Administrative Services Agreement

This Administrative Services Agreement between: (i) UMR, Inc., on behalf of itself and its Affiliates ("UMR"), (ii) EmblemHealth Plan, Inc. ("Emblem") (UMR and Emblem each individually a "Co-Administrator" and together the "Co-Administrators"), and (iii) the City of New York acting through the Mayor's Office of Labor Relations. ("Plan Sponsor"), is effective as of [Effective Date] (the "Effective Date") (together, with all appendices and exhibits incorporated herein, the "Agreement"). This Agreement governs the claims administration and related administrative services Co-Administrators will provide to Plan Sponsor (as more specifically defined herein, the "Services") with respect to the Plan (as hereinafter defined). Each Co-Administrator and Plan Sponsor may be referred to herein individually as a "Party" or collectively as the "Parties".

WHEREAS, Plan Sponsor has established a health benefit plan for Participants; and

WHEREAS, on October 17, 2022 OLR's request for approval to enter into a Negotiated Acquisition to provide health benefit services for New York City employees, pre-Medicare retirees and their dependents who are eligible for the City's Health Benefits Program was approved by the City Chief Procurement Officer; and

WHEREAS, OLR issued a public notice for a negotiated acquisition (EPIN 00223N0002) in conformance with the New York City Procurement Policy Board Rules ("PPB") and had otherwise advertised in order to solicit vendors through the Notice of Intent to provide health benefits services for Eligible Individuals and their dependents (the "Negotiated Acquisition"); and

WHEREAS, Co-Administrators submitted a response for such services, as provided in the public notice for the Negotiated Acquisition to OLR and responses were evaluated by an evaluation committee; and

WHEREAS, pursuant to the Plan, Plan Sponsor desires to retain certain services offered by Co-Administrators, as further specified in this Agreement and in the Exhibits attached hereto; and

WHEREAS, Co-Administrators desire to provide such services to Plan Sponsor.

NOW THEREFORE, in consideration of the mutual covenants and promises stated herein and other good and valuable consideration, the Parties hereby enter into this Agreement, which sets forth the terms and conditions under which Co-Administrators agree to render the Services, and under which Plan Sponsor hereby agrees to receive and compensate Co-Administrators for such Services.

Section 1: Definitions

The following terms have the meanings set forth below.

Access/Administration of Provider Network: Arrangement for the provision of medical and behavioral health and substance abuse benefits that are covered under the Plan to Participants, Claim-specific negotiations with Network Providers and non-Network Providers (other than Direct Contracted Providers and Customer-Specific Providers), and Network Provider services (provider-facing call line, inquiries, requests and communications relating to the Provider Network).

ACPNY: As defined in Section 11.5(a).

Affiliated Membership Administrator: As defined in Section 6.4(a).

Affiliates: With respect to any entity, an entity that, directly or indirectly, controls, is controlled by, or is under common control with such entity. For purposes of this definition, "control" means, with respect to any entity, the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such entity, whether through the ownership of voting securities (or other ownership interest), by contract or otherwise.

Agreement: As defined in the recitals hereto.

Bank Account: As defined in Section 4.2(a).

Business Associate Agreement: Each agreement entered into between each Co-Administrator and Plan Sponsor attached hereto as **Appendix C-1** (with respect to Emblem) and **Appendix C-2** (with respect to UMR).

CAA: As defined in Section 5.3.

Claim: A notification that a health care service or product has been rendered or furnished to a Participant and reimbursement under the Plan for such service or product is requested.

Claim Supporting Documentation: With respect to any Claim, the itemized Claim form(s) and all clinical records and other relevant supporting documentation required in order for Co-Administrators to accurately process the Claim as a Clean Claim.

Claims Adjudication and Claim Payment Services: The following Services: (i) pricing and re-pricing of Claims; (ii) Claims payment determinations; (iii) Claims adjudication, including management of pended Claims, and subsequent review of such Claims; and (iv) issuing Claims payments to providers.

