunder.

31. Authority to Transact Business*
The Contractor shall pursuant to Code of Virginia §2.2-4311.2, be and remain authorized to transact business in the Commonwealth of Virginia during the Initial Term and any Subsequent Contract Term(s) of this Contract. A contract entered into by a Contractor in violation of this requirement is voidable, without any cost or expense, at the sole option of APS.

32. Relation to APS*
The Contractor will be legally considered as an independent contractor and neither the Contractor nor its employees will, under any circumstances, be considered employees, servants or agents of APS. APS will not be legally responsible for any negligence or other wrongdoing by the Contractor, its employees, servants or agents. APS will not withhold payments to the Contractor for any federal or state unemployment taxes, federal or state income taxes, Social Security tax, or any other amounts for benefits to the Contractor. Furthermore, APS will not provide to the Contractor any insurance coverage or other benefits, including workers' compensation, normally provided by APS for its employees.

33. Antitrust
By entering into this Contract, the Contractor conveys, sells, assigns and transfers to APS all rights, title, and interest in and to all causes of action the Contractor may now have or hereafter acquire under the antitrust laws of the United States or the Commonwealth of Virginia, relating to the goods or services purchased or acquired by APS under this Contract.

34. Report Standards
Reports or written material prepared by the Contractor in response to the requirements of this Contract or request of the Project Officer shall, unless otherwise provided for in the Contract, meet standards of professional writing established for the type of report or written material provided, shall be thoroughly researched for accuracy of content, shall be grammatically correct and not contain spelling errors, shall be submitted in a format approved in advance by the Project Officer, and shall be submitted for advance review and comment by the Project Officer. The cost of correcting grammatical errors, correcting report data, or other revisions required to bring the report or written material into compliance with these requirements shall be borne by the Contractor.

When submitting documents to APS, The Contractor shall comply with the following guidelines:

- All submittals and copies shall be printed on at least thirty percent (30%) recycled-content and/or tree-free paper;
- All submittals must be in the required tabular format in a binder.
- Report covers / binders shall be recyclable, made from recycled materials, and/or easily removable to allow for recycling of report pages (reports with glued bindings that meet all other requirements are acceptable);
- The use of plastic covers or dividers should be avoided; and
- Unnecessary attachments or documents not specifically asked for should not be submitted, and superfluous use of paper should be avoided.

35. Audit
The Contractor agrees to retain all books, records and other documents related to this Contract for at least five (5) years after final payment. APS or its authorized agents shall have full access to and the right to examine any of the above documents during this period and during the Initial Contract Term or any Renewal Contract Term. If the Contractor wishes to destroy or dispose of records (including confidential records to which APS does not have ready access) within five (5) years after final payment, the Contractor shall notify APS at least thirty (30) days prior to such disposal, and if APS objects, shall not dispose of the records.

36. Amendments
This Contract shall not be modified except by written amendment executed by persons duly authorized to bind the Contractor and APS

37. Arlington Public Schools Procurement Resolution and Policies*
Notwithstanding any provision to the contrary herein, no provision of the Procurement Resolution or any applicable APS policy is waived in whole or in part.

38. Dispute Resolution*
All disputes arising under this Contract, or its interpretation, whether involving law or fact, or extra work, or extra compensation or time, and all claims for alleged breach of Contract shall be submitted in writing to the Project Officer for decision at the time of the occurrence or beginning of the Work upon which the claim is based, whichever occurs first. Such claims shall state the facts surrounding it in sufficient detail to identify it together with its character and scope. Claims denied by the Project Officer may be submitted to APS Superintendent or designee in writing no later than sixty (60) days after final payment in accordance with the Procurement Resolution.

The time limit for final written decision by APS Superintendent or designee in the event of a contractual dispute, as that term is defined in the Procurement Resolution, is thirty (30) days. Procedures for considering contractual claims, disputes, administrative appeals, and protests are contained in the Procurement Resolution, incorporated herein by reference. A copy of the Procurement Resolution is available upon request from the Office of the Procurement Agent. The Contractor shall not cause a delay in the Work pending a decision of the Project Officer, APS Superintendent or designee, School Board, or a court of competent jurisdiction.

39. Applicable Law, Forum, Venue and Jurisdiction*
This Contract and the Work performed hereunder shall be governed in all respects by the laws of the Commonwealth of Virginia and the jurisdiction, forum, and venue for any litigation with respect thereto shall be in the Circuit Court for Arlington County, Virginia, and in no other court. In performing the Work under this Contract, the Contractor shall comply with applicable federal, state, and local laws, ordinances and regulations.

40. Arbitration
It is expressly agreed that nothing under the Contract shall be subject to arbitration, and any references to arbitration are expressly deleted from the Contract.

41. Nonexclusivity of Remedies
All remedies available to APS under this Contract are cumulative, and no such remedy shall be exclusive of any other remedy available to APS at law or in equity.

42. No Waiver
The failure of either party to exercise in any respect a right provided for in this Contract shall not be deemed to be a subsequent waiver of the same right or any other right.

43. Severability
The sections, subsections, paragraphs, sentences, clauses and phrases of this Contract are severable, and if any phrase, clause, sentence, paragraph, subsection, or section of this Contract shall be declared invalid by the valid judgment or decree of a court of competent jurisdiction, such invalidity shall not affect any of the remaining phrases, clauses, sentences, paragraphs, subsections, and sections of this Contract.

44. No Waiver of Sovereign Immunity*
Notwithstanding any other provision of this Contract, nothing in this Contract or any action taken by APS pursuant to this Contract shall constitute or be construed as a waiver of either the sovereign or governmental immunity of APS. The parties intend for this provision to be read as broadly as possible.

45. Survival of Terms
In addition to any numbered section in this Contract which specifically state that the term, paragraph or subsection survives the expiration of termination of this Contract, the following sections if included in this Contract also survive: Indemnification; Relation to APS; Ownership and Return of Records; Audit; Copyright; Intellectual Property Indemnification; Confidential Information, and Data Security and Protection.

46. Headings
The section headings in this Contract are inserted only for convenience and are not to be construed as part of this contract or a limitation on the scope of the particular section to which the heading refers.

47. Ambiguities
Each party and its counsel have participated fully in the review and revision of this Contract . Any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in interpreting this Contract. The language in this Contract shall be interpreted as to its fair meaning and not strictly for or against any party.

48. Non-Discrimination Notice*
APS does not discriminate against faith-based organizations.

49. Contractor’s Insurance:

A. Overview

During the term of this Contract, The Contractor and all of their Subcontractors shall procure and maintain the **types of insurance that are referenced in section D below**. All insurance policies shall be with insurance companies that meet the following criteria:

1. Are authorized to do business under the laws of the Commonwealth of Virginia and acceptable to the APS, in its sole discretion.

2. Are rated with an AM Best rating of A- or better. APS reserves the right to require the Contractor and/or its Subcontractors to change their insurance to an insurance company that has the minimum required AM Best rating. This right can be exercised at any time the insurance requirements set forth in the Contract Documents remain applicable. If the AM Best rating of the insurance company changes to a rating under A- during the Contract Term, the Contractor and/or its Subcontractors will notify APS in writing immediately upon discovery and change the insurance immediately to an insurance company that meets or exceeds the AM Best rating of A-.

3. If APS suffers damages under the Contract and makes a claim on the named insurance company by APS, and the claim is not paid in full by the insurance company, Contractor acknowledges that it shall remain wholly liable for the full amount of the claim regardless of the solvency of the insurance company or the insurance company’s willingness to pay the claim in full.

4. The Contractor and/or its Subcontractors must disclose in the Certificate of Insurance the amount of any deductible or self-insurance component applicable to all required insurance policies herein, if any. APS has the right to request additional information to determine if the Contractor and/or its Subcontractors have the financial capacity to meet their obligations under a deductible or self – insurance program. If, in its discretion, APS is not satisfied as to the Contractor and/or its

Subcontractors financial capacity to meet its obligations under a proposed deductible or self – insurance program, the Contractor and/or its Subcontractors shall re-submit revised acceptable insurance coverage at the sole discretion of APS and with no obligation to do so agree to alternative approaches proposed by the Contractor and/or its Subcontractors to ensure protection for APS.

B. Certificates of Insurance & Additional Insured Status:

1. Contractor

The Contractor is required to provide a Certificate of Insurance that names Arlington County School Board, including elected and appointed officials, agents, and employees as additional insureds by endorsement for all insurance policies except Workers Compensation, Professional Liability, and Cyber Liability coverage.

2. Subcontractors

- All Subcontractors will provide the Contractor with Certificates of Insurance for the policies that are required under this contract. All Certificates of Insurance should by endorsement name Arlington County School Board, including elected and appointed officials, agents, and employees as additional insureds for all contracts of insurance except Workers Compensation & Professional Liability.

- All Subcontractors shall provide the Contractor with a certificate of insurance that will serve as proof of insurance for their Cyber Liability coverage, but APS will not need to be added as an additional insured.

- The Contractor will maintain all certificates of insurance for their subcontractors.

- The Contractor will provide APS with its Subcontractors certificates of insurance at any time upon request.

C. Termination & or Augmentation of Insurance Policies:

1. All required insurance policies must be endorsed through a Certificate of Insurance to provide that the insurance company shall give **forty-five (45) days written notice** to the Owner if the policies are to be terminated or if any changes are made during the life of the Contract which will affect in any way the insurance requirements set forth herein. Before commencing Work, the Contractor shall provide APS with a Certificate of Insurance referencing each policy which it and each of its Subcontractors shall carry in accordance herewith, together with receipted bills evidencing proof of premium payment. Contractors and or their Subcontractors terminating or augmenting any insurance policy without giving APS forty-five (45) days' notice will be in direct violation of the terms and conditions of the Contract.

2. If insurance coverage is allowed to lapse and a loss occurs, the Contractors and or their Subcontractors will still be required to indemnify and hold APS harmless for all losses sustained. Regardless of whether insurance is present or not.

D. Insurance Required by The Contract:

Casualty Insurance:

1. Commercial General Liability - Occurrence-Based Insurance:

Commercial General Liability occurrence-based insurance shall be in place until APS confirms the Contract has expired. Such insurance shall cover claims for bodily injury, property damage and personal injury arising out of operations under the Contract, whether such actions are performed by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them.

For work that specifically deals with purchase, construction and or maintenance of physical property the insurance coverage for contractors and subcontractors shall also include coverage for explosions, collapse, underground utilities and completed products and operations. Coverage afforded under this policy shall be primary to all other insurance with respect to Arlington County School Board including its elected and appointed officials, agents, and employees.

2. Sexual Abuse and Molestation (SAM) -Occurrence-Based Insurance:

Sexual Abuse and Molestation (SAM) Coverage must be included if the Contractor and or their Subcontractors are working around students where a 1 on 1 situation is possible.

In addition to providing this coverage the Contractor and or their Subcontractors will run both criminal background checks and sex offender checks on all employees that are interacting with APS students (Upon award and every 2 years afterward) as well as require their employees to receive training upon award and annually on the prevention of abuse and molestation. Criminal background checks should go back at least 5 years. The Contractor and or their Subcontractors further agrees to keep all training records, background and sex offender checks on file and to provide APS with copies whenever APS requests them.

Lastly, the Contractor and or their Subcontractors agrees to abide by the 2-person rule at all times when working with students. If there are times when the 2-person rule cannot be followed APS should be notified immediately and the activity will be evaluated by APS, the Contractor and or their Subcontractors.

Type of Insurance	Limit Per Occurrence	Aggregate Limit
Commercial General Liability	$4,000,000	$6,000,000
Sexual Abuse and Molestation (SAM) Coverage	N/A	N/A

3. Subcontractor's Commercial General Liability Insurance:

The Contractor shall require each of its Subcontractors to procure and maintain during the life of its subcontract, subcontractor's Commercial General Liability Insurance in amounts satisfactory to the contract.

Type of Insurance	Limit Per Occurrence	Aggregate Limit
Subcontractors Commercial General Liability	N/A	N/A

4. **Worker's Compensation and Employer's Liability Insurance**:

Worker's Compensation and Employer's Liability Insurance is mandatory for the Contractor's employees engaged in the Work under this Contract, in accordance with the laws of the Commonwealth of Virginia. The Contractor shall require each of its Subcontractors to provide Worker's Compensation and Employer's Liability Insurance for all the Subcontractor's employees engaged on such subcontracts. If any class of employees engaged in work under the Contract is not protected under the Worker's Compensation laws in Virginia, the Contractor shall provide similar protection for these employees in amounts not less than the legal requirements.

Type of Insurance	Limit Per Occurrence	Aggregate Limit
Worker's Compensation	N/A	N/A
Employer's Liability	N/A	N/A

5. **Commercial Automobile Liability Insurance**:

Commercial Automobile Liability insurance, including coverage for owned, non-owned and hired vehicles shall be in place for the Contractor and all of its Subcontractors.

Type of Insurance	Limit Per Occurrence	Aggregate Limit
Commercial Automobile Liability	$1,000,000	$2,000,000

6. **Professional Liability / Errors & Omissions:**

Vendor shall carry Professional/and/or/Miscellaneous Errors and Omissions insurance which will pay for damages arising out of errors or omissions in the rendering, or failure to render professional services under the Contract.

Type of Insurance	Limit Per Occurrence	Aggregate Limit
Professional Liability/Errors & Omissions	$2,000,000	$4,000,000

7. **Cyber Liability Insurance:**

Cyber insurance which shall be in place for all contractors and subcontractors. All cyber insurance policies shall have Arlington County School Board, including elected and appointed officials, agents, and employees as an additional named insured.

Type of Insurance	Per Project Limit Per Occurrence	Per Project Aggregate Limit
Cyber Liability	$4,000,000	N/A

8. **Professional Liability including Network and Privacy Security Liability Insurance ("Tech E&O"):**

Tech E&O insurance shall be in place for Contractor and all of its subcontractors. Coverage to include: Economic Loss arising out of Contractor's capacity for which it is being hired, and Coverage resulting from the ability of a third-party to gain access to APS' computer system, Contractor's failure to prevent unauthorized access (e.g., breach) to or use of an Insured's computer system, and unauthorized access (e.g., breach) or use of confidential information (Personally

Identifiable Information (PII), Protected Health Information (PHI), and corporate confidential information protected by a confidentiality agreement). Coverage shall include but not be limited to:

- Data Breach & Incident Response
- Network Security, Privacy and Data Breach Liability
- Regulatory Liability
- PCI Fines & Assessments
- Data Restoration
- Cyber Extortion Including Ransomware
- Media Liability
- Social Engineering & Fraud Event
- Forensics

Type of Insurance	Limit Per Claim	Aggregate Limit
Technical Errors & Omissions	N/A	N/A

9. **<u>Property Insurance:</u>**

<u>Builder's Risk</u>:

The Contractor shall purchase Builder's Risk insurance upon the entire Work at the Project Site to the full value of the Contract Sum of the new improvements thereof**.** This insurance shall include the interests of APS, Subcontractors and Sub-Subcontractors in the Work, and shall insure against all risks of loss, except for exclusions included in the Certificate of Insurance and approved by Owner. This insurance shall include coverage for the following:

a) Loss by explosion of boilers during testing (any exclusion applicable to such loss shall be waived).

b) Partial or complete occupancy by the Owner (any exclusion applicable to occupancy shall be removed).

c) Loss without coinsurance penalty (coinsurance or similar "insurance to value" requirements shall be eliminated).

d) Coverage of property in transit and unscheduled locations sufficient in limits to adequately cover maximum anticipated values at risk.

e) Coverage of Contractor's labor, overhead and profit.

f) Coverage of materials stored or installed on the Project Site, until said materials are accepted by the Owner per Substantial Completion and Acceptance requirements. Payment by Owner for materials stored or installed on the Project Site does not eliminate

Contractor's responsibility or liability with regards to theft and vandalism or other damage.

Please Note: At APS's sole discretion, Builder's Risk insurance may be purchased by the Owner as specified above. In this event, cost for such coverage shall be deducted from the Contract Sum.

Type of Insurance	Limit Per Occurrence	Aggregate Limit
Builder's Risk	N/A	N/A

All risk insurance covering damage, loss or injury to the Work, excluding earthquake damage. The policy shall be payable to the Owner, and the proceeds thereof, when paid, shall be retained by APS as security for the performance by the Contractor of its obligations under this Contract and, upon such performance, shall be released to the Contractor. Such policy shall be in an amount equal to the Contract Sum.

E. Receipt of Certificates of Insurance:

Proof of satisfaction, of insurance for each type of coverage listed herein shall be provided to APS **within ten (10) days** of the Contractor's receipt of the Notice to Proceed and no work, shall proceed unless all such insurance is in effect. The Contractor shall not allow any Subcontractor to commence work on its subcontract until all insurance required of the Subcontractor has been obtained and approved by the Contractor and found to be in accordance with the requirements set forth herein.

F. Use of Excess / Umbrella Liability Insurance:

The use of Excess / Umbrella Liability insurance is permitted. If Excess / Umbrella insurance is used the policy must be endorsed to show that the lines that the policy is bolstering are covered under the policy. All Excess / Umbrella Liability insurance coverage is subject to review by APS' Risk Manager and its use can be denied based on that review.

Type of Insurance	Limit Per Occurrence	Aggregate Limit
Use of Excess / Umbrella Liability Insurance	$4,000,000	N/A

G. Consideration of Claims Made Insurance Coverage:

APS will consider claims made insurance coverage on a case-by-case basis **APS reserves the right to accept or deny the use of Claims Made Insurance coverage at any time.**

If the liability insurance purchased by the Contractor has been issued on a "claims made" basis, the Consultant must comply with the following additional conditions. The limits of liability and the extensions to be included as described previously in these provisions, remain the same. The Contractor must either:

1. Agree to provide certificates of insurance evidencing the above coverages for a period of two (2) years after final payment for the Contract for General Liability policies five (5) years for Professional Liability & Cyber policies. This certificate shall evidence a "retroactive date" no later than the beginning of the Consultant's work under this Contract.

or

2. Purchase the extended reporting period endorsement for the policy or policies in force during the term of this Contract and evidence the purchase of this extended reporting period endorsement by means of a certificate of insurance or a copy of the endorsement itself.