Claims Data: All data generated through, collected in connection with, or relating to Claim activity, including, but not limited to, enrollment and other kinds of information, including, without limitation: (i) Claim identification information, including all Claim and Claim adjustment numbers and other identifiers, admission source, place of service, service dates, plan and group identifiers, bill type, Claim type, surprise bill indicators, QPA amount; (ii) Participant/patient and dependent information and identifiers; (iii) provider information and identifiers; (iv) Claim adjudication fields including Claim paid/check date, denial information, revenue code, in-network processing status, denial reason, pre-authorization number, billed charges amount, paid amount, Participant financial responsibility fields, allowed amount, COB indicators and information, payer status, benefit codes, remark codes such as CARC & RARC; and (v) disease/procedure coding information, as well as all derivatives, modifications, updates, adaptations, enhancements; and other derivative works and improvements of any of the foregoing.

Clean Claim: A Claim timely submitted without errors, discrepancies, or missing information such as Claim Supporting Documentation that contains all required elements for Claim processing in accordance with Co-Administrators' policies and procedures, this Agreement, the Plan Design, and the Plan Documents.

Co-Administrator & Co-Administrators: As defined in the recitals hereto.

Co-Administrator Confidential Information: All information disclosed or made available to Plan Sponsor or its Affiliates that is marked confidential, restricted, proprietary or with a similar designation as of the time of disclosure, or would otherwise reasonably be understood by the recipient to be confidential, restricted or proprietary based on the nature of, and circumstances surrounding, the information being made available, excluding Plan Sponsor Confidential Information. Co-Administrator Confidential Information also includes the following information pertaining to Co-Administrators and their respective Affiliates,

regardless of form or the manner in which it is furnished and regardless of whether expressly designated as confidential, provided that such information is not Plan Sponsor Confidential Information: (i) financial information and related pricing information; (ii) manuals, reports, certain symbols, trademarks, service marks, designs, data, processes, plans, and procedures; and (iii) commercial information, including Network Provider agreements or contract information.

Co-Administrator Confidential Information does not include: (A) information that is or becomes generally available to the public other than as a result of a disclosure by Plan Sponsor or its Affiliates in violation of this Agreement or other agreement between the Parties; (B) information obtained by Plan Sponsor or its Affiliate from a third party (other than any Party to this Agreement or their respective Affiliates or Subcontractors) if Plan Sponsor can demonstrate such information was lawfully obtained by the third party and by Plan Sponsor from such third party and not subject to another obligation of confidentiality; (C) information independently and lawfully developed by Plan Sponsor without reference to Co-Administrator Confidential Information, if Plan Sponsor can demonstrate such independence through contemporaneous written records; or (D) any protected health information, personal information, personally identifiable information, or personal data (each as defined by applicable Law).

Consultant: As defined in Section 6.12(c).

Core Services: Collectively: (i) Claim Adjudication and Claim Payment Services; (ii) Access/Administration of Provider Network; (iii) Membership Administration Services; and (iv) Member Services. For the avoidance of doubt, the Core Services do not include Services or functions relating to any Value-Added Services.

Covered Emblem Affiliate: As defined in Section 11.5(a).

Customer-Specific Provider: Provider, who may or may not be a Network Provider, who has entered into, or is governed by a provider contract with a Co-Administrator with a fee schedule that is specifically for Plan Sponsor or specific to the Plan.

Data Privacy and Security Requirements: Collectively: (i) the rules, policies, and procedures (whether physical, administrative, or technical in nature, or otherwise) of Plan Sponsor that apply to or are used by Plan Sponsor; (ii) all requirements of Laws governing the creation, collection, access, use, disclosure, transfer, maintenance, transmittal, safeguarding, privacy, security, processing, and confidentiality of "protected health information" or "personal information", including HIPAA; Public Health Service Act, 42 U.S.C. §§ 290dd-3, 290dee-3 and implementing regulations; the Telephone Consumer Protection Act (47 U.S.C. § 227 et seq.); the Telemarketing Sales Rules (16 C.F.R. Part 310); the Telemarketing and Consumer Fraud and Abuse Prevention Act; the Fair and Accurate Credit Transaction Act; the Fair Credit Reporting Act; the CAN-SPAM Act; the Federal Trade Commission Act (15 U.S.C. §§ 41-58); the Children's Online Privacy Protection Act; the Gramm-Leach-Bliley Act; the Privacy Act of 1974; any applicable Law concerning website and mobile application privacy policies; applicable U.S. state and local data breach Laws; applicable U.S. state and local Laws governing health information and biometric information, including but not limited to Article 27-F of the New York Public Health Law; New York Public Health Law §§ 18 (Access to Patient Information) and 2780 et seq. (Confidential HIV Related Information); New York Mental Hygiene Law §§ 22.05 (Patient Chemical Dependence Services Records) and 33.13 (Confidentiality of Clinical Records); New York Civil Rights Law § 79-l (Confidentiality of Genetic Test Records); and New York General Business Law §§ 399-ddd (Confidentiality of Social Security Account Number), 399-h (Disposal of Records Containing Personal Identifying Information), & 899-aa (New York Breach Notification Statute); applicable U.S. state consumer protection Laws and Laws related to unfair or deceptive trade practices; applicable U.S. state and local laws governing Personal Information; and (iii) the Payment Card Industry Data Security Standard issued by the PCI Security Standards Council.