If claims made insurance is utilized by the Contractor and or their Subcontractors and a claim occurs that relates back to the vendor's services. The Contractor and or their Subcontractors will indemnify and hold APS harmless of all losses regardless of whether they have insurance coverage in place or not.

H. Contract Identification:

All certificates of insurance shall state the Contract number and title.

50. Accessibility of Web Site:
If any work performed under this Contract results in design, development, maintenance or responsibility for content and/or format of any APS websites, or APS' presence on other party websites, the Contractor shall perform such work in compliance with the requirements set forth in the U.S. Department of Justice document entitled "Accessibility of State and Local Government Websites to People with Disabilities." The document is located at: http://www.ada.gov/websites2.htm.

51. Arlington County Business License
The Contractor must comply with the provisions of Chapter 11 (Business Licenses) of the Arlington County Code. For further information on the provisions of this chapter and its applicability to this contract, contact the Arlington County Business License Division, Commissioner of the Revenue of Arlington, Virginia, Telephone Number (703) 228-3060.

52. Failure to Deliver
In case of failure to deliver goods or services in accordance with the contract terms and conditions, APS, after due oral or written notice, may procure the goods or services from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies which APS may have; provided that if public necessity requires the use of materials or supplies not conforming to the specifications, they may be accepted and payment therefore shall be made at a reduction in price to be determined solely by APS.

53. Subcontracts
The Contractor shall not enter into any subcontract with any subcontractor who has been suspended or debarred from doing federal, state or local government work for any reason.

The Contractor shall be as fully responsible for the acts or omissions of its subcontractors, and of persons either directly or indirectly employed by them as for the acts or omissions of persons directly employed by the Contractor.

The Contractor shall insert appropriate clauses in all subcontracts to bind subcontractors to the terms and conditions of this contract insofar as they are applicable to the Work of subcontractors.

Nothing contained in this contract shall create any contractual relationship between any subcontractor and APS.

54. Non-Endorsement Clause for Contracts and Agreements
APS may be identified as a "Participant" in the Work with the following statement added: "This shall not constitute an endorsement of any products or services". For further information, please contact the APS Department of Schools and Community Relations.

55. Advertising and Use of Proprietary Marks or Logos
Contractor shall not use the name of APS or any authorized user or refer to APS or any authorized user, directly or indirectly, in any press release or formal advertisement without receiving prior written consent of APS or such authorized user. In no event may Contractor use a proprietary mark of APS or an authorized user without receiving the prior written consent of APS or the authorized user.

56. Extension of Contract Term
The Procurement Office, at its sole and absolute discretion, may extend the Contract Term or final Renewal Contract Term of the resultant Contract for a period of not more than six (6) months, unless specifically stated otherwise in the solicitation.

57. Student Data Usage and Privacy Agreement
Intentionally deleted.

58. Contractor Certification Regarding Criminal Convictions
All Contracts with APS, where the Contractor or its employees, or its Subcontractors or their employees, will have direct contact with students on school property during regular school hours, or during school-sponsored activities, shall require the Contractor to certify that neither it nor any of its employees nor any of its Subcontractors' nor any of its Subcontractors' employees, who will have direct contact with students, have been:

(1) convicted of a felony or of a sexually violent offense as defined in Va. Code Ann. § 9.1-902 as mandated by Va. Code Ann. § 18.2-370.5,

(2) convicted of an offense occurring on or after July 1, 2006, where the offender was more than three years older than the victim involving:

(a) the rape of a child under age 13 pursuant to Va. Code Ann. § 18.2-61.A(iii),

(b) forcible sodomy of a child less than 13 years of age pursuant to Va. Code Ann. § 18.2-67.1.A.1,

(c) object sexual penetration of a child under 13 years of age pursuant to Va. Code Ann. § 18.2-67.2.A.1, or

(d) any similar offense under the laws of any foreign country or any political subdivision thereof, or the United States or any political subdivision thereof.

This requirement is applicable without exception for a person convicted of a felony or of a sexually violent offense as defined in Va. Code Ann. § 9.1-902, but for all other offenses set forth above this requirement does not apply unless the qualifying offense was done in the commission of, or as a part of the same course of conduct of, or as part of a common scheme or plan as a violation of:

(a) abduction or kidnapping in violation of Va. Code Ann. § 18.2-47.A,

(b) abduction with intent to extort money of for immoral purpose in violation of Va. Code Ann. § 18.2-48,

(c) burglary in violation of Va. Code Ann. § 18.2-89,

(d) entering a dwelling house with intent to commit murder, rape, robbery or arson in violation of Va. Code Ann. § 18.2-90,

(e) aggravated malicious wounding in violation of Va. Code Ann. § 18.2-51.2, or

(f) any similar offense under the laws of any foreign country or any political subdivision thereof, or the United States or any political subdivision thereof.

The Contractor certification covers its employees, its Subcontractors and the employees thereof. (Submit completed Appendix A).

The Contractor certification shall also cover its employees, its Subcontractors and employees thereof, assigned to the Work after Contract award. The Contractor, upon demand from APS, shall provide all information which allowed for the Contractor's certification

59. Cooperative Contract for Use by Other Public Bodies
This Contract has been awarded by APS not only for its benefit but for the benefit of any other public body eligible to participate in use of the services herein solicited by means of cooperative procurement as provided by, and to the extent permitted by, §2.2-4304 of the Virginia Public Procurement Act.

60. Contractor Prohibited in Assisting Person for New Job if Engaged in Misconduct With Minor*
As a condition of awarding a Contract, or Contract Renewal, the Contractor acknowledges it is prohibited from assisting the elected and appointed officials of APS, its officers, current and former employees, agents, departments, agencies, boards, and commissions employee, and contractors, including all levels of subcontractors, in obtaining a new job if the Contractor knows or has probable cause to believe that the elected and appointed officials of APS, its officers, current and former employees, agents, departments, agencies, boards, and commissions employee, and contractors, including all levels of subcontractors, engaged in sexual misconduct regarding a minor or student in violation of law.

61. Vaccine Requirement
All employees and students, all employees and subcontractors of the Contractor who are assigned to this Contract, must be fully vaccinated against COVID-19. Any Contractor employee or subcontractor who is not fully vaccinated, must follow a weekly testing protocol as established by the Contractor unless exempt pursuant to a valid reasonable accommodation under state of federal law. During the Contract Term, the Contract certifies that it will comply with this provision and will ensure that its subcontractors, if any, will as well.

End of Contract Terms and Conditions

Attachment G

Certificate(s) of Insurance

Attachment H

Sample Purchase Order

Page: 1 of 1

Standard Purchase Order
Arlington Public Schools

PROCUREMENT OFFICE
2110 Washington Blvd
Arlington, Virginia 22204
Telephone: (703) 228-6123

ACCOUNTS PAYABLE
2110 Washington Blvd
Arlington, Virginia 22204
Telephone: (703) 228-6121
Email: aps.payables@apsva.us

Please note that our billing address has changed.

Unless otherwise instructed, please email invoices to: aps.payables@apsva.us.

Purchase Order	**1234567**
Purchase Order Date	01-02-3456
Change Order Number	0
Change Order Date	
Procurement Specialist/Phone	Hamed Hameedi 703-228-6193
Requisitioner/Ph#/Email	Harris, Ramona J 703-228-6110 ramona.harris@apsva.us
FEIN	54-6001128
Website: https://www.apsva.us/procurement-office/	

SUPPLIER: ABC INC
1234 ABC ST
XYZ VA 56789

This PURCHASE ORDER NUMBER shown above must appear on all invoices, packing slips & related correspondence. For questions regarding the order, contact the REQUISITIONER shown above.

Ship To: Arlington Public Schools
Human Resources
2110 Washington Blvd
Arlington, VA 22204

Payment Terms	Freight Terms	FOB
NET 30	Prepaid	Destination

Line	Vendor Part	Item Description	Due Date	Quantity	UOM	Unit Price	Amount
1		This is for Example	01-02-3456	1	XYZ	$123.00	$123.00

The Purchase Order Terms and Conditions found on the Arlington Public Schools Procurement Office Website, at the link provided below, are incorporated in, and become part of, this contract. It is the responsibility of the Vendor to carefully read and understand the Purchase Order Terms and Conditions.

The Purchase Order Terms and Conditions have been amended effective August 1, 2022.

https://www.apsva.us/wp-content/uploads/2022/07/2022-07-26-PO-TsCs-Amended-2022-08-01.pdf

IMPORTANT: There have been incidents of scammers pretending to be school representatives and ordering thousands of dollars of goods. <u>Purchases by APS are authorized only if an APS Purchase Order is issued in advance of the transaction</u>, indicating that the ordering agency has sufficient funds available to pay for the purchase. Vendors providing goods or services without a signed APS Purchase Order, do so at their own risk.

Authorized by: David Webb

David J. Webb, C.P.M.
Director of Procurement

Purchase Order Total: $123.00

End of Sample Purchase Order

Appendix I
Administrative Services Agreement

Section I: Recitals

This Administrative Services Agreement ("this Agreement") governs the relationship between the Sponsor and Group Hospitalization and Medical Services, Inc. (hereafter referred to as "CareFirst"). The Sponsor and CareFirst are hereinafter collectively referred to as the "Parties." As such, this Agreement is not contained in the Evidence of Coverage (EOC) provided by CareFirst for the use of Members.

WHEREAS, the Sponsor has established a self-funded group medical benefits plan which it sponsors and maintains for its employees and their eligible dependents.

WHEREAS, the Plan is funded by the Sponsor.

WHEREAS, CareFirst maintains healthcare provider networks and has considerable administrative and operational experience and the necessary equipment and personnel to administer claims under the Plan and provide other services.

REPRESENTATIONS:

1. The Plan is not a Multiple Employer Welfare Arrangement ("MEWA") as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

2. All participating employers under the Plan are deemed to be a single employer under Internal Revenue Code Section 414(b) or (c), for this purpose, the employer or Sponsor.

3. All reimbursements of Expenditures under the Plan will be paid from the employer's or Sponsor's general assets.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the Parties agree as follows:

CareFirst provides administrative claims payment services only and does not assume any financial risk or obligation with respect to those claims.

Where language in this Agreement conflicts with any contractual language in the final contract and any document incorporated and mutually agreed upon exceptions thereto applicable to the services referenced herein, then such conflicting language in this Agreement shall not apply.

It is understood and agreed that CareFirst is empowered and required to act with respect to the Plan only as expressly stated herein and in accordance with the provisions of this Agreement, but in all instances, CareFirst shall comply with those laws and regulations that apply to the actions of CareFirst including but not limited to:

1. The Affordable Care Act ("ACA");
2. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended;
3. Transparency in Coverage requirements;
4. The Consolidated Appropriations Act ("CAA"), 2021;
5. Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007; and
6. ERISA.

The provisions set forth on the following pages, including any amendments and any Attachments to this Agreement, hereto are a part of this Agreement with the exception that the CareFirst Stop Loss Insurance Policy, if attached as an Exhibit, provides coverage that is not otherwise set forth in this Agreement.

Section II: Definitions

For the purposes of this Agreement, the following terms shall have the meanings provided below. Certain capitalized terms used in this Agreement are defined in the Evidence of Coverage and other Attachments/Exhibits to this Agreement.

Administrative Fee is the charge for administrative services performed by CareFirst under this Agreement. For billing purposes and as a courtesy to the Sponsor, CareFirst invoices will include commissions, bonuses, fees, etc., payable by the Sponsor to producers (brokers) and/or consultants to the extent that they apply.

Affordable Care Act ("ACA") means the Patient Protection and Affordable Care Act, Pub. L. 111-148, enacted on March 23, 2010 and the Health Care and Education Reconciliation Act, Pub. L. 111-152, enacted on March 30, 2010, as amended.

Agreement Period coincides with the initial term of this Agreement and each successive term thereafter; provided, however, that the first Agreement Period commences with the Effective Date of this Agreement and the final Agreement Period terminates upon the termination of this Agreement.

Applicable Law means the state, federal and international laws and regulations that apply to the Parties and the subject matter of this Agreement.

Attachments mean those portions of this Agreement that are identified by corresponding Roman numeral and made part of this Agreement.

Care Support Services means claims for acute and chronic medical and behavioral healthcare management services as set forth in the Evidence of Coverage ("EOC").

Claims Administrator means CareFirst.

Covered Service(s) means services and supplies rendered or delivered to a Member eligible to receive such services and/or supplies under the Plan (at the time such services and/or supplies are rendered or delivered) which are Medically Necessary as determined pursuant to the terms and conditions of the Plan or which are otherwise expressly stated as covered under the Plan, stated as a benefit within the Plan and not otherwise excluded from coverage under the Plan, and prescribed and/or rendered by providers within the scope of their license. This may include, but is not limited to:

1. Care Support Services;
2. The services set forth in Attachment V: Health Promotion/Wellness and Member Incentive;
3. Other healthcare-related services set forth in any Attachments; and
4. Associated claims, some of which, as set forth in the EOC, may have a zero Member cost-sharing provision.

Disease Management means a coordinated, confidential program, which may be carried out with help from a Disease Management Coach, and that is designed to manage a Member's chronic disease so that action can be taken to improve outcomes in the future.

ERISA means the Employee Retirement Income Security Act of 1974, as amended. Nothing herein shall be construed to mean or imply that a non-ERISA group health plan has deemed itself subject to ERISA unless specifically stated herein.

Evidence of Coverage (EOC), as amended, means the document issued by CareFirst to the Sponsor through which the Plan benefits are administered as described therein. The EOC is not the same as the Summary Plan Description (SPD).

Expenditures means Paid Claims plus the Administrative Fee and any other charges set forth in Attachment X: Financial Terms and CareFirst Stop Loss Insurance Policy charge(s), if applicable.

External Review means a review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to the Claims Procedures section of the EOC in accordance with Applicable Law. CareFirst contracts with Independent Review Organizations (IROs) for assignments under the Plan and shall rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). External Review does not apply to dental care benefits and vision care benefits, if applicable, unless such benefits are embedded in the EOC via rider.

Final Termination Settlement means CareFirst's final settlement report to the Sponsor no later than 14 months following the date of termination of this Agreement setting forth any payment adjustments to be made between the Parties.

Medical Pharmacy Rebates means Rebates CareFirst may become entitled to for the limited Prescription Drug Covered Services under the medical portion of the EOC. CareFirst may employ the services of utilization management or other professional organizations in order to obtain these Medical Pharmacy Rebates. CareFirst will retain rebates as set forth in Attachment X: Financial Terms to cover its internal and external costs relating to the administration of the rebate program and to cover the costs of various pharmacy programs which CareFirst provides without a separate charge to the Sponsor.

Member(s) means a Participant and any other eligible person enrolled under the Plan. For purposes of the Administrative Fee and or any other applicable charges Members may be categorized by Type of Coverage (Membership Categories), such as: Individual, Individual and Child, Individual and Adult, Family.

Miscellaneous Recoveries means funds that could include consolidated or class action lawsuits and if applicable, lump-sum compromise settlements and miscellaneous credits and may or may not be attributed to a specific claim or claims.

Paid Claims is the amount paid by CareFirst for Covered Services under the Plan. Inter-Plan Arrangements Fees and Compensation, as set forth in Attachment II: Inter-Plan Arrangements Disclosure, as amended, if applicable, may also be included in Paid Claims.

Participant means an eligible Subscriber, as defined in the EOC, who is covered under the Plan.

Plan means that portion of the welfare benefit plan established by the Sponsor that provides for health care benefits set forth in the EOC.

Plan Administrator means the Sponsor, or the person or persons designated by the Sponsor/Plan Sponsor and identified in the Plan Document. The Sponsor and CareFirst agree that the services rendered by CareFirst under this Agreement shall not include the power to be the "Plan Administrator" of the Plan.

Plan Benefits Litigation means a demand asserted or litigation, proceedings or arbitration, commenced by a Member, Plan beneficiary or healthcare provider to recover Plan benefits and, if applicable, attorney fees, court costs and expenses incurred in connection with such demand, litigation, proceedings or arbitration.

Plan Document means the written instrument adopted by the Plan Sponsor that fully describes the Plan.

Producer of Record (Broker) Fee is the fee agreed upon by the Sponsor to be paid by CareFirst to the producer of record, if applicable.

Run-Out means claims for Covered Services incurred by a Member during the Agreement Period but not paid by CareFirst during the Agreement Period.

Run-Out Administrative Fee means the fee charged to the Sponsor by CareFirst for Run-Out claims processing.

Stop Loss means separate insurance coverage purchased for the employer group sponsoring the health Plan from CareFirst or another carrier. A copy of the CareFirst Stop Loss Insurance Policy is attached hereto as an exhibit, if applicable.

Summary Plan Description (SPD) means the disclosure document furnished to Participants by the Plan Administrator describing the terms and conditions of the Plan.

Value-Driven Healthcare Incentive means a healthcare provider incentive or an incentive to another organization providing access to healthcare and/or loss-sharing program which rewards improved cost-efficiency and/or care quality and may hold providers or the applicable organization accountable for failure to meet certain quality and/or cost efficiency targets.

Section III: CareFirst Administration and Services

A. ADMINISTRATIVE SERVICES: CareFirst shall provide the following administrative services:

1. Assign an experienced account management team to the Sponsor's account to assist the Sponsor in connection with the services provided under this Agreement;

2. A detailed implementation plan;

3. Marketing material and assistance with the Sponsor's open enrollment meeting(s);

4. Access to an online provider directory and cost estimation tool;

5. Design and installation of a group structure by class of employees, division, subsidiary, or other classification reasonably requested by the Sponsor;

6. Summary of Benefits and Coverage (SBC): While CareFirst has no obligation to send the Summary of Benefits and Coverage (SBC) required of an employer pursuant to the ACA, CareFirst will send SBCs per the Sponsor's product choice, in an editable format, within a reasonable period after receipt of notice of an event requiring such SBC to be sent, as a service to the Plan Sponsor. The Sponsor is responsible for any translation costs CareFirst may incur. The Sponsor is ultimately responsible for the SBC content and agrees

to indemnify CareFirst in the event that there are any claims, fines, or penalties arising from the content of the SBC. To the extent the Sponsor requests edits/customizations to the SBC, such edits may be subject to additional charges.