Deliverables: As defined in Section 7.5(a).

Direct Contracted Provider: Any provider, who may or may not be a Network Provider, who has entered into, or is governed by, direct contractual arrangements with Plan Sponsor or indirect contractual arrangements with a "Center of Excellence" or similar third party, under which the provider agrees to provide health care services to Participants and accept negotiated fees for such services.

Dispute: As defined in Section 8.6.

Downstate Counties (each a "Downstate County"): New York, Kings, Queens, Bronx, Richmond, Nassau, Suffolk, Westchester, Orange, Rockland, Putnam, Dutchess, and Ulster Counties.

Effective Date: As defined in the recitals hereto.

Eligible Individuals: New York City employees, pre-Medicare retirees who are eligible for the New York City Health Benefits Program and who Plan Sponsor deems eligible for participation in the Plan.

Embedded IP: As defined in Section 7.5(c).

Excluded Party(ies): Any Person that has been charged with or convicted of a crime related to health care fraud warranting mandatory exclusion from, or is currently excluded debarred, suspended or otherwise ineligible to participate in any "Federal Health Care Program" (as defined by 42 U.S.C. § 1320a–7b(f)) or federal procurement or nonprocurement program.

Fee: Any fee or other compensation (including, for the avoidance of doubt, compensation in the form of amounts payable for Payment Integrity Services and other shared savings programs) Plan Sponsor pays to Co-Administrators for Services provided under this Agreement.

GCPCA: As defined in Section 5.3.

HIPAA: The Health Insurance Portability and Accountability Act of 1996 and the Health Information Technology for Economic and Clinical Health Act (Title XIII of the American Recovery and Reinvestment Act of 2009), as the same may be amended, modified or supplemented from time to time.

Infeasible or Infeasibility: As defined in the Infeasibility Notice definition.

Impact Statement: A written notice issued by Co-Administrators to Plan Sponsor advising Plan Sponsor of proposed modifications to Fees, Guarantees, and/or other relevant terms of this Agreement, as applicable, resulting from a Plan Sponsor-requested Plan Design modification, Insourcing Request, or new Direct Contracted Provider or Customer-Specific Provider arrangement.

Implementation Manager: As defined in Section 3.2(c).

Implementation Period: As defined in Section 3.2(a).

Implementation Plan: As defined in Section 3.2(a).

Implementation Services: As defined in Section 3.2(a).

Implementation Timeline: The Implementation Services schedule set forth in **Exhibit J**.

Infeasibility Notice: A written notice advising Plan Sponsor of Co-Administrators' determination that any Insourcing Requests or new Direct Contracted Provider arrangements, as applicable, would make Co-Administrator's performance of the Core Services operationally infeasible or impossible due to non-Fee-based operational, contractual, technical, or regulatory reasons in accordance with industry standard administrative practices ("Infeasible" or "Infeasibility"). Such Infeasibility Notice shall: (i) state with specificity the operational, contractual, technical, or regulatory basis for the determination; (ii) identify all concrete alternatives considered by Co-Administrators and explain why each alternative would not eliminate the Infeasibility; (iii) affirmatively represent that Co-Administrators have not permitted any of their other then-current self-funded group health plan clients to insource the same function or materially similar functionality or undertake the same Direct Contracted Provider arrangement, as applicable, that is subject to the Infeasibility Notice; and (iv) include an affidavit by an officer signatory of Co-Administrator, that the statements contained in the Infeasibility Notice are true, correct, and complete to the best of such officer's knowledge after reasonable inquiry.