7. An electronic enrollment platform. Customized enrollment files/Sponsor vendor changes may incur additional fees.

8. Standard Identification (ID) Cards ("Standard Identification (ID) Card" means a card that includes all Blue Cross Blue Shield Association required elements). CareFirst shall issue Standard ID Cards prior to initial effective date and, if required, upon renewal to reflect Member/Plan changes. Upon request, CareFirst may arrange for Sponsor re-card or for the custom printing of ID cards due to Sponsor-specific attributes such as logos/phone numbers/vendors and customized inserts to accompany the ID cards. All costs shall be borne by the Sponsor. CareFirst shall provide the cost of such service within a reasonable timeframe after receipt of the request.

9. Electronic EOCs (Member benefit booklets). Print versions are available for a fee.

10. Standard reports as set forth in Section VI: Reports; Reports Required by Law; Tax, COBRA Compliance, and Other Employer Responsibilities.

11. File such forms and process payments on behalf of the Plan for such surcharges and assessments related to Covered Services in accordance with and as required by Applicable Law and regulation, including but not limited to surcharges and assessments under the:

   a) Health Safety Net3 (previously Massachusetts Uncompensated Care Act (MUCA));

   b) Michigan Health Insurance Claims Act; and

   c) New York Health Care Reform Act of 1996 (section 2807-t of the New York Public Health Law).

   The Plan is ultimately responsible for determining what surcharges and assessments apply.

12. Services not listed above, including, but not limited to, microsites and customized marketing communications/promotional items/health-related literature/printing and mailing shall be priced at time of request.

B. TRANSLATION SERVICES: CareFirst shall not be responsible for any translation costs incurred as a result of Section 1557 of the ACA or any other federal or state law.

C. CLAIM SERVICES: Sponsor authorizes CareFirst to do all things and to perform all acts which CareFirst deems necessary or appropriate to properly administer and facilitate claims processing with respect to the Plan. CareFirst shall, subject to the terms of this Agreement:

1. Receive and review claims for Plan benefits. CareFirst will receive and price all claims incurred within its Service Area according to the applicable provider agreement(s) in effect on the date the service is rendered; such agreement(s) may include a Value-Driven Healthcare Incentive. Any pricing error will be corrected upon identification and debited/credited to Paid Claims accordingly.

2. Determine the Plan benefits payable, if any, for such claims;

3. Disburse payments of Plan benefits to claimants, including Value-Driven Healthcare Incentives if applicable; and

4. Provide in the manner and time frames required by Applicable Law, notification to claimants of:

    a) coverage determination; or

    b) any anticipated delay in making a coverage determination beyond the time required by Applicable Law.

5. Member and Healthcare Provider Services: CareFirst shall maintain one or more service centers, responsible for handling calls and other correspondence from claimants with respect to questions relating to the Plan and Covered Services under this Agreement.

D. ADJUSTMENTS TO CLAIMS: When a request for adjustment of a Paid Claim is made within the applicable timely filing period, CareFirst shall adjust improperly processed claims. When a request for adjustment is made outside of the applicable timely filing period, CareFirst shall only adjust improperly Paid Claims if specifically directed in writing to do so by Sponsor or if CareFirst specifically directs a provider to correct a claim. Otherwise, CareFirst shall not have any obligation to adjust improperly processed claims if more than two (2) years have elapsed between the date of payment and the request for reprocessing.

E. CLAIM RECOVERY SERVICES: If an overpayment or an improper payment is made to any Participant or any provider on behalf of a Participant, or any payment is made to an ineligible person, CareFirst shall, as applicable:

1. Make a written demand upon such individual for the return of the overpayment or improper payment, and request that the individual complete and file any necessary forms to recover overpayments;

2. Offset any overpayment to a Participant against any unpaid claim of the Participant;

3. Offset any overpayment to a provider against any subsequent payments due the provider; however, offsets shall not be applied to a Department of Veterans Affairs/Department of Defense provider. Any offset shall be made solely with respect to subsequent payments due under the Plan and shall not be made with respect to any payments due from any plan sponsored by an entity that is not affiliated with Sponsor.

F. CREDIT FOR MISCELLANEOUS RECOVERIES:

1. Miscellaneous Recoveries which can be attributed to a specific claim or claims. CareFirst shall credit Miscellaneous Recoveries in accordance with Attachment V: Data Mining/Payment Integrity Shared Savings Program and in accordance with the Shared Savings provision as set forth in Attachment VII: Financial Terms.

2. Miscellaneous Recoveries which cannot be attributed to a specific claim or claims.

a) CareFirst shall credit Miscellaneous Recoveries proportionately to its self-funded customers, generally based on the following formula:

1) The percentage of Group Hospitalization and Medical Services, Inc. self-funded customers vs. the total CareFirst population. The "total CareFirst population" constitutes the District of Columbia, Maryland, and portions of Virginia.

2) The applicable percentage for each Group Hospitalization and Medical Services, Inc. self-funded customer is then determined based on the amount paid by the self-funded customer.

b) CareFirst has no obligation to participate in consolidated or class action lawsuits on behalf of the Sponsor in its capacity as a plaintiff. To the extent CareFirst pursues recovery of moneys under the category of Miscellaneous Recoveries, all recoveries shall be apportioned among all insured and self-insured plans of Group Hospitalization and Medical Services, Inc. and any affiliate in a like manner. The proration may be based on the number of covered persons, claims volume, or any other basis as determined in the sole discretion of CareFirst.

3. CareFirst shall provide disclosure of associated fees which can be reasonably tracked.

G. SUBCONTRACTORS, VENDORS, OR OTHER THIRD PARTIES, ETC.: In fulfilling its obligations under this Agreement, CareFirst reserves the right to contract with administrators, subcontractors, vendors, claims processors or other third parties it deems necessary to administer the Plan. There is no obligation for CareFirst to obtain prior approval from the Plan named herein as a condition precedent to entering into any such contract. CareFirst may enter into arrangements with one or more of these entities which allow for CareFirst to share in certain revenues realized by such entity as a result of services related to the Plan. This share of revenue shall be retained by CareFirst as compensation for its administrative services.

H. AFFILIATES: CareCo, LLC, ("CareCo") which is an affiliate of CareFirst, may provide certain Care Support Services to Members, which services may be reimbursed as a Paid Claim under the terms of the Plan. Such payment may include an amount reimbursing CareCo for administrative expenses for the rendering and/or management of these services. CareFirst may contract with other entities, including affiliates or other entities in which it has a financial interest, to assist in the administration of benefits under the Plan and may utilize the same or similar payment methodology for those entities as used for CareCo.

Section IV: Sponsor Obligations

A. The Sponsor will be responsible for the following duties associated with sponsoring and funding the Plan:

1. Eligibility and Enrollment: The Sponsor or the Sponsor's administrator on its behalf shall:

a) Deliver to CareFirst all information necessary for CareFirst to process claims for benefit payments under the Plan on or before the first day of the initial term of this Agreement and all subsequent renewal term(s);

b) Enter all new and amended enrollment or changes into the CareFirst Connect platform, or other electronic platform, to be transmitted periodically throughout the month to CareFirst;

c) Ensure that the enrollment and/or changes have been successfully accepted by the electronic platform;

d) Ensure that when paper application forms are used, the Sponsor shall deliver to CareFirst all new and amended enrollment or change applications for the Plan which have been collected.

e) Retroactively terminate a Member's coverage no earlier than the first of the calendar month in which termination is requested or required under the Plan;

f) Reimburse CareFirst for all benefits paid for services rendered to a terminated or ineligible Member after the date of termination until notice of that termination is received by CareFirst.

The Sponsor agrees that clerical errors or delays in recording or reporting dates will not invalidate coverage which would otherwise be in effect or continue coverage which would otherwise terminate, subject to the requirements of the ACA. Upon discovery of errors or delays, or upon any request for a retroactive enrollment, an equitable adjustment of charges and benefits will be made.

2. Notice of Plan or Benefit Changes: Sponsor shall notify CareFirst in writing of any off-renewal changes in Plan benefits at least 90 days prior to the effective date of such changes. CareFirst will have 30

days following receipt of such notice to inform Sponsor whether CareFirst will agree to administer the proposed changes. If the proposed changes increase CareFirst's cost, require that ID cards be re-printed, alter CareFirst's ability to meet any performance standards or otherwise impose operational challenges, CareFirst may require an adjustment to the Administrative Fee or other financial terms. Any amendment to the Plan design shall not be binding on CareFirst for purposes of this Agreement until CareFirst has received proper written notice of such amendment.

3. General Assistance: The Sponsor, in conjunction with CareFirst as they may mutually agree, shall supply eligible Participants with enrollment or change applications, identification cards, EOCs, claim forms and other materials necessary or appropriate for the proper administration of the Plan. In addition, the Sponsor shall make a reasonable best effort to promptly assist CareFirst with respect to its duties hereunder when requested to do so by CareFirst.

4. Employee Notices: The Sponsor shall:

a) Furnish each Participant covered by the Plan written notices required by law;

b) Notify CareFirst of a Participant address change;

c) Accept and distribute information, notices, benefit changes, and other materials intended to be communicated to Members enrolled under the Plan.

5. The Plan's Notice of Privacy Practices:

a) Preparation and Mailing of the Plan's Notice of Privacy Practices

The Plan shall be responsible for the preparation and mailing of its Notice of Privacy Practices. To facilitate this preparation, upon request, CareFirst shall provide to the Plan a sample template that the Plan may use as the basis for its own notice. The Plan shall modify this template to reflect specific aspects of the Plan. The Plan will be solely responsible for review and approval of the content of its Notices of Privacy Practices, including that its content accurately reflects the Plan's privacy policies, procedures and practices and complies with all the requirements of 45 Code of Federal Regulations § 164.520.

b) CareFirst's Review of the Plan's Notice

CareFirst shall have the right, but not the obligation, to review the Notice of Privacy Practices prepared by the Plan if it differs from the standard federal form or the CareFirst sample template. The Plan shall provide this notice to CareFirst no later than forty-five (45) days prior to its intended mailing date for the notices. If CareFirst identifies for the Plan aspects of the Plan's notice that are inconsistent with CareFirst's Notice of Privacy Practices, CareFirst is not obligated to follow the Plan's notice, so long as CareFirst's notice complies with the Privacy Rule. The Plan will cooperate with CareFirst in preparing a notice that is consistent with CareFirst's notice.

c) Amendment of the Plan's Notice of Privacy Practices

The Plan and Plan Sponsor will notify CareFirst of any material change in the Plan's privacy policies, procedures or practices, including any material change in any Plan administration function that Plan Sponsor may undertake so that CareFirst can revise its implementation of the Plan's Notices of Privacy Practices to conform to such material change (unless CareFirst identifies inconsistent practices pursuant to the above paragraph). Neither the Plan nor Plan Sponsor will institute such material change before the effective date of the Plan's revised Notices of Privacy Practices.

6. Compliance with Laws: Sponsor is solely responsible for ensuring the Plan's compliance with all Applicable Laws, regulations and regulatory guidance, including but not limited to complying with the requirements of ERISA, issuance of SPD, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), the Plan's grandfathered status pursuant to the ACA, the applicability of ACA requirements and if applicable the determination of what constitutes Essential Health Benefits. Sponsor assumes sole responsibility for maintaining all necessary documentation in support of any claimed grandfathered status for its health coverage and for providing any such documentation to anyone who has the right to examine it. In addition, Sponsor shall be responsible for determining whether any benefit or benefit plan incentive results in any tax consequences, either to the Sponsor or to any Participant. Sponsor is liable for any tax, assessment, fee or cost based upon the existence of the Sponsor's group health Plan, including all fines, penalties, losses, damages, costs, expenses, attorneys' fees and court costs incurred in connection with any assessment and all other fees.

Section V: Funding Arrangement and Payment Terms

A. CareFirst's notification to the Sponsor of the amount due is based on the "Sponsor's entire experience." The "Sponsor's entire experience" is the aggregate of Expenditures for all coverage, including coverage addressed in any Attachment(s) and Run-Out experience under the equivalent rating arrangements of terminated groups.

1. Invoicing: CareFirst, or CareFirst's administrator acting on behalf of CareFirst, will notify the Sponsor, or Sponsor's administrator acting on behalf of Sponsor, of the amount due as follows:

a. Administrative Fee and any other charges set forth in Attachment VII: Financial Terms.

By the 15th day of the month preceding the payment due date. For example: CareFirst will notify the Sponsor of the amount due for the month of January by December 15th.

b. Paid Claims

Every Monday except for federal holidays, in which case Tuesday. The claims invoice shall include a billing for any applicable Value-Driven Healthcare Incentive.

CareFirst's second and all subsequent notifications will specify adjustments to these amounts, such as Paid Claims debits/credits not previously captured, any other applicable credits/debits, CareFirst's application of any late fees, and Member incentive/Value-Driven Healthcare Incentive program reimbursements, if applicable.

2. Payment Due Date(s):

a. Administrative Fee and any other charges set forth in Attachment VII: Financial Terms.

Payment is due prior to the first day of the coverage month.

b. Paid Claims

Payment is due every Friday except for federal holidays, in which case the following business day.

3. Taxes, Other Charges or Fees with Respect to Payment of Covered Services: If CareFirst is assessed with taxes, other charges or fees with respect to any benefit payments made or effected by CareFirst under the Plan and or this Agreement, the Sponsor shall promptly reimburse CareFirst for said amount upon receipt of a written request for such reimbursement. This includes, but is not limited to, the New York State Health Care Reform Act of 1996, as amended, the Massachusetts Health Safety Net3 (previously Uncompensated Care Act (MUCA)), and any taxes, interest, and penalties incurred by the Sponsor for failure(s) to meet any federally mandated coverage requirements.

4. Payment of Invoices: Each payment must notify CareFirst which invoice(s) is addressed by the payment; however, CareFirst reserves the right to apply the payment to an amount due and owing at its discretion. For example, CareFirst may apply payments to oldest amount due regardless of any allocation requested by Sponsor at time of payment. In the absence of any justifiable credits, CareFirst will have the discretion to apply payments to reimbursement for Paid Claims or the Administrative Fee. In the event Sponsor pays less than due, CareFirst shall consider Sponsor allocation, but retains discretion.

5. Overdue Amounts and Late Fees: CareFirst reserves the right to charge late fees on overdue amounts.

Overdue amounts are subject to a late fee of [redacted] which begins at the start of the next billing cycle when the invoice is unpaid/underpaid as of the due date. Overdue amounts include, but are not limited to:

a. Failure to pay the Administrative Fee as invoiced;

b. Failure to provide reimbursement of Paid Claims as invoiced;

c. Failure to pay any applicable deposit amounts;

d. Notification of Insufficient Funds: The Sponsor is responsible for all bank fees incurred by CareFirst, including bank fees for CareFirst's subsequent ACH debit(s) for payment, if applicable.

CareFirst reserves the right to withhold payment of claims in any of these circumstances and notify Participants to the extent that it is considered necessary under the law and/or to protect its legal interests.

Nothing in this section limits the right of CareFirst to terminate this Agreement in accordance with Section VII: Term, Renewal, Termination and Default contained herein.

6. If Payment is Via Wire Transfer: Payments via wire transfer shall be to the banking institution designated by CareFirst, as agent for CareFirst.

7. If Payment is Via Automated Clearing House (ACH) debits: Prior to the first day of the first month of the Agreement Period the Sponsor will perform all functions required by its bank authorizing CareFirst to initiate Automated Clearing House (ACH) debits from the Sponsor's bank account.

The Sponsor is responsible for:

a. Ensuring sufficient funds are available to cover CareFirst debits;

b. Providing ample notice to CareFirst of changes to the Sponsor's bank or bank account information, including but not limited, to ABA number, account number, bank name and address;

c. Reconciling the bank account;

d. The payment of any bank charges incurred in connection with the bank account.

Interest: Any interest payable by the banking institution as a result of the funds in the bank account shall be the sole property of the Sponsor.

Section VI: Reports; Reports Required by Law; Tax, COBRA Compliance, and Other Employer Responsibilities

A. STANDARD REPORTS: Standard reports that are available on CareFirst's online data reporting and electronic invoicing systems evolve over time. Specific information as to the standard reports currently available is available upon request. Access to these standard reports is included in the Administrative Fee. Additional reports and/or customized reports may be made available. CareFirst may charge a fee for such additional reports.

B. OTHER REPORTS/DATA/INFORMATION: Upon request, CareFirst will provide other reports/data/information, e.g., data integration, Stop Loss reports. However, CareFirst reserves the right to charge additional fees for such data and information.

C. REPORTS REQUIRED BY LAW; TAX, COBRA COMPLIANCE, AND OTHER EMPLOYER RESPONSIBILITIES:

1. The Sponsor shall:

   a. Prepare and submit in timely fashion all reports required by the Internal Revenue Code and the regulations thereunder, the Internal Revenue Service, the Department of Labor and all other federal or state agencies;

   b. Make any payment required to accompany such reports.

2. CareFirst shall have no responsibility with respect to such reports except to provide to the Sponsor, upon the written request of the Sponsor, information in the possession of CareFirst which may be needed to complete such reports. CareFirst will provide Sponsor with Plan data and assistance necessary for preparation of the Plan's information returns and forms required by ERISA or other federal or state laws. Form 5500s are the responsibility of Sponsor; however, CareFirst shall provide timely information.

Section VII: Term, Renewal, Termination and Default

A. TERM: The term of this Agreement shall be from January 1, 2024 through December 31, 2026, both dates inclusive.

B. EFFECT OF TERMINATION:

1. Upon termination of this Agreement, CareFirst shall administer payment of Run-Out claims in accordance with Section VIII: Run-Out Provisions.

2. “Winding Up”: If this Agreement, or any portion thereof, is terminated for any reason, the following “winding up” shall occur:

a. Termination as Provided in Section VII: Term, Renewal, Termination and Default, paragraph C.1: CareFirst shall continue to process claims and perform all other duties as specified herein until the effective date of the termination of this Agreement, or portion thereof.

b. Termination After a Default by Sponsor as specified in Section VII: Term, Renewal, Termination and Default, paragraph E: All obligations of CareFirst shall cease immediately.

3. Preexisting Rights or Liabilities: Termination of this Agreement for any reason shall not affect the rights or obligations of either Party which arise prior to the date of termination unless otherwise set forth in this Agreement.

C. DEFAULT:

1. Default by the Sponsor: The Sponsor shall be in default under this Agreement for failure to adhere to the provisions set forth in Section V: Funding Arrangement and Payment Terms. if upon written notice of such failure the Sponsor does not reimburse CareFirst for undisputed amounts within 10 days of failure to fund claims payments and within 30 days of failure to reimburse for undisputed administrative fees.

2. Termination Upon Default: Upon any default hereunder, the non-defaulting Party may, at its option and without notice to the other Party, terminate this Agreement immediately. Any termination shall be without prejudice to any other rights and remedies which the non-defaulting Party may have against the defaulting Party with respect to such default.

Section VIII: Run-Out Provisions

A. PRIOR TO TERMINATION (TERMINATED GROUP NUMBER(S)): As set forth in Section V: Funding Arrangement and Payment Terms CareFirst’s notification to the Sponsor of the amount due is based on the “Sponsor's entire experience.” CareFirst shall process Run-Out for terminated group numbers in accordance with the Proofs of Loss provision of the EOC, which generally requires that claims be submitted within 12 months following the date services were rendered for the fee set forth in Attachment VII: Financial Terms.

B. POST-TERMINATION: Not earlier than forty-five (45) days following the date of termination and for 12 months subsequent, CareFirst shall invoice the Sponsor for the services related to Run-Out. The first invoice following termination will include the Run-Out Administrative Fee, if applicable. CareFirst will notify the Sponsor of Run-Out Paid Claims amounts due.

C. FINAL TERMINATION SETTLEMENT: CareFirst will provide a final settlement report to the Sponsor no later than 14 months following the date of termination of this Agreement setting forth any payment adjustments to be made between the Parties.

Section IX: Fiduciary Duties

A. DUTIES: The fiduciary duties between the Parties are described below.

1. The Plan: The Sponsor, as Plan Administrator, retains complete authority and responsibility for the Plan, its operation, and the benefits provided thereunder. CareFirst is empowered to act on behalf of the Sponsor in connection with the Plan only to the extent expressly set forth in this Agreement or as agreed to in writing by CareFirst and the Sponsor.

2. Eligibility: The Sponsor has the sole and complete authority to determine eligibility of persons to participate in the Plan, subject to an External Review decision in accordance with Applicable Law.

3. Claims: The Sponsor and CareFirst agree that with respect to Section 503 of ERISA, as amended, or applicable state law as appropriate, CareFirst will be the "appropriate named fiduciary" of the Plan and shall make final decisions regarding interpretations of the Plan and the benefits provided thereunder, including:

a. Utilization Review;

b. Case Management;

c. Full discretion and authority to interpret the Plan, reconcile inconsistencies, supply omissions and resolve ambiguities;

d. The initial and final determination of claims under the Plan, subject to federal law requirements applicable to an External Review decision in accordance with Applicable Law. Such decisions shall be final and binding.

Nothing in this Agreement shall be construed as making CareFirst a fiduciary for any other activity, function or responsibility in connection with the Plan and in no event will CareFirst be liable for any breach of duty by any other fiduciary of the Plan.

B. LEGAL ACTIONS BY MEMBER: Unless otherwise limited by the Plan Document, any legal actions by a Member against CareFirst shall be brought within the time periods specified by ERISA, if applicable. Otherwise, any legal actions by a Member against CareFirst shall accrue on the date of the occurrence giving rise to the action. For example, in the case of a dispute involving payment of a claim, the date of occurrence is the date of the final claim adjudication giving rise to the action.

CareFirst shall immediately notify the Sponsor of any claim or suit made or filed against CareFirst or other subcontractors regarding any matter resulting from or relating to the obligations of CareFirst under this Agreement and will cooperate, assist, and consult with the Sponsor in the defense or investigation of any claim, suit or action made or filed against the Sponsor as a result of or relating to the performance of CareFirst under this Agreement.

C. PLAN BENEFITS LITIGATION: In the event of a legal, administrative or other action arising out of the administration, processing or determination of a claim for benefits under the Plan involving whether or not coverage is provided pursuant to the provisions of the Plan language, the Sponsor shall undertake the defense of such action regardless of whether or not the Sponsor has been included in the action. The Sponsor shall pay all expenses associated with the action and settle such action when in its reasonable judgment it appears expedient to do so. The Sponsor agrees to pay the amount of benefits under the Plan included in any judgment or settlement in such action, including but not limited to legal expenses and punitive damages.

The Parties understand and agree that the Sponsor is always liable for the full amount of all Covered Services determined to be available under the provisions of the Plan. Additionally, the Sponsor is always liable for the full amount of any Covered Services or other amounts included in any judgment or settlement paid as a result of Plan Benefits Litigation determined to be available under the provisions of the Plan. and, as between the Parties to this Agreement, for any legal fees and court costs incurred and recovered by the Member and/or healthcare provider in connection therewith. In no event will CareFirst be liable for any amount of Covered Services recovered by a member and/or healthcare provider in connection with Plan Benefits Litigation as described herein; and if CareFirst advances payment for same, the Sponsor will promptly reimburse.

Section X: Liability

A. LIABILITY: The Parties hereto shall use ordinary care and due diligence in the performance of their duties hereunder, but neither shall be liable to the other or any other person for any mistake of judgment or other action taken in good faith, or for any loss or damage occasioned thereby, unless the loss or damage is due to the Party's gross negligence or willful misconduct.

With the exception of legal, administrative, or other actions set forth in Section IX: Fiduciary Duties, neither Party has an obligation to provide legal counsel or defense to the other or its subcontractors in the event that a suit, claim or action of any character is brought by any person not a party of this Agreement against either of the Parties or their subcontractors as a result of or relating to their obligation under this Agreement.

Section XI: Data Use

A. CAREFIRST'S USE OF DATA: Notwithstanding any provision of this Agreement to the contrary, any use or disclosure of Protected Health Information (PHI) by Claims Administrator must be consistent with the Business Associate Agreement (BAA). In addition to the uses of PHI or other claims data authorized under the BAA the Sponsor agrees that Claims Administrator may use and or disclose PHI or other claims data for the following purposes, provided all such disclosure is consistent with HIPAA Privacy standards: (i) internal exchange and study between and among Claims Administrator and its affiliates for purposes of utilization studies, cost analyses or modeling initiatives, quality assurance, provider profiling, credentialing and network management, fraud and abuse monitoring or investigation, administrative or process improvement and cost comparison studies and reports for actuarial analyses; and (ii) release in a de-identified format of claims information to a third party data aggregation service or data warehouse for purposes of utilization studies, cost analyses or modeling initiatives, quality assurance, provider profiling, credentialing and network management, fraud and abuse monitoring or investigation, administrative or process improvement, cost comparison studies and reports for actuarial analyses and/or other commercial purposes.

B. SPONSOR'S USE OF INTER-PLAN DATA:

1. Sponsor agrees that it shall use and access Inter-Plan Data solely for plan administrative purposes. For purposes of this Agreement, Inter-Plan Data shall mean information that relates to another Blue Plan, including, but not limited to, pricing information (e.g., Blue Plan fees, network discounts). Sponsor will not use Inter- Plan Data in any other manner or for any other purpose. Sponsor will make Inter-Plan Data available only to those of its employees and its contractors that need to access Inter-Plan Data for the purposes of plan administration. Sponsor will not disclose or provide Inter-Plan Data, or otherwise make Inter-Plan Data available, to any third party, except with the written consent of CareFirst or as required by applicable federal, state or local laws, regulations, codes and rules.

2. Sponsor shall not use Inter-Plan Data for any analytical purposes other than for plan administrative purposes. Sponsor agrees that it will not and will not permit any contractor or any other authorized third party to de-aggregate Inter-Plan Data to identify a Blue Plan.

3. Sponsor shall promptly destroy Inter-Plan Data, and any materials (e.g., records, notes, presentations) in its possession that reference Inter-Plan Data. Upon request from CareFirst, an officer of Sponsor will certify to all such destruction subject to the Sponsor's data retention requirements, as required by Applicable Law. To the extent that data is retained by the Sponsor, the confidentiality requirements of this Agreement shall apply.

4. If CareFirst reasonably believes that Sponsor is not in compliance with this provision, then CareFirst may, upon written notice to Sponsor, audit Sponsor and its systems and processes related to the Inter-Plan Data for the purposes of evaluating such compliance.

Section XII: General Terms

A. PROPRIETARY INFORMATION: The Sponsor and CareFirst acknowledge that, in the course of the relationship contemplated under this Agreement, the Sponsor may come into possession of proprietary information, particularly information concerning provider reimbursement or discounts, which is the exclusive property of CareFirst. The Sponsor agrees that it will not disclose such information to third persons without first having obtained written consent from CareFirst. This provision is not intended to restrict the Sponsor from the disclosure of such information as it may find necessary for the proper operation of the Plan.

Any and all of CareFirst's proprietary or trade secret information released by CareFirst or by any other entity to the Sponsor shall not be used for any purpose other than for the purpose discussed herein.

Any and all proprietary or trade secret information communicated by CareFirst or by any other entity to the Sponsor shall not be disclosed to any employee within the Sponsor's organization who does not have a need to know such information and that such need arises from the obligations of the Sponsor to the Plan. That any information communicated by CareFirst or by any other entity to the Sponsor shall not be disclosed to any third party, person, company, entity, organization or corporation, other than the Sponsor and its authorized representatives.

The Sponsor will use all reasonable means, not less than those which would be used to protect its own proprietary information, to safeguard any proprietary or trade secret information transmitted to it by CareFirst or by any other entity.

B. RETENTION OF RECORDS: CareFirst shall retain and maintain all records and documents relating to this Agreement for seven (7) years after the end of the Agreement Period or any applicable period of time required by Applicable Law or judicial order, whichever is longer, and shall make these records and documents available for inspection and audit by authorized representatives of the Sponsor. Records obtained or created in the performance of this Agreement must be maintained in accordance with the confidentiality requirements of all applicable federal and state laws and regulations. Upon expiration or termination of this Agreement, the Sponsor may require that the data, reports and other documents developed by CareFirst under this Agreement may be required to be delivered to the Sponsor at no additional cost unless the manner of storage of the data or information renders the return or destruction commercially impracticable.

C. AMENDMENTS: This Agreement constitutes the entire agreement between the Parties and all other communications prior to its execution, whether written or oral, with reference to the subject matter of this Agreement are superseded by this Agreement. Any amendment to this Agreement must first be approved in writing by the Sponsor. No amendment to this Agreement shall be binding unless so approved and unless it is in writing and signed by the Party to be changed.

The Parties agree that in the event legislation, regulation, ordinance or order of court become effective during any term of this Agreement which materially modifies the terms and conditions of this Agreement, or the obligations, duties and or liabilities of any Party hereto, this Agreement shall be modified to comply with any such legislation, regulation, ordinance or order of court.

D. INVALID PROVISION: If any provision hereof is determined to be invalid under an applicable statute or rule of law, to the extent such provision is determined to be invalid, such provision is deemed to be omitted from this Agreement.

E. WAIVER: No delay or failure of either Party in exercising any right hereunder and no partial or single exercise thereof shall be deemed of itself to constitute a waiver of such right or any other rights hereunder.

F. ASSIGNMENT: This Agreement may not be assigned by either Party without the express, written consent of the other Party, which consent shall not be unreasonably withheld.

G. BINDING EFFECT; NO THIRD-PARTY BENEFICIARIES: This Agreement shall be binding upon and inure to the benefit of the Parties hereto and their respective successors and permitted assigns. Nothing in this Agreement express or implied, is intended to confer upon any other person's rights, remedies or obligation under or by reason of this Agreement.

H. LIMITATION ON CLAIMS BY SPONSOR: Any claim by the Sponsor against CareFirst based on any breach or alleged breach by CareFirst of its duties hereunder shall be invalid unless delivered to CareFirst, in writing, by the later of the termination of this Agreement or the date one hundred eighty (180) days after the date of the breach or alleged breach. Nothing in this Section or this Agreement, however, shall serve to limit any Statute of Limitations applicable to a cause of action arising out of or related to this Agreement.

I. AUDITS: If there is an audit, such audit will be conducted in accordance with CareFirst's "External Audit and Investigation Policy," as may be amended from time to time, a copy of which shall be provided to the Sponsor upon request.

J. BLUE CROSS BLUE SHIELD ASSOCIATION GUIDELINES: CareFirst responsibilities shall be subject to Blue Cross Blue Shield Association guidelines as amended from time to time.

1. CareFirst shall make all payments and provide all notices to providers located within its service area on documents that display the Blue Cross Blue Shield Association and CareFirst brands.

2. CareFirst shall process all interactions (e.g., inquiries, claims status, claims payments, etc.) with all providers located within its service area.

K. FORCE MAJEURE: Plan Sponsor recognizes that certain natural disasters and other similar major emergencies may disrupt or seriously threaten to disrupt health care and other services provided for under this Agreement. If such a disaster or emergency occurs, or is imminent, Plan Sponsor authorizes CareFirst to make appropriate business decisions to implement and act in accordance with the threat or risk, including but not limited to any action necessitated by declarations, rules, regulations or similar official statements by state or federal authorities with jurisdiction over the Plan, Plan Sponsor, or CareFirst. Plan Sponsor agrees to reimburse CareFirst for Paid Claims and services provided to Members of the Plan during this period, even if not compliant with the EOC or this Agreement.

CareFirst shall not be liable under this Agreement for failure to meet any of its administrative duties or guarantees under this Agreement if such failure arises from events beyond the reasonable control of CareFirst that materially affect its ability to perform its obligations under this Agreement, including, but not limited to, governmental action, fires, floods, weather events, pandemics, explosions, acts of terrorism, civil unrest, war or rebellion (a “Force Majeure Event”).

L. BUSINESS CONTINUITY/DISASTER RECOVERY: CareFirst shall maintain and periodically test a business continuity and disaster recovery plan that includes, at a minimum, (i) procedures to minimize the likelihood that a business interruption event or other uncontrollable circumstance will adversely affect CareFirst’s performance of the services under this Agreement; and (ii) procedures for responding to a business interruption event or other uncontrollable circumstance and for restoring services adversely affected within a reasonable period based on the nature and extent of any such business interruption event or other uncontrollable circumstance. CareFirst shall use its best efforts to execute recovery of essential operations within the defined Recovery Time Objective (RTO), such time period as in conformity with industry standards. CareFirst shall ensure that all claims, enrollment, and system data, including, but not limited to, databases, applications, application programs, and system software, are backed up on a daily basis.

M. ACCEPTANCE: Sponsor may accept the terms and provisions of this Agreement either by returning a signed copy of this Agreement to CareFirst or by making any of the required administrative or claims payments provided for under this Agreement. Such acceptance renders all terms and provisions set forth in this Agreement binding on CareFirst and Sponsor.

Section XIII: Transparency in Coverage

A. APPLICABLE PROVISIONS AND EFFECTIVE DATES: The applicable provisions and effective dates of the Transparency in Coverage Final Regulations as of the date this Agreement is issued include the provisions set forth in the below table. To the extent these provisions are not overturned or modified such changes shall be applicable to CareFirst's obligations under this Agreement.

Cite and Title	**Effective Date**
29 CFR Part 2590-Rules and Regulations for Group Health Plans	
Transparency in Coverage § 2590.715-2715A1 Transparency in coverage—definitions.	
§ 2590.715-2715A2 Required Disclosures to Participants and Beneficiaries	Specific list of 500 items and services: • Plan years beginning on or after January 1, 2023 All covered items and services: • Plan years beginning on or after January 1, 2024
§ 2590.715-2715A3 Requirements for Public Disclosure	In-network rates and out-of-network allowed amounts and billed charges • With respect to Plan years beginning on or after July 1, 2022 All covered items and services: • Plan years beginning on or after January 1, 2024

Section XIV: Consolidated Appropriations Act, 2021

A. DEFINITIONS: For the purposes of this section, the following term shall have the meaning provided below:

Consolidated Appropriations Act, 2021 ("CAA") means an act making consolidated appropriations for the fiscal year ending September 30, 2021, providing coronavirus emergency response and relief, and for other purposes, as amended.

Qualifying Payment Amount ("QPA") shall be an amount calculated based on the median contracted rate for all plans offered by CareFirst in the self-funded group medical benefits plan market for the same or similar item or service that is:

1. Provided by a healthcare provider in the same or similar specialty or facility of the same or similar facility type; and
2. Provided in the geographic region in which the item or service is purchased.

B. APPLICABLE PROVISIONS AND EFFECTIVE DATES: The applicable provisions and effective dates of the CAA as of the date this Agreement is issued include the provisions set forth in "Division BB—Private Health Insurance and Public Health Provisions" and set forth in the below table. To the extent these provisions are not overturned or modified such changes shall be applicable to CareFirst's obligations under this Agreement. Several of the requirements stated below are subject to additional federal rule making and regulatory guidance. The applicable dates contained therein; therefore, may be subject to change consistent with effective dates of implementation and enforcement as stated in ongoing federal guidance.