Initial Term: As defined in Section 3.1.

Insourced Services: As defined in Section 6.10(a).

Insourcing Request: As defined in Section 6.10(a).

JV Agreement: As defined in Section 5.7.

Key Personnel: The following roles or their functional equivalents: (i) prior authorization lead; (ii) Implementation Manager; (iii) pharmacy benefit lead; (iv) dedicated reporting analyst; (v) with respect to Emblem: SVP- Labor Markets; AVP- Client Relationships Management, Labor and Government; AVP-NYC Strategic Relationship; and (vi) with respect to UMR: Vice President of Client Management, Strategic Account Executive, Project Manager.

Law: Any federal, state or local statute, law, rule, regulation, code, binding interpretation or guidance, subpoena, decision, order, injunction or ordinance having the binding effect of law of the United States, any foreign country or any domestic or foreign state, county, city or other political subdivision of any governmental entity or authority applicable to the Plan, the Services, or any Party's activities, duties, or operations hereunder, including, without limitation: (i) the New York City Charter; (ii) the New York City Administrative Code; (iii) the PPB; (iv) any local rule of the City of New York; (v) the CAA; (vi) the Patient Protection and Affordable Care Act of 2010 ("PPACA"); and (vii) Data Privacy and Security Requirements.

Material Network Provider Contract: Any provider contract entered into by either Co-Administrator or any of their respective Affiliates covering (i) any hospital location in a Downstate County, including any hospital or health system with locations both within and outside the Downstate Counties; or (ii) any other non-hospital Network Provider that, either individually or in the aggregate with other Network Providers covered under the same Network Provider agreement, represents more than $12,000,000 of allowed Claims funded by the Plan (or its predecessor plan, as applicable) during the twelve (12) month period preceding the then-current date.

Medical Benefit Drug Rebate: Any discount, price concession, or other direct or indirect remuneration from a drug manufacturer under a rebate agreement or other rebate arrangement resulting from Participant use of a J-Code prescription drug billed under the Plan's medical benefit. Medical Benefit Drug Rebate does not include any discount, price concession, administration fees, or other direct or indirect remuneration received: (i) in relation to a prescription drug that is not billed or covered under the Plan's medical benefit; (ii) in connection with any agreement related to Participant use of a prescription drug under the Plan's

prescription drug benefit plan; or (iii) for any prescription drug the Plan reimburses in connection with **Exhibit B**, including covered Affordable Care Act drugs required to be reimbursed under the Plan medical benefit and diabetic drugs.

Membership Administration Services: Membership Administration Services shall include: (i) processing, handling and updating of Participant enrollment and related eligibility information; (ii) formatting, storing and providing eligibility data for Plan Sponsor and vendors; and (iii) managing issues related to Participant enrollment and membership, including the creation, distribution and updates to Participant ID cards.

Member Services: Includes (i) intake of Participant communications, inquiries, and requests related to the Plan; and (ii) maintenance of a Plan-specific Participant phone number.

NDC: National Drug Code.

Network: The group of Network Providers that Co-Administrators make available to the Plan who have entered into or are governed by contractual arrangements with Co-Administrators or their Affiliates under which they agree to provide covered health care services to Participants and accept negotiated fees for those services.

Network Adequacy Standards: The standards attached hereto as **Exhibit I**.

Network Provider: Physician, medical professional, medical professional group, facility, health system, or other healthcare provider which participates in a Network. A provider is only a Network Provider if they are participating in a Network at the time services are rendered to the Participant.

Obligations: As defined in Section 8.5.

OLR: The Mayor's Office of Labor Relations.

Overpayments: Payments that exceed the amount payable under the Plan.

Participant: An Eligible Individual who elects coverage by the Plan through the City of New York.

Party or Parties: As defined in the recitals hereto.

Payment Integrity Services: As defined in **Exhibit A**.

Person: A natural