<table>
<tr><th colspan="2">Cite and Title</th><th rowspan="3">Effective Date</th></tr>
<tr><th>Public Health Service Act (PHSA)</th><th>ERISA</th></tr>
<tr><th colspan="2">CAA Title I: No Surprises Act</th></tr>
<tr><td colspan="2">Preventing Surprise Medical Bills</td><td rowspan="4">Plan years beginning on or after January 1, 2022

Applicable IDR fees shall apply</td></tr>
<tr><td>Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part: PART D--ADDITIONAL COVERAGE PROVISIONS Sec. 2799A-1</td><td>Subpart B of part 7 of title I of ERISA (29 U.S.C. 1185 et seq.) is amended by adding at the end the following Section 716</td></tr>
<tr><td colspan="2">(a) Coverage of Emergency Services.
(b) Coverage of Non-emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities.</td></tr>
<tr><td colspan="2">Summary
• Prohibits Balance Billing in certain situations

• If benefits are provided for Emergency Services:
➢ Prior authorization is not required
➢ Provider may be Participating or Non-Participating

• If Emergency Services or non-Emergency Services are provided by a Non-Participating Provider, including Ancillary Services and services for unforeseen urgent medical needs at a Participating facility:
➢ Cost sharing shall not be greater than if services were provided by a Participating Provider, including counting such cost-sharing toward any In-Network Deductible and In-Network Out-of-Pocket Maximum
➢ CareFirst shall pay the Provider directly

• Member cost sharing shall be calculated based on the QPA where an All-Payer Model Agreement or specified state law does not apply

• Provides for an Independent Dispute Resolution ("IDR") process in cases of failed negotiations</td></tr>
<tr><td colspan="2">Ending Surprise Air Ambulance Bills</td><td rowspan="3">Plan years beginning on or after January 1, 2022

Applicable IDR fees shall apply</td></tr>
<tr><td>Part D of title XXVII of the Public Health Service Act, as added and amended by section 102 and further amended by the previous provisions of this title, is further amended by inserting after section 2799A-1 the following: SEC. 2799A-2</td><td>Subpart B of part 7 of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), as amended by section 102(b) and further amended by the previous provisions of this title, is further amended by inserting after section 716 the following: SEC. 717</td></tr>
<tr><td colspan="2">Summary
• Provides cost-sharing requirements, payment, and Balance Billing protections for services received from Non-Participating ambulance service providers
• Provides for open negotiation of Out-of-Network rates to be paid by health plans
• Cost-sharing amounts for air ambulance services provided by Non-Participating Providers of air ambulance services must be calculated using the lesser of the billed charges or the QPA where an All-Payer Model Agreement or specified state law does not apply.
• Provides for an IDR process in cases of failed negotiations</td></tr>
</table>

<table>
<tr><th colspan="2">Cite and Title</th><th rowspan="3">Effective Date</th></tr>
<tr><th>Public Health
Service Act (PHSA)</th><th>ERISA</th></tr>
<tr><th colspan="2">CAA Title I: No Surprises Act</th></tr>
<tr><td colspan="2">Determination of Out-of-Network Rates to Be Paid by Health Plans; Independent Dispute Resolution Process</td><td rowspan="4">Plan years beginning on or after January 1, 2022

Applicable IDR fees shall apply</td></tr>
<tr><td>Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part: PART D--ADDITIONAL COVERAGE PROVISIONS Sec. 2799A-1</td><td>Section 716 of ERISA, as added by section 102, is amended-
(1) by redesignating subsection (c) as subsection (d); and
(2) by inserting after subsection (b) the following new subsection 716</td></tr>
<tr><td colspan="2">(c) Determination of Out-of-Network Rates to Be Paid by Health Plans; Independent Dispute Resolution Process</td></tr>
<tr><td colspan="2">Summary
The Out-of-Network rate for an item or service provided by a Non-Participating Provider shall be:
1. The amount that the State approves under its All-Payer Model Agreement, if applicable
2. If there is no All-Payer Model Agreement, the amount determined in accordance with applicable State law
3. If neither an All-Payer Model Agreement amount or applicable State law applies, then the Out-of-Network Rate shall be the lesser of the billed charges or the QPA
4. In certain circumstances where allowed by law CareFirst may enter into an agreement for a specific Out-of-Network Rate to be paid to the Non-Par Provider
5. Independent Dispute Resolution ("IDR") is available in cases of failed negotiations</td></tr>
<tr><td colspan="2">Consumer Protections through Application of Health Plan External Review in Cases of Certain Surprise Medical Bills</td><td rowspan="3">January 1, 2022 unless grandfathered in which case Plan years beginning on or after January 1, 2022</td></tr>
<tr><td>Section 110 of CAA</td><td>Section 110 of CAA</td></tr>
<tr><td colspan="2">Summary
Extends External Review process to any adverse determination in cases of certain surprise medical bills - applies to grandfathered health plans with respect to Adverse Benefit Determinations involving items and services within the scope of the requirements for Out-of-Network Emergency Services, non-Emergency Services performed by Non-Participating Providers at Participating facilities, and air ambulance services furnished by Non-Participating Providers of air ambulance services under PHS Act sections 2799A-1 and 2799A-2 and §§ 149.110 through 149.130.</td></tr>
<tr><td colspan="2">Other Patient Protections</td><td rowspan="3">Plan years beginning on or after January 1, 2022</td></tr>
<tr><td>Part D of title XXVII of the Public Health Service Act, as added by paragraph (1), is amended by adding at the end the following new section: Sec. 2799A-7</td><td>Subpart B of part 7 of title I of ERISA (29 U.S.C. 1185 et seq.), as amended by paragraph (1), is further amended by adding at the end the following Section 722</td></tr>
<tr><td colspan="2">Summary
Members may select any Participating Primary Care Provider who is available to accept the individual, including a Participating pediatrician for a child. Referral/authorization is not required prior to receiving obstetrical or gynecological care from a Participating Provider.</td></tr>
</table>

<table>
<tr><th colspan="2">Cite and Title</th><th rowspan="3">Effective Date</th></tr>
<tr><th>Public Health
Service Act (PHSA)</th><th>ERISA</th></tr>
<tr><th colspan="2">CAA Title I: No Surprises Act</th></tr>
<tr><td colspan="2">Transparency Regarding In-network and Out-of-Network Deductibles and Out-of-pocket Limitations</td><td rowspan="4">Plan years beginning on or after January 1, 2022</td></tr>
<tr><td>Section 2799A-1 of the Public Health Service Act, as added by section 102(a) and amended by section 103, is further amended by adding at the end the following new subsection: 2799A-1</td><td>Section 716 of ERISA, as added by section 102(b) and amended by section 103, is further amended by adding at the end the following new subsection 716</td></tr>
<tr><td colspan="2">(e) Transparency Regarding In-Network and Out-of-Network Deductibles and Out-of-Pocket Limitations</td></tr>
<tr><td colspan="2">Summary
Requirement to include Deductible, Out-of-Pocket Maximum, phone number, and Internet address on ID cards</td></tr>
<tr><td colspan="2">Air Ambulance Report Requirements</td><td rowspan="3">Plan years beginning on or after January 1, 2022 (reporting dates to be determined after the date on which a final rule of the No Surprises Act is promulgated)</td></tr>
<tr><td>Part D of title XXVII of the Public Health Service Act, as added by section 102(a)(1), is amended by adding after section 2799A-7, as added by section 102(a)(2)(A) of this Act, the following new section: Sec. 2799A-8</td><td>Subpart B of part 7 of title I of ERISA (29 U.S.C. 1185 et seq.) is amended by adding after section 722, as added by section 102(b)(2)(A) of this Act, the following new section 723</td></tr>
<tr><td colspan="2">Summary
Reporting requirements on disaggregated air ambulance services</td></tr>
<tr><td colspan="2">Consumer Protections through Health Plan Requirement for Fair and Honest Advance Cost Estimate</td><td rowspan="4">Plan years beginning on or after January 1, 2022</td></tr>
<tr><td>Section 2799A-1 of the Public Health Service Act (42 U.S.C. 300gg-19a), as added by section 102 and as further amended by the previous provisions of this title, is further amended by adding at the end the following new subsection:</td><td>Section 716 of ERISA, as added by section 102 and further amended by the previous amendments of this title, is further amended by adding at the end the following new subsection:</td></tr>
<tr><td colspan="2">(f) Advanced Explanation of Benefits</td></tr>
<tr><td colspan="2">Summary
Requirement for a pre-service Explanation of Benefits ("EOB") that includes:
• Provider Participating/Non-Participating status
• Estimate of the amount CareFirst will pay
• Estimate of Member cost sharing responsibility, including amounts the Member has incurred toward Deductible/Out-of-Pocket Maximum
• Disclaimer if service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols
• Any other relevant information</td></tr>
</table>

<table>
<tr><th colspan="2">Cite and Title</th><th rowspan="3">Effective Date</th></tr>
<tr><th>Public Health Service Act (PHSA)</th><th>ERISA</th></tr>
<tr><th colspan="2">CAA Title I: No Surprises Act</th></tr>
<tr><td colspan="2">Continuity of Care</td><td rowspan="3">Plan years beginning on or after January 1, 2022</td></tr>
<tr><td>Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended, in the part D, as added and amended by section 102(a) and further amended by the previous provisions of this title, by inserting after section 2799A-2 the following new section: SEC. 2799A-3</td><td>Subpart B of part 7 of subtitle B of title I of ERISA (29 U.S.C. 1185 et seq.), as amended by section 102(c) and further amended by the previous provisions of this title, is further amended by inserting after section 717 the following new section: 718</td></tr>
<tr><td colspan="2">Summary
Requirement to provide notice of termination of a Provider's participating status to a Member who is a continuing care patient of a Provider and to permit the Member to continue to have benefits as if the Provider had not terminated with respect to a course of treatment for a limited period of time</td></tr>
<tr><td colspan="2">Maintenance of Price Comparison Tool</td><td rowspan="3">Plan years beginning on or after January 1, 2023</td></tr>
<tr><td>Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended, in part D, as added and amended by section 102 and further amended by the previous provisions of this title, by inserting after section 2799A-3 the following new section: 2799A-4</td><td>Subpart B of part 7 of subtitle B of title I of ERISA (29 U.S.C. 1185 et seq.), as amended by sections 102, 105, and 113, is further amended by inserting after section 718 the following new section: 719</td></tr>
<tr><td colspan="2">Summary
Requirement to provide price comparison guidance by telephone and Internet website a price comparison tool that (to the extent practicable) that allows a Member and Participating Providers with respect to a Member's coverage per Plan year and geographic region, to compare the amount of cost sharing that the Member would be responsible for paying under such Plan with respect to the furnishing of a specific item or service by any such Provider</td></tr>
<tr><td colspan="2">State All Payer Claims Databases</td><td rowspan="3">On and after December 27, 2021, CareFirst will provide the Sponsor's data to the applicable State All Payer Claims Database</td></tr>
<tr><td>Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end the following: SEC. 320B. STATE ALL PAYER CLAIMS DATABASES</td><td>Subpart C of part 7 of subtitle B of title I of ERISA (29 U.S.C. 1191 et seq.) is amended by adding at the end the following: SEC. 735. STANDARDIZED REPORTING FORMAT</td></tr>
<tr><td colspan="2">Summary
Provides a one-time grant to eligible States to establish or improve a State All Payer Claims Database</td></tr>
</table>

<table>
<tr><th colspan="2">Cite and Title</th><th rowspan="3">Effective Date</th></tr>
<tr><th>Public Health
Service Act (PHSA)</th><th>ERISA</th></tr>
<tr><th colspan="2">CAA Title I: No Surprises Act</th></tr>
<tr><td colspan="2">Protecting Patients and Improving the
Accuracy of Provider Directory Information</td><td rowspan="3">Plan years beginning on or after January 1, 2023</td></tr>
<tr><td>Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added and amended by section 102 and further amended by the previous provisions of this title, is further amended by inserting after section 2799A-4 the following: Sec. 2799A-5</td><td>Subpart B of part 7 of subtitle B of title I of ERISA (29 U.S.C. 1185 et seq.), as amended by sections 102, 105, 113, and 114, is further amended by inserting after section 719 the following: Sec. 720</td></tr>
<tr><td colspan="2">Summary
Internet website healthcare Provider directory requirements:
A list of each healthcare Provider and healthcare facility with which CareFirst has a direct or indirect relationship
Provider directory information with respect to each such Provider and facility including name, address, specialty, telephone number, and digital contact information
Cost-sharing and Balance Billing protections for services provided based on reliance on incorrect Provider network information</td></tr>
</table>

<table>
<tr><th colspan="2">Cite and Title</th><th rowspan="3">Effective Date</th></tr>
<tr><th>Public Health
Service Act (PHSA)</th><th>ERISA</th></tr>
<tr><th colspan="2">CAA Title II: Transparency</th></tr>
<tr><td colspan="2">Increasing Transparency by Removing Gag Clauses on Price
and Quality Information</td><td rowspan="3">December 27, 2021</td></tr>
<tr><td>Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as added and amended by title I, is further amended by adding at the end the following: Sec. 2799A-9</td><td>Subpart B of part 7 of subtitle B of title I of (29 U.S.C. 1185 et seq.), as amended by title I, is further amended by adding at the end the following: Sec. 724</td></tr>
<tr><td colspan="2">Summary
Prohibition against entering an agreement with a healthcare Provider, network or association of Providers, third-party administrator, or other service provider offering access to a Provider network that would directly or indirectly restrict:
Providing Provider-specific cost or quality of care information or data
Electronically accessing de-identified claims and encounter information
Sharing information or data described above with a Business Associate</td></tr>
</table>

<table>
<tr><th colspan="2">Cite and Title</th><th rowspan="3">Effective Date</th></tr>
<tr><th>Public Health Service Act (PHSA)</th><th>ERISA</th></tr>
<tr><th colspan="2">CAA Title II: Transparency</th></tr>
<tr><td colspan="2">Disclosure of Direct and Indirect Compensation for Brokers and Consultants to Employer-Sponsored Health Plans</td><td rowspan="3">Agreements that are executed or renewed on and after December 27, 2021</td></tr>
<tr><td>Section 202 of CAA</td><td>408(b)(2)</td></tr>
<tr><td colspan="2">Summary
Requirement for a covered service provider to disclose to a Plan fiduciary, in writing:
• A description of the services to be provided
• If applicable, a statement that the services will be provided as a fiduciary
• A description of all direct compensation
• A description of all indirect compensation</td></tr>
<tr><td colspan="2">Strengthening Parity in Mental Health and Substance Use Disorder Benefits</td><td rowspan="3">February 10, 2021

CareFirst will upon request provide the information within its control necessary for the Sponsor or the Sponsor’s designated third party to perform the Comparative Analysis</td></tr>
<tr><td>Section 2726(a) of the Public Health Service Act (42 U.S.C. 300gg-26(a)) is amended by adding at the end the following: Sec. 2726(a)(8) Compliance requirements</td><td>Section 712(a) of ERISA (29 U.S.C. 1185a(a)) is amended by adding at the end the following: (6) Compliance program guidance document</td></tr>
<tr><td colspan="2">Summary
Requirement for a Group Health Plan that imposes nonquantitative treatment limitations (“NQTLs”) on mental health or substance use disorder benefits to perform and document comparative analyses of the design and application of the NQTLs and make available to the Secretary of Health and Human Services or the Secretary of Labor, upon request, the comparative analyses and:
• Specific Plan terms regarding the NQTLs and a description of all benefits to which each such term applies in each respective benefits classification
• The factors used to determine the NQTLs
• The evidentiary standards used for the factors identified above
• The comparative analyses demonstrating parity between mental health or substance use disorder benefits and medical or surgical benefits
• The specific findings and conclusions that indicate non-compliance</td></tr>
</table>

<table>
<tr><th colspan="2">Cite and Title</th><th rowspan="3">Effective Date</th></tr>
<tr><th>Public Health
Service Act (PHSA)</th><th>ERISA</th></tr>
<tr><th colspan="2">CAA Title II: Transparency</th></tr>
<tr><td colspan="2">Reporting on Pharmacy Benefits and Drug Costs</td><td rowspan="3">Notwithstanding anything to the contrary herein, CareFirst will prepare the Prescription Drug data file required to be furnished to the Secretaries of the Department of Health and Human Services, Labor and Treasury in accordance with ERISA and the Internal Revenue Code

CareFirst will provide the data file to Sponsor for review within five business days of receipt from its Pharmacy vendor</td></tr>
<tr><td>Part D of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 201, is further amended by adding at the end the following: SEC. 2799A-10</td><td>Subpart B of part 7 of subtitle B of title I of ERISA (29 U.S.C. 1185 et seq.), as amended by section 201, is further amended by adding at the end the following: SEC. 725.</td></tr>
<tr><td colspan="2">Summary
Requirement for a Group Health Plan to submit to the Secretary of Health and Human Services or the Secretary of Labor with respect to the Plan in the previous year:
• The beginning and end dates of the Plan year
• The number of enrollees
• Each State in which the Plan is offered
• The 50 Brand Name Drugs most frequently dispensed by Pharmacies for the Plan and the total number of Paid Claims for each such Brand Name Drug
• The 50 most costly Prescription Drugs with respect to the Plan by total annual spending, and the annual amount spent by the Plan for each such Prescription Drug
• The 50 Prescription Drugs with the greatest increase in Plan expenditures over the Plan year preceding the Plan year that is the subject of the report, and, for each such Prescription Drug, the change in amounts expended by the Plan in such Plan year
• Total spending on healthcare services, broken down by:
A. The type of costs, including
1. Hospital costs;
2. Healthcare Provider and clinical service costs, for primary care and specialty care separately;
3. Costs for prescription drugs; and
4. Other medical costs, including wellness services; and
B. Spending on Prescription Drugs by the
1. Health plan; and
2. Enrollees.
• The average monthly premium paid by employers on behalf of enrollees, as applicable; and paid by enrollees.
• Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the Plan or its administrators or service providers, with respect to Prescription Drugs prescribed to enrollees in the Plan, including the amounts so paid for each:
A. Therapeutic class of drugs; and
B. Of the 25 drugs that yielded the highest amount of rebates and other remuneration under the Plan from drug manufacturers during the Plan year.
• Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described above</td></tr>
</table>

Section XV: Independent Dispute Resolution Process

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

WHEREAS, the No Surprises Act provides Members with In-Network cost-sharing, no Balance Billing in certain situations, and other protections with respect to:

1. Emergency Services;
2. Non-Emergency Services performed by Non-Participating Providers at Participating Provider facilities, including Ancillary Services and unforeseen urgent medical needs; and
3. Air ambulance services performed by Non-Participating Providers.

WHEREAS, the No Surprises Act provides a formula for determination of Out-of-Network amounts to be paid by CareFirst on behalf of the Plan for the above noted services, which is:

1. The amount that the State approves under its All-Payer Model Agreement, if applicable;
2. If there is no All-Payer Model Agreement, the amount determined in accordance with State law, if applicable;
3. If there is no All-Payer Model Agreement or State law, the amount agreed upon by CareFirst and the Non-Participating Provider.

WHEREAS, the No Surprises Act includes an Independent Dispute Resolution ("IDR") process for a Non-Participating Provider and CareFirst to negotiate a payment to the healthcare provider if there is no All-Payer Model Agreement or State law and if negotiations between CareFirst and the Non-Participating Provider ("Provider[s]") are not successful.

NOW THEREFORE, in consideration of the provisions of the No Surprises Act as outlined above, the Parties agree as follows.

A. DETERMINATION OF PAYMENT AMOUNT THROUGH OPEN NEGOTIATION AND INITIATION OF THE FEDERAL IDR PROCESS

1. Determination of payment amount through open negotiation: During the 30-business-day period beginning on the day the Provider receives an initial payment or notice of a denial of payment regarding the item or service the Provider may initiate an open negotiation period for purposes of determining the Out-of-Network rate (the "Rate") for such item or service by providing information sufficient to identify the item or service, an offer of a Rate, and contact information.

2. Initiating the IDR process: With respect to an item or service for which CareFirst and the Provider do not agree upon a Rate by the last day of the open negotiation period, either party may initiate the Federal IDR process by submitting written notice (the "Notice") of the IDR initiation to the other party and to the Secretary, using the standard form developed by the Secretary through the Federal IDR portal (the "Portal"), during the four-business-day period beginning on the 31st business day after the start of the open negotiation period.

a. Federal IDR process following initiation

1) Selection of certified IDR entity (as defined by law): The party receiving the Notice may agree or object to the preferred IDR entity identified in the Notice. Failure to object within three business days means the IDR entity in the Notice will be selected, provided there is no conflict of interest. If the party receiving the Notice objects, that party must notify the initiating party and propose an alternative IDR entity. The initiating party must then agree or object to the alternative IDR entity; if they fail to agree or object, the alternative IDR entity will be selected. The parties must agree to the IDR entity no later than three business days after the IDR initiation; failure to agree shall result in the Secretary selecting the IDR entity.

2) Failure to select a certified IDR entity: If the parties fail to select a certified IDR entity, the initiating party must notify the Secretary of the failure no later than one business day after the date of such failure by electronically submitting the Notice and indicating the failure. In addition, if the non-initiating party believes that the IDR process is not applicable, they must also provide information regarding the inapplicability through the Portal by the same date that the notice of failure to select must be submitted.

Upon notification of the failure of the parties to select a certified IDR entity, the Secretary will select a certified IDR entity that charges a fee within the allowed range of certified IDR entity fees through a random selection method not later than six business days after the date of initiation of the Federal IDR process and will notify CareFirst and the Provider of the selection. If there are insufficient certified IDR entities that charge a fee within the allowed range of certified IDR entity fees available to arbitrate the dispute, the Secretary, jointly with the Secretary of Health and Human Services and Secretary of the Treasury, will select a certified IDR entity that has received approval to charge a fee outside of the allowed range of certified IDR entity fees.

3) Review by certified IDR entity: The IDR entity must review the selection and attest that it meets the requirements for review; failure to do so within three business days shall result in the parties selecting another certified IDR entity. The selected certified IDR entity must review the Notice to determine whether the Federal IDR process applies and notify the Secretary and the parties within three business days if the process does not apply.

b. Authority to continue negotiations: If the parties to the Federal IDR process agree on a Rate for a qualified IDR item or service after providing the Notice to the Secretary, but before the certified IDR entity has made its payment determination, the amount agreed to by the parties for the qualified IDR item or service will be treated as the Rate for the qualified IDR item or service. To the extent the amount exceeds the initial payment amount (or initial denial of payment) and any cost sharing paid or required to be paid by the Member, payment must be made directly by CareFirst on behalf of the Plan to the Provider not later than 30 business days after the agreement is reached. In no instance may either party seek additional payment from the Member, including in instances in which the Rate exceeds the qualifying payment amount. The initiating party must send a notification to the Secretary and to the certified IDR entity (if selected) electronically, through the Portal, as soon as possible, but no later than three business days after the date of the agreement. The notification must include the Rate for the qualified IDR item or service and signatures from authorized signatories for both parties. The certified IDR entity is required to return half of each parties' certified IDR entity fee, unless directed otherwise by both parties; however, the administrative fee described later in this section will not be returned to the parties.

c. Payment determination – submission of offers: Not later than 10 business days after the selection of the certified IDR entity, CareFirst and the Provider:

1) Must each submit to the certified IDR entity:

(a) An offer of an out-of-network rate expressed as both a dollar amount and the corresponding percentage of the qualifying payment amount represented by that dollar amount;

(b) Information requested by the certified IDR entity relating to the offer.

(c) Additional information, as applicable may be required to be submitted by both the Provider and CareFirst and as relates to air ambulance services.

d. Payment determination and notification: Not later than 30 business days after the selection of the certified IDR entity, the certified IDR entity shall select the Rate and provide written notification of its decision to CareFirst and the Provider. Such decision is binding upon the parties, in absence of fraud or evidence of material representation of material facts presented to the certified IDR entity; and is not subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9, United States Code.

e. Payment: If applicable, the Rate selected by the certified IDR entity (less the sum of the initial payment and any Member cost-sharing) must be paid to the Provider no later than 30 calendar days after the payment determination by the certified IDR entity. If the Rate is less than the sum of the initial payment and any Member cost-sharing, the Provider must pay the difference to CareFirst no later than 30 calendar days after the payment determination by the certified IDR entity.

B. Suspension of certain subsequent IDR requests: In the case of a determination made by a certified IDR entity under this section, the party that submitted the Notice may not submit a subsequent Notice involving the same other party with respect to a claim for the same or similar item or service that was the subject of the initial Notice during the 90-calendar-day period following the determination.

C. Subsequent submission of requests permitted: If the end of the open negotiation period specified in this section occurs during the 90-calendar-day suspension period regarding claims for the same or similar item or service that were the subject of the initial Notice of IDR determination as described in this section, either party may initiate the Federal IDR process for those claims by submitting a Notice as specified in this section during the 30-business-day period beginning on the day after the last day of the 90-calendar day suspension period.

D. COSTS OF IDR PROCESS

1. Certified IDR entity fee:

a. With respect to the Federal IDR process following initiation, the party whose offer submitted to the certified IDR entity is not selected is responsible for the payment to the certified IDR entity of the predetermined fee charged by the certified IDR entity.

b. Each party to a determination for which a certified IDR entity is selected under must pay the predetermined certified IDR entity fee charged by the certified IDR entity to the certified IDR entity at the time the parties submit their offers. The certified IDR entity fee paid by the prevailing party whose offer is selected by the certified IDR entity will be returned to that party within 30 business days following the date of the certified IDR entity's determination.

2. Administrative fee:

a. Each party to a determination for which a certified IDR entity is selected, at the time the certified IDR entity is selected, pay to the certified IDR entity a non-refundable administrative fee due to the Secretary for participating in the Federal IDR process described in this section.

The administrative fee amount will be established in guidance published annually by the Secretary in a manner such that the total fees paid for a year are estimated to be equal to the projected amount of expenditures by the Departments of the Treasury, Labor, and Health and Human Services for the year in carrying out the Federal IDR process.

Attachments

Attachments I through IX are part of this Agreement with the Sponsor.

Attachment I: Summary Plan Description (SPD)

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

Sponsor acknowledges that Attachment II: Inter-Plan Arrangements Disclosure specifies additional/alternative provisions that apply to Sponsor with respect to claims that are processed through Inter-Plan Arrangements. Sponsor further acknowledges that CareFirst is required by the Blue Cross Blue Shield Association to disseminate the Inter-Plan Arrangements Disclosure language. The language included in Attachment II: Inter-Plan Arrangements Disclosure is intended for the Sponsor. The language included in the EOC is intended for Members. Sponsor shall include the EOC Inter-Plan Arrangements Disclosure language, in its entirety, in Sponsor's Summary Plan Description (SPD).

Attachment II: Inter-Plan Arrangements Disclosure

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

DEFINITIONS

In addition to any definitions in this Agreement, the following terms have the following meaning for purposes of this disclosure:

Fees associated with claims processing:

Access Fee: The Access Fee is charged by the Host Blue to CareFirst for making its applicable provider network available to Sponsor's Members. The Access Fee will not apply to nonparticipating provider claims. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential CareFirst receives from the applicable Host Blue subject to a maximum of [redacted] per claim.

BlueCard Program Access Fees: A BlueCard Program Access Fee may be charged only if the Host Blue's arrangement with its healthcare provider prohibits billing Members for amounts in excess of the negotiated payment. However, a healthcare provider may bill Members for non-covered healthcare services and for cost sharing (for example, deductibles, copayments and/or coinsurance) related to a particular claim.

How the Blue Card Program Access Fee Affects Sponsor: Sometimes the Access Fee is a negative amount, which is known as an Access Fee Credit. Any Access Fee Credits will be credited to CareFirst and CareFirst will pass the entire Access Fee Credit on to Sponsor.

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

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

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

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

See below for the BlueCard Program Fees.

Out-of-Area Services

Overview

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

Typically, when accessing care outside the geographic area CareFirst serves, Members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. CareFirst remains responsible for fulfilling its contractual obligations to Sponsor. CareFirst payment practices in both instances are described below.

Some CareFirst products limit in-network benefits to certain services and/or cover only limited healthcare services received outside of CareFirst's service area, e.g., Emergency Services. If applicable, any difference between benefits for care received in CareFirst's service area and care received outside the geographic area CareFirst serves is stated in the Schedule of Benefits.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that Dental Care Benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by CareFirst to provide the specific service or services are not processed through Inter-Plan Arrangements.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Members access Covered Services outside the geographic area CareFirst serves, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim – In General

a. Member Liability Calculation

Unless subject to a fixed dollar Copayment, the calculation of the Member liability on claims for Covered Services will be based on the lower of the participating provider's billed charges for Covered Services or the negotiated price made available to CareFirst by the Host Blue.

b. Sponsor Liability Calculation

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

2. **Claims Pricing**

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

a. An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; orb. An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; orc. An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Sponsor pays on a specific claim and the actual amount the Host Blue pays to the provider. However, the BlueCard Program requires that the amount paid by the Member and Sponsor is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to Sponsor will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Sponsor. If Sponsor terminates, Sponsor will not receive a refund or charge from the variance account.Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest. Host Blues may retain interest earned on funds held in variance accounts.

3. BlueCard Program Fees and Compensation

Sponsor understands and agrees to reimburse CareFirst for certain fees and compensation which Sponsor is obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Sponsor are set forth below. BlueCard Program Fees and compensation may be revised from time to time.

Only the BlueCard Program Access Fee may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in the Administrative Fee.

The Access Fee is charged by the Host Blue to CareFirst for making its applicable provider network available to Sponsor's Members. The Access Fee will not apply to nonparticipating provider claims. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential CareFirst receives from the applicable Host Blue subject to a maximum of [redacted] per claim. CareFirst may pass the Access Fee directly on to Sponsor.

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

The Administrative Fee encompasses fees CareFirst charges to Sponsor for administering Sponsor's benefit plan. They may include both local within CareFirst's service area and Inter-Plan fees. For purposes of this disclosure, they include the following BlueCard Program-related fees other than the BlueCard Program Access Fee: namely, Administrative Expense Allowance (AEA) Fee, Central Financial Agency Fee, ITS Transaction Fee, and BCBS Global Core fees, if applicable.

FEES AND COMPENSATION: BlueCard Program	AMOUNT
The BlueCard Access Fee, included in Paid Claims, is:	Up to [redacted]% of network savings, capped at $[redacted] per claim
Administrative Expense Allowance Fees, included in Paid Claims, is:	Up to [redacted] per professional claim Or

	Up to [redacted] per institutional claim
Central Financial Agency (CFA) Fees, ITS Transaction Fees, and, if applicable, BCBS Global Core fees	Included in the Administrative Fee

B. Negotiated Arrangements

With respect to one or more Host Plans, instead of using the BlueCard Program, CareFirst may process your Member claims for Covered Services through Negotiated Arrangements.

In addition, if CareFirst and Sponsor have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this Agreement, then the terms and conditions set forth in CareFirst's Negotiated Arrangement(s) for National Accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when Members access such network(s). In negotiating such arrangement(s), CareFirst is not acting on behalf of or as an agent for Sponsor, Sponsor group health plan or Sponsor Members.

Member Liability Calculation

If CareFirst has entered into a Negotiated Arrangement with a Host Blue, Member liability calculation will be based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to CareFirst and that allows Sponsor Members access to negotiated participation agreement networks of specified participating providers outside of CareFirst's service area.

Under certain circumstances, if CareFirst pays the Healthcare Provider amounts that are the responsibility of the Member CareFirst may collect such amounts from the Member.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, CareFirst may include a factor for such settlement reconciliations as part of the fees CareFirst charges to Sponsor.

Where Sponsor agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, Members will be responsible for the amount that the healthcare provider bills for a specified procedure above the reference benefit limit for that procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a provider's billed charge, the Member will incur no liability, other than any applicable Member cost sharing under this Agreement.

Fees and Compensation

Sponsor understands and agrees to reimburse CareFirst for certain fees and compensation which CareFirst is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time. In addition, the participation agreement with the Host Blue may provide that CareFirst must pay an administrative and/or a network Access Fee to the Host Blue, and Sponsor further agrees to reimburse CareFirst for any such applicable administrative and/or network Access Fees. The specific fees and compensation that are charged to Sponsor under Negotiated Arrangements are set forth below, if applicable.

C. Special Cases: Value-Based Programs

Definitions

In addition to any other definitions in this Agreement and this disclosure, the following terms have the following meaning for purposes of this section:

Accountable Care Organization (ACO): A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

Care Coordination: Organized, information-driven patient care activities intended to facilitate the appropriate responses to a Member's healthcare needs across the continuum of care.

Care Coordinator: An individual within a provider organization who facilitates Care Coordination for patients.

Care Coordinator Fee: A fixed amount paid by a Blue Cross and/or Blue Shield Plan to providers periodically for Care Coordination under a Value-Based Program.

Global Payment/Total Cost of Care: A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services, and prescription drugs.

Negotiated Arrangement: An agreement negotiated between a Control/Home Licensee and one or more Par/Host Licensees for any National Account that is not delivered through the BlueCard Program.

Patient-Centered Medical Home (PCMH): A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

Provider Incentive: An additional amount of compensation paid to a healthcare provider by a Blue Cross and/or Blue Shield Plan, based on the provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of covered persons.

Shared Savings: A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

Value-Based Program (VBP): An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

*Value-Based Programs Overview*Sponsor's Members may access Covered Services from providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.*Value-Based Programs under the BlueCard Program**Value-Based Programs Administration*Under Value-Based Programs, a Host Blue may pay providers for reaching agreed-upon cost/quality goals in the following ways:The Host Blue may pass these provider payments to CareFirst, which CareFirst will pass directly on to Sponsor as either an amount included in the price of the claim or an amount charged separately in addition to the claim.When such amounts are included in the price of the claim, the claim may be billed using one of the following pricing methods, as determined by the Host Blue:(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the claim. These charges are passed to Sponsor via an enhanced provider fee schedule.(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time. This pricing method may be used only for non-attributed Value-Based Programs.When such amounts are billed separately from the price of the claim, they may be billed as follows:Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. CareFirst will pass these Host Blue charges directly through to Sponsor as a separately identified amount on the group billings.The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the

BlueCard claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If Sponsor terminates, Sponsor will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest. Host Blues may retain interest earned on funds held in variance accounts.Note: Members will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay providers under Value-Based Programs.*Care Coordinator Fees*

Host Blues may also bill CareFirst for Care Coordinator Fees for provider services which we will pass on to Sponsor as follows:

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

Value-Based Programs under Negotiated Arrangements

If CareFirst has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Sponsor's Members, CareFirst will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

For negotiated arrangements, when Control/Home Licensees have negotiated with accounts to waive member cost sharing for care coordinator fees, the following provision will apply: As part of this Agreement, CareFirst and Sponsor may agree to waive Member cost sharing for care coordinator fees.

D. Prepayment Review & Return of OverpaymentsIf a Host Blue conducts prepayment review activities including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits, the Host Blue may bill CareFirst up to a maximum of [redacted] of the savings identified, unless an alternative reimbursement arrangement is agreed upon by CareFirst and the Host Blue, and these fees may be charged to Sponsor. If a Host Blue engages a third party to perform these activities on its behalf, the Host Blue may bill CareFirst the lesser of the full amount of the third-party fees or up to [redacted] of the savings identified, unless an alternative reimbursement arrangement is agreed upon by CareFirst and the Host Blue, and these fees may be charged to Sponsor.

Recoveries of overpayments/from a Host Blue or its participating and nonparticipating providers from post-payment review activities can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recovery amounts determined in the ways noted above will be applied in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to CareFirst they will be credited to Sponsor account. When a Host Blue identifies and collects these overpayments/recovery amounts, the Host Blue may bill CareFirst up to a maximum of [redacted] of the savings identified, unless an alternative reimbursement arrangement is agreed upon by CareFirst and the Host Blue, and these fees may be charged to Sponsor. In some cases, the Host Blue will engage a third party to assist in identification or collection of overpayments/recovery amounts. When this occurs, the Host Blue may bill the lesser of the full amount of the third party fees or up to [redacted] of the savings identified, unless an alternative reimbursement arrangement is agreed upon by CareFirst and the Host Blue, and these fees may be charged to Sponsor.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, CareFirst will request the Host Blue to provide full refunds from participating healthcare providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements, and Care Coordination Fees or (c) would jeopardize the Host Blue's relationship with its participating healthcare providers, notwithstanding to the contrary any other provision of this Agreement.

E. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, CareFirst will disclose any such surcharge, tax or other fee to Sponsor, which will be

Sponsor liability.**F.Nonparticipating Providers Outside CareFirst's Service Area**

1. Member Liability Calculation

a. In General

When Covered Services are provided outside of CareFirst's service area by nonparticipating providers, the amount(s) a Member pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by Applicable Law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

b. Exceptions

In some exception cases, at Sponsor direction CareFirst may pay claims from nonparticipating healthcare providers outside of CareFirst's service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to a participating provider, as determined by CareFirst {in CareFirst's sole and absolute discretion} or by Applicable Law. In other exception cases, at Sponsor direction CareFirst may pay such claims based on the payment CareFirst would make if CareFirst were paying a nonparticipating provider inside of CareFirst's service area, as described elsewhere in this Agreement. This may occur where the Host Blue's corresponding payment would be more than CareFirst's in-service area nonparticipating provider payment. CareFirst may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment CareFirst will make for the Covered Services as set forth in this paragraph.

2. Fees and Compensation

Sponsor understands and agrees to reimburse CareFirst for certain fees and compensation which CareFirst is obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Sponsor are set forth below. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

FEES AND COMPENSATION: Non-Participating Providers Outside the CareFirst Service Area	AMOUNT
Central Financial Agency (CFA) Fees, ITS Transaction Fees	Included in the Administrative Fee
Administrative Expense Allowance Fees, included in Paid Claims, is:	Up to [redacted] per professional claim Or Up to [redacted] per institutional claim

G. Blue Cross Blue Shield Global® Core

1. General Information

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, the Members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

In most cases, if Members contact the service center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit Member claims to the service center to initiate claims processing. However, if the Member paid in full at the time of service, the Member must submit a claim to obtain reimbursement for Covered Services. **Members must contact CareFirst to obtain precertification for non-emergency inpatient services.**

- **Outpatient Services**

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

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When Members pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Members should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center address on the form to initiate claims processing. The claim form is available from CareFirst, the service center, or online at www.bcbsglobalcore.com. If Members need assistance with their claim submissions, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. Blue Cross Blue Shield Global Core-Related Fees

Sponsor understands and agrees to reimburse CareFirst for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Sponsor under Blue Cross Blue Shield Global Core are set forth below. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

FEES AND COMPENSATION: **Blue Cross Blue Shield Global Core**	**AMOUNT**
Administrative Expense Allowance (AEA) Fees, Central Financial Agency (CFA) Fees, ITS Transaction Fees, Blue Cross Blue Shield Global Core transaction fees	Included in the Administrative Fee

Attachment III: 24-Hour Nurse Advice Line

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

A. DEFINITIONS: For the purposes of this Attachment, the following term shall have the meaning provided below:

24-Hour Nurse Advice Line is the medical advice service Members may call to obtain answers to health care questions. The nurse line provides support and guidance for any non-emergency situation. CareFirst does not provide this service. An independent company provides the 24-hour nurse advice services and is solely responsible for the advice.

B. 24-HOUR NURSE ADVICE LINE: Members may call the 24-Hour Nurse Advice Line to obtain answers to health care questions.

Attachment IV: Health Promotion/Wellness and Member Incentive

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

A. DEFINITIONS: For the purposes of this Attachment, the following term shall have the meaning provided below:

Health Promotion/Wellness means a coordinated program, which may be carried out with help from a lifestyle coach, and that is designed to prevent disease, identify a Member's risk factors for disease or detect early stages of a Member's disease so that action can be taken to prevent poor outcomes in the future. The Sponsor may elect to include Member incentives.

B. PROGRAM REQUIREMENTS, ETC.: Certain elements of the Health Promotion/Wellness program are subject to minimum participation and notice requirements along with cancellation charges (e.g. worksite biometric screenings, etc.). CareFirst will make Sponsor aware of these requirements prior to scheduling of any program event.

C. If applicable, an incentive is provided to encourage behaviors that contribute to Members' health and well-being. Within this framework, it is possible for the Sponsor to customize the amounts of various incentive activities that focus on Member wellness and improving and maintaining healthy behaviors. Implementation of a highly-customized incentive program that deviates from CareFirst's framework is subject to negotiation and may involve additional lead time and cost for implementation.

Funding for all Member incentives is provided by the Plan Sponsor.

D. Wellness incentives based on Member outcomes are subject to federal requirements relating to the percentage of the cost of coverage, reasonable design, and reasonable alternatives to avoid prohibited discrimination.

E. Certain services are handled as a Paid Claim.

Attachment V: Data Mining/Payment Integrity Shared Savings Program

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

A. DEFINITIONS: For the purposes of this Attachment, the following term shall have the meaning provided below:

Shared Savings means a fee structure in which CareFirst and Sponsor share savings/recoveries based upon the terms set forth in this Attachment V: Data Mining/Payment Integrity Shared Savings Program.

B. PROGRAMS: CareFirst administers data mining/payment integrity programs to contain costs with respect to charges for health care services/supplies that are Covered Services under the Plan including medical, dental, pharmacy, and vision, as applicable. In administering these programs, CareFirst may contract with vendors to perform program related services. The programs include, but are not limited to gross savings or recoveries arising from:

1. Coding audits and chart (medical records) audits for professional and institutional medical providers.

2. Mass tort, product liability recoveries, and class action lawsuits, subject to the pro-rata Credit for Miscellaneous Recoveries as set forth in Section III: CareFirst Administration and Services.

3. Coordination of benefits, workers' compensation, and subrogation.

C. SHARED SAVINGS:

1. Savings/recoveries shall be credited to Paid Claims as set forth in Attachment VII: Financial Terms.

2. CareFirst's charge for administering these programs is the percentage (set forth in Attachment VII: Financial Terms) of either:

   a. The "gross savings" (i.e. the difference between what the provider's payment would have been regardless of the date(s) of service absent the program savings and the actual payment to the provider as a result of the program savings) as of the effective date of this Attachment V: Data Mining/Payment Integrity Shared Savings Program, as applicable; or

   b. The "recovery" received (i.e. the amount recovered by CareFirst acting on behalf of the Sponsor's self-funded Plan regardless of the date(s) of service or the date when the recovery was initiated) as of the effective date of this Attachment V: Data Mining/Payment Integrity Shared Savings Program, as applicable.

D. VENDOR FEES: Information regarding vendor fees is available upon request.

1. CareFirst shall be responsible for applicable vendor fees for "gross savings" and "recoveries" except in the case of "CareFirst Error(s)".

E. CAREFIRST ERROR(S): CareFirst shall not retain a share of the savings/recoveries in the case of CareFirst Error(s) and Sponsor shall be responsible for applicable vendor fees. Applicable savings/recoveries shall be credited to Paid Claims. CareFirst Error(s) include adjustments to claims as a result of an incorrect adjudication of a claim where the error is caused by CareFirst. CareFirst Error(s) do not include incorrectly adjudicated claims arising from a healthcare provider's error relating to the submission or the content of a claim. CareFirst Error(s) also do not occur when an improper adjudication arises from the failure of the Sponsor to provide correct information as required under this Agreement for the proper adjudication of a claim.

Attachment VI: Out-of-Network Healthcare Provider Savings

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

A. CareFirst agrees to implement various services on behalf of the Sponsor aimed at generating savings on claims. Services may include, but are not limited to:

1. Obtaining discounts through secondary networks;
2. Fee negotiations with non-participating providers; and
3. Arrangements with participating non-network providers.

Notwithstanding anything herein to the contrary, the cost savings program may include claim pricing in accordance with a nationally recognized database of one or more vendors of CareFirst. In such cases, the allowance established by such database(s) shall supersede the otherwise applicable price for such non-participating provider claim that was established by a "Host Blue." (See Attachment II: Inter-Plan Arrangements Disclosure.) CareFirst shall retain a percentage of savings as set forth in Attachment VII: Financial Terms in exchange for this service. If no discount is obtained, there is no cost to Sponsor for this service. This applies to savings received by CareFirst as of the effective date of this Attachment VI: Out-of-Network Healthcare Provider Savings, regardless of the date(s) of service or the date when the saving was initiated.

B. Applicable vendor fees are included in savings.

C. Database pricing does not apply to claims paid to non-participating providers at the recognized amount of the out-of-network amount (following negotiation or arbitration) under the No Surprises Act.

Attachment VII: Financial Terms

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

A. TERMS MATERIAL TO THE PRICING ANALYSIS:

1. Administrative Fees provided do not include the Patient Centered Outcomes Research Institute (PCORI) Fees, Reinsurance Fees, or other fees imposed on plan sponsors under the Affordable Care Act.

2. The ACA premium tax does not apply to self- insured groups.

3. CareFirst reserves the right to revise the fees/guarantees/credits if the actual enrollment varies by more than 10% from that used in the original pricing, or if Applicable Law requires such revisions. CareFirst also reserves the right to revise fees/guarantees/credits at any point throughout the Agreement Period if enrollment varies by more than 15% from the enrollment on the effective date of the Agreement.

4. Administrative Fees include administration of:

   a) PCMH and Care Support Services;

   b) The services set forth in Attachment IV: Health Promotion/Wellness and Member Incentive, and;

   c) Unless otherwise set forth in this Attachment VII: Financial Terms, administration of other healthcare-related services set forth in any Attachments.

5. The Plan Sponsor shall be responsible for Value-Driven Healthcare Incentive rewards for certain providers who meet certain quality and cost efficiency targets.

6. The Sponsor has received a renewal guarantee under this Agreement based on a multi-year commitment to stay with CareFirst. If the Sponsor terminates before the end of that multi-year commitment, then the Sponsor shall pay CareFirst an amount equal to three months of the Administrative Fee set forth in the fee table in Section A, above.

7. Fees provide for administration of Pharmacy Prescription Drug (Card) coverage. See Attachment VIII: Pharmacy Financial Provisions, and Attachment IX: Terms Material to the Pharmacy Guarantees.

8. CareFirst shall withhold [redacted]% of the Medical Pharmacy Rebates under the medical coverage.

9. Administrative Fees are based on CareFirst as fiduciary for final claims determinations.

10. Weekly funding of claims and monthly funding of fixed costs via Automated Clearing House (ACH) Debit or Wire Transfer is required.

11. First year Administrative Fees are mature, therefore, additional Run-Out Administrative Fees at termination are not required. A "mature" Administrative Fee is based on all claims paid during a 12-month period regardless of when the claims are incurred. Pricing based on a Mature Administrative Fee results in a Run-Out Administrative Fee of zero.

12. Paid Claims shall be credited pursuant to any cost-containment programs including pre-payment savings and post-payment recoveries. CareFirst shall retain 40% percent of the gross savings/recoveries and shall be responsible for any applicable vendor fees.

13. CareFirst shall retain 40% of out-of-network healthcare provider savings. If no discount is obtained, there is no cost to Sponsor for this service.

14. Additional reporting fees apply when Stop Loss is with a non-preferred carrier. A non-preferred carrier is a Stop Loss carrier that does not have an agreement with CareFirst to share information at no cost.

15. As stated in the Inter-Plan Arrangement Disclosure section of this Agreement, under the proposed BlueCard program, a Host BCBS plan may withhold an access fee. The access fee may be charged only if the Host Plan's arrangement with the participating provider prohibits billing the participant in connection with cost-sharing amounts in excess or the negotiated payment rate. Additionally, Host Plans may also charge an Administrative Expense Allowance (AEA) fee, which is a per claim fee included in the definition of Paid Claim(s) of this Agreement.

Attachment VIII: Pharmacy Financial Provisions

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

A. RECITALS

WHEREAS, the Sponsor requires certain administrative, Claims processing, and Drug Utilization Review ("DUR") services with respect to the Prescription Drug benefits under the Plan; and

WHEREAS, CareFirst has contracted with a Pharmacy Benefit Manager ("PBM"), to administer Pharmacy-Dispensed Prescription Drug benefits; and

WHEREAS, CareFirst has the capability to provide, through its relationship with PBM, the services required by the Sponsor; and

WHEREAS, the Sponsor desires CareFirst to render such services in connection with the Plan;

WHEREAS, the Sponsor, through CareFirst, authorizes PBM to contract with pharmaceutical companies for Rebates as a group purchasing organization for the Plan;

NOW, THEREFORE, in consideration of the mutual promises contained herein, the Parties agree as follows:

B. DEFINITIONS

For the purposes of this Attachment, the following terms shall have the meanings below. All other terms used, but not otherwise defined, in this Attachment shall have the same meaning as those terms in this Agreement and/or in the EOC.

Ancillary PBM Services means ancillary services as described herein that are not Program Services.

Average Wholesale Price (or AWP). The "average wholesale price" for a Program Drug based on the most current pricing information provided to PBM by MediSpan Prescription Pricing Guide (with supplements) at the date and time the Program Drug is dispensed by the Contracting Pharmacy. The AWP of a Program Drug shall be the AWP as reported by the Pricing Source for the eleven (11) digit NDC, drug specific, quantity appropriate actual package size dispensed by the Contracting Pharmacy. PBM shall not use AWPs of licensed re-packagers where the data source identifies an AWP greater than the AWP reported by the pharmaceutical manufacturer. PBM shall update AWP data no less than weekly.

Brand Name Drug means a Program Drug that is not a Generic Drug. When a drug is classified as a Brand Name Drug, it shall be considered a Brand Name Drug for all purposes under this Agreement, including adjudication, therapeutic classification, drug ontology, pricing, and all guarantees related thereto. Brand Name Drugs include biosimilar drugs unless they are required to be classified as Generic Drugs under FDA standards.

Specialty Brand Name Drug means, for purposes of calculation of Rebates, a Prescription Drug categorized by the PBM as a Brand Name Drug and which is categorized as a Specialty Drug.

Claim(s) means a request for payment for drugs or Pharmacy services submitted by a Contracting Pharmacy or Member that passes through Pharmacy edits at the point of service and results in either the Dispensing of a Program Drug, or the return of a Prescription to the Member under the Plan.

Compound Drug means a Prescription where two or more solid, semi-solid, or liquid medications are mixed together, at least one of which is a Program Drug. The end product must not be available in an equivalent commercial form. The product will not be considered a Compound Drug if it is reconstituted or if, to the active ingredient, only water, alcohol, flavoring, coloring, or sodium chloride solutions are added. Compound Drugs shall be priced using the NCPDPD.0 standard which shall capture each ingredient used in the medication.

Contracting Pharmacy means a Pharmacy/Mail Order Pharmacy that has contracted with CareFirst's PBM to provide Members access to Program Drugs.

Discount means a reduction off of the AWP which may be used to determine ingredient cost.

Dispense(d) (or Dispensing) means a Pharmacy's filling of a Prescription; however, Dispensing by a Mail Order Pharmacy also requires placing the Prescription in an order form (or package), and affixing postage to the order form through the mail manifest process. Dispensing by a Specialty Pharmacy shall be as directed by CareFirst.

Dispensing Fee means the fee paid to a Pharmacy for Dispensing a Prescription. The Dispensing Fee is added to the discounted AWP or Maximum Allowable Cost.

Drug Utilization Review (or DUR) means the process whereby the therapeutic effects and cost effectiveness of various drug therapies are reviewed, monitored, and acted upon consistent with the Plan.

Eligible Claim(s) means any Claim paid for a Program Drug that is covered under the Plan for a Member. Eligible Claims exclude any reversals or Claims for an ineligible person.

Formulary (or Formularies or Drug Formulary) means the lists of Prescription Drugs approved by the CareFirst Pharmacy & Therapeutics (P&T) Committee or the PBM P&T Committee if the Sponsor has selected a PBM Formulary. Formularies may include all drugs approved by the United States Food and Drug Administration for which a Prescription is necessary.

The Formularies will be available to Contracting Pharmacies, Members, Prescribing Providers, or other healthcare providers for purposes of providing information about the coverage and tier status of Program Drugs.

Generic Drug means a drug:

1. That is a non-innovator product;

2. For which pharmaceutical equivalent products are available from multiple marketplace sources;

3. That is not protected by patent(s), exclusivity, or cross-licensure;

4. That is a product identified as the holder of an Abbreviated New Drug Application (ANDA), which is an application to market a duplicate drug that has already been approved under the full NDA; however, not all Generic Drugs have an associated ANDA, or;

5. That is defined by MediSpan, or another nationally recognized source selected by PBM for its book of business, as a Generic Drug (e.g., the Multisource Code field as defined by MediSpan contains a "Y" or a multi-source brand that adjudicates at the Maximum Allowable Cost List).

Generic Drugs also shall include Brand Name Drugs that are treated as "house" generic drugs (DAW5) by the Network Pharmacy, Single Source Generic Drugs, and authorized generics. When a drug is identified as a Generic Drug, it shall be considered a Generic Drug for all purposes under this Agreement, including adjudication, therapeutic classification, drug ontology, pricing, and all guarantees related thereto.

Mail Order Pharmacy means a PBM affiliate or owned Contracting Pharmacy that has been approved by CareFirst as a Mail Order Pharmacy and whose primary method of delivery of Program Drugs is shipping through mail, express delivery, or other similar vehicle.

Mail Service means the provision of a Program Drug by a Mail Order Pharmacy.

Maintenance Drug Retail Network means optional programs that allow Members and Sponsor to receive enhanced pricing discounts at designated Retail Network Pharmacies.

Manufacturer means a company that manufactures, distributes, or is a wholesaler of pharmaceutical drug products, also referred to as a pharmaceutical manufacturer.

Maximum Allowable Cost ("MAC") Refers to a payer or PBM-generated list of products that includes the upper limit or maximum amount that a plan will pay for Generic Drugs and Brand Name Drugs that have Generic Drug versions available.

- MAC prices are updated frequently to keep pace with market changes in the purchase prices of Generic Drugs available to Pharmacies.

- MAC pricing is designed to promote competitive pricing for Pharmacies as an incentive to purchase the least costly Generic Drugs available in the market, regardless of the manufacturer's list price.

Maximum Allowable Cost ("MAC") List(s) is a PBM and Retail Pharmacy term that means the proprietary database listing(s), owned and maintained by PBM, of multi-source pharmaceutical drug products and supplies, and the corresponding MAC.

Member Benefit Adjustment(s) means, for purposes of determining the Sponsor's liability for a Program Drug after Member cost sharing: (i) Coinsurance; (ii) Copays; (iii) Deductibles; (iv) CareFirst's waiver of (i), (ii), or (iii); (v) if applicable, the differential paid by a Member between the price of a Brand Name Drug and the price of a Generic Drug when the Member chooses the Brand Name Drug; and (vi) the differential between Contracting Pharmacy and Non-Contracting Pharmacy prices for a Program Drug.

Multi-Source Brand Name Drug means a Prescription Drug categorized by Medi-Span® as of the Dispensed date as a Multisource Brand Name Drug where the Medi-Span® multisource field equals "O" and which is not categorized as a Specialty Drug.

Network means:

Broad Network. PBM's largest Retail 30-Day Network consisting of Network Pharmacies throughout the United States, Puerto Rico, Guam and the Virgin Islands. Additions to the Broad Network are made as pharmacies open or are otherwise contracted by PBM, or at the request of CareFirst or its Members.

Narrow Network. A Retail 30-Day Network consisting of Network Pharmacies with less Pharmacies than the Broad Network.

Non-Contracting Pharmacy means a Pharmacy/Mail Order Pharmacy that has not contracted with CareFirst's PBM to be paid directly for a Program Drug.

Prescribing Provider means a physician, institution, or health care professional licensed to prescribe Prescription Drugs.

Prescription means a prescription or authorized refill for a Program Drug prescribed for a Member by a Prescribing Provider.

Program Drug(s) means all drugs available under the Plan. Such drugs consist of (i) certain drugs (including insulin) that, under federal law, require the written Prescription of a Prescribing Provider; (ii) such other drugs, including Over-the Counter drugs; and Diabetic Supplies if identified as a Covered Service under the EOC.

Program Drug Paid Claims is the amount the Sponsor pays CareFirst for Program Drugs. Dispensing Fees are also included in Program Drug Paid Claims.

Program Services means those services that Plan Sponsor directs CareFirst (through its PBM) to provide pursuant to this Agreement, including, but not limited to:

1. Account management;
2. Retail Pharmacy Network management;
3. Claims adjudication;
4. Mail Service and Specialty Drug Prescription processing and Dispensing;
5. Customer services support;
6. Clinical management, including Formulary management;
7. Rebate contracting and management services; and
8. Any additional services offered by CareFirst that Sponsor may direct CareFirst or its PBM to provide.

Rebate Guarantee means the Rebate that CareFirst guarantees it will pay the Sponsor for Eligible Claims submitted by Contracting Pharmacies as set forth herein.

Rebates means Formulary rebates, including base and market share rebates, price protection, and performance/incentive rebates, from various pharmaceutical companies that are attributable to the utilization of Brand Name Drugs by Members. CareFirst has employed a PBM in order to obtain these Rebates. PBM or its affiliates may receive concurrent or retrospective discounts from pharmaceutical companies which are attributable to or based on products purchased by PBM affiliated Dispensing Pharmacies. The term "Rebates" shall not include any compensation, concurrent, or retrospective discounts associated with the purchase price of products which belong exclusively to PBM or its affiliates.

Retail 30-Day Network means a Pharmacy network of Retail Pharmacies contracted with PBM to provide Members with one-month (i.e., less than 84 days) supplies of Program Drugs at the pricing set forth in Attachment XII: Pharmacy Guarantees. The Retail 30-Day Network includes the Broad Network and Narrow Network.

Retail 90-Day Network means a Pharmacy network of Retail Pharmacies contracted with PBM to provide Members with Dispensing days' supply in excess of one month (i.e., 84 days or more) of Program Drugs at the preferential pricing set forth in Attachment XII: Pharmacy Guarantees.

Retail Network or Retail Pharmacy Network means a Pharmacy network of Retail Pharmacies, including the Retail 30-Day Network and the Retail 90-Day Network that will provide Members with Program Drugs.

Retail Pharmacy(ies) means Contracting Pharmacies licensed to provide Program Drugs and whose primary method of delivery is not shipping through mail, express delivery, or other similar vehicle.

Single Source Generic Drug ("SSG") means a Generic Drug provided by only one Manufacturer, including authorized Generic Drugs with limited availability, exclusivity, or competition which is likely to have market rates which more closely mirror a Brand Name Drug than a Generic Drug.

Specialty Drug means a list of Program Drugs defined solely by CareFirst or PBM which include, but are not limited to, drugs that are very expensive, large molecule, high potential for adverse effects, have stability concerns – requiring special handling, and/or are often derived from biologic processes rather than chemical processes. These drugs are often highly effective when used according to a strict administration regimen and therefore may require support and management services.

Specialty Pharmacy Network (or Specialty Pharmacy) means a network of Specialty Drug Contracting Pharmacies.

Exclusive Specialty Pharmacy Network means a limited Specialty Pharmacy Network. A Member must use a Specialty Pharmacy designated as "Exclusive" to obtain benefits for a Specialty Drug.

Open Specialty Pharmacy Network means an open Specialty Pharmacy Network. A Member may use any Pharmacy to obtain benefits for a Specialty Drug, subject to that Pharmacy's stocking of the Specialty Drug.

Usual and Customary (or U&C) means the price a Pharmacy would charge a particular customer without any insurance coverage if such customer were paying cash for the identical Program Drug on the date Dispensed. This includes any applicable discounts, including but not limited to senior discounts, frequent shopper discounts, and other special discounts offered to customers.

C. FUNDING ARRANGEMENT AND PAYMENT TERMS:

Sponsor shall pay the applicable Program Drug Paid Claims reimbursement amounts plus other applicable fees in accordance with Sponsor reimbursement of Paid Claims as set forth in Section V: Funding Arrangement and Payment Terms. The Sponsor acknowledges that the amount charged by CareFirst to the Sponsor for a Program Drug may vary from the amount charged by PBM to CareFirst.

D. IMPLEMENTATION:

1. In consultation with Sponsor, CareFirst shall develop a mutually agreeable implementation project plan prior to the Effective Date, or prior to the implementation of any new group or Plan during the Term of this Agreement.

2. Sponsor or Sponsor's designee shall provide to CareFirst prior to the Effective Date, or prior to the implementation of any new group or Plan during the Term of this Agreement:

a. The initial eligibility test data and the initial full eligibility data;

b. Sponsor's acceptance of CareFirst's benefit design form reflecting its desired Plan benefits;

c. A refill file (if available) in a format acceptable to PBM.

Any delays by Sponsor or its designee in providing this information may delay the implementation of services by CareFirst.

3. Subject to timely receipt of a refill file or prescription, CareFirst will begin filling prescriptions through its Mail Service Pharmacies as of the Effective Date.

4. CareFirst will make available electronically implementation information to Plan Participants which may include the following materials:

a. Introductory cover letter;

b. Standard identification cards for use within the Retail Network which shall include PBM's name and toll free number;

c. Mail Service order form;

d. Paper Claim reimbursement form, if applicable; and

e. At Sponsor's expense and election, CareFirst may prepare printed information, materials or envelopes for mailing such information to Plan Participants. CareFirst will use Plan Participant address information provided as part of the eligibility information submitted in accordance with Section IV: Sponsor Obligations.

5. Any reprints or customization of any communication materials/ID cards requested by Sponsor shall be at Sponsor's expense.

E. GUARANTEES:

1. Discount Guarantee Calculation: CareFirst offers an average annual Discount guarantee as outlined in Attachment XII: Pharmacy Guarantees and measured on the Sponsors' aggregate annual utilization as set forth in Attachment XII: Pharmacy Guarantees according to the following formula:

[1 - (Sum of annual Discounted AWP / Sum of annual AWP)] = AWP Discount Percentage

The annual Discounted AWP will include the amount the Sponsor reimbursed CareFirst for Program Drugs equaling the lesser of: (i) Average Wholesale Price less the Discount; (ii) Maximum Allowable Cost; or (iii) the Usual and Customary price.

If the average AWP Discount Percentage during the Agreement Period is lower than the Discount guarantees set forth in Attachment XII: Pharmacy Guarantees, CareFirst will pay the Sponsor the difference.

2. Dispensing Fee Guarantee Calculation: CareFirst offers an average annual Dispensing Fee Guarantee as set forth in Attachment XII: Pharmacy Guarantees and measured on the Sponsors' aggregate annual utilization as follows:

(Sum of annual Dispensing Fees / total annual Claim volume) = Average Dispensing Fee

If the Average Dispensing Fee during the Agreement Period is higher than the Dispensing Fee Guarantee as outlined in Attachment XII: Pharmacy Guarantees, CareFirst will pay the Sponsor the difference.

3. Rebate Guarantee Calculation: CareFirst will pay the Sponsor the amount specified for Rebates in Attachment XII: Pharmacy Guarantees for each Brand Name Drug Claim/Specialty Brand Name Drug Paid Claim.

a. Rebate Payouts: CareFirst will remit the Rebate Guarantee to the Sponsor on a quarterly basis in accordance with Attachment XII: Pharmacy Guarantees.

This provides the full remittance of funds under Attachment XII: Pharmacy Guarantees.

F. INCLUDED ANCILLARY PBM SERVICES

1. General: In addition to the guarantees described herein, Sponsor desires for CareFirst to provide additional services ancillary to the PBM services as follows.

2. Formulary Management: CareFirst shall monitor Members' adherence to the CareFirst Formulary selected by Plan Sponsor in accordance with applicable Formulary policies as published in Formulary description documents.

3. Pharmacy Services: CareFirst shall provide Pharmacy services which may include utilization management, Specialty Drug management and care coordination for high cost medications. Additional services include comprehensive medication reviews and clinical programs aimed at improving medication adherence, reducing pharmacy costs, and monitoring the over utilization of controlled substances.

4. Plan Design Services and Programs

a. Maintenance Drug Retail Network & Mail Service Program

At the election of the Plan Sponsor, with 90 days' notice, this plan design feature can help improve Member adherence by leveraging Mail Service and Retail Pharmacy capabilities to provide Members a choice in how they receive a 90-day supply of a Maintenance Medication. Members can choose to receive their Maintenance Medications through Mail Service or at a CareFirst-designated Retail Pharmacy – at the Mail Service plan design pricing and Copay. This program must be implemented by the Sponsor in accordance with CareFirst guidelines in order for these Prescription Drugs to be included in the guarantee for Mail Service pricing.

b. Enhanced Clinical Services and Programs

For example, prior authorization requirement for all Specialty Drugs.

c. Appeals Program

CareFirst will administer Prescription Drug benefits appeals in accordance with the Claims Procedures section of the EOC.

d. Pharmacy Reporting Tools

CareFirst will provide Sponsor access to available online reporting tools in a manner consistent with the tools provided in Section VI: Reports; Reports Required by Law; Tax, COBRA Compliance, and Other Employer Responsibilities.

e. Benefit Exclusion Plan Design

This program allows the Sponsor to exclude certain Prescription Drugs that have limited clinical value and which have clinically-appropriate, lower-cost alternatives. For example, Brand Name Drugs that are combinations of existing Generic or Over-the-Counter Drugs and new formulations of existing drugs. CareFirst shall determine which Prescription Drugs meet the criteria for exclusion. Acceptance of this program may require an adjustment to Rebate Guarantees.

G. ADJUSTMENTS/LAG TIME

1. CareFirst processes health care benefits claims and loads Pharmacy Claims data in date-received order. This process may result in simultaneous payments being made by CareFirst and PBM due to lag time, timely or otherwise, including, but not limited to delays due to manufacturer coupon/copay programs. CareFirst shall adjust Paid Claims and Member cost-sharing provisions as applicable.

Attachment IX: Terms Material to the Pharmacy Guarantees

WHEREAS, this Attachment replaces and supersedes any previous agreement(s) Sponsor and CareFirst may have entered into with respect to any matters set out in this Attachment.

A. CareFirst may exclude the following from any Discount and Dispensing Fee guarantees:

1. 340B Pharmacy Claims
2. Compound Drug Claims
3. 100% Member-paid plans including indemnification plans and/or health savings accounts
4. Vaccines and vaccine administration Claims
5. Claims where the Sponsor is the secondary payer
6. Over-the-Counter drugs as identified by Medi-Span® as of the Dispensing date
7. Claims from a Non-Contracting Pharmacy and any paper or Member submitted Claims for a Program Drug from a Contracting Pharmacy
8. Program Drug Paid Claims credit adjustments
9. Covid-19 Vaccines.

B. CareFirst may exclude the following from any Rebate guarantees:

1. 340B Pharmacy Claims
2. Compound Drug Claims
3. Limited distribution and exclusive distribution Prescription Drugs
4. Biosimilar Claims
5. Vaccines and vaccine administration Claims
6. Claims where the Sponsor is the secondary payer
7. Over-the-Counter drugs as identified by Medi-Span® as of the Dispensing date
8. Claims from a Non-Contracting Pharmacy and any paper or Member submitted Claims for a Program Drug from a Contracting Pharmacy
9. Program Drug Paid Claims credit adjustments
10. Covid-19 Vaccines.

C. The Generic Drug Discount guarantees are inclusive of MAC and non-MAC multisource Generic Drugs available from 2 or more ANDA Generic Drug Manufacturers and sufficient inventory and/or competition to supply marketplace demand.

D. Discount and Dispensing Fee guarantees offered to Sponsor are measured in aggregate whereby CareFirst may use any over-performance in any other guarantee(s) offered to Sponsor to offset under-performance in any other guarantees.

E. The proposed rates do not necessarily reflect the Contracting Pharmacy contracted rates and CareFirst may retain the difference. The Network(s) proposed is(are) based on the approximate number of Network Pharmacies as of the date of these Pharmacy guarantees. Pharmacy Network participation will vary over time and CareFirst does not guarantee the approximate number of Network Pharmacies.

F. The Contracting Pharmacy may collect from the Member the lower of the applicable cost share or the Contracting Pharmacy's Usual and Customary price.

G. Rebate Guarantee assumes alignment with the CareFirst Formulary 2 (Medium Exclusions) Formulary, allowing up to 90 days' supply via Mail Service, and Claim utilization, and proposed plan design are as represented by the Sponsor.

H. Rebate Guarantee for Specialty Drugs assumes a 90-day supply.

I. To qualify for three-tier qualifying Rebates, Members under this Agreement must be covered under a three-tier qualifying plan design. A three-tier qualifying plan design consists of a plan design with the first tier comprised of Generic Drugs, the second tier comprised of Preferred Brand Name Drugs, and the third tier comprised of Non-Preferred Brand Name Drugs, with at least a $15.00 co-payment differential between Preferred and Non-Preferred Brand Name Drugs, at least a $15.00 differential in the minimum Copayment, or a differential of Coinsurance 1.5 times or 50 percentage points between the Preferred and Non-Preferred Brand Name Drug (for example, if Preferred Brand Name Drug Coinsurance was 20%, the Non-Preferred Brand Name Drug Coinsurance would need to be 30% to qualify).

J. This Generic Drug pricing program is monitored based on the Sponsor's utilization, and prices are adjusted to meet our account commitments.

K. Mail Service pricing will be fixed for the term of the Agreement, provided that pricing may be adjusted to reflect any increases in cost of postage or shipping over the term of the Agreement.

L. All financial terms set forth herein are conditioned upon Sponsor utilizing specified standard Formularies and network, execution of the Agreement and no 100% Copayment plans. CareFirst reserves the right to revise financial terms if any of the following occur:

1. A change in the scope of services, conditions or assumptions of Attachment VIII: Pharmacy Financial Provisions, or this Attachment IX: Terms Material to the Pharmacy Guarantees;
2. Any government-imposed change in federal, state or local laws or interpretation thereof or industry wide change that would make CareFirst's performance of its duties hereunder materially more burdensome or expensive;
3. Change in Formulary or benefit plans and drug coverage rules/clinical programs or any other change that may impact the amount of Rebates;
4. Sponsor allows on-site clinics and/or Sponsor-owned Pharmacies to dispense Program Drugs to Members;
5. Changes to enrollment as set forth in Attachment X: Financial Terms, Terms Material to the Pricing Analysis;
6. Movement of a branded product to off-patent or where there are generic or Over-the-Counter substitutes available; or
7. Changes made to the AWP benchmark or the methodology by which AWP is calculated or reported.
8. Implementation of a 100% Copayment plan.

M. In the event Medi-Span, or other nationally available AWP reporting source used by CareFirst for pricing purposes, discontinues the reporting of AWP or changes the manner in which AWP is calculated prior to the implementation of your business, or during the term of the Agreement, then CareFirst reserves the right to modify the pricing terms to be effective as of the date of such discontinuation or change, so as to maintain the parties' relative economic positions as existed immediately before the effective date of such discontinuation in reporting or change in the calculation of AWP, as measured across all products on an aggregate basis. Such modifications may include the utilization of alternate pricing benchmarks, the adjustment of AWP to the methodology relied upon by such reporting source prior to such modification of AWP methodology, the adjustment of the AWP discount, or adjusting the pricing terms to reflect the new manner by which AWP is calculated.

Signatures

The Sponsor on behalf of itself and its Members hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Sponsor and CareFirst, which is an independent corporation operating under a license from the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting CareFirst to use the Blue Cross and Blue Shield Service Marks in the District of Columbia, Maryland, and portions of Virginia and that CareFirst is not contracting as the agent of the Association. The Sponsor further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than CareFirst and that no person, entity, or organization other than CareFirst shall be held accountable or liable to the Sponsor for any of CareFirst's obligations to the Sponsor created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of CareFirst other than those obligations created under other provisions of this Agreement.

Business Associate Confirmation Form

See attached Business Associate Confirmation Form
(next page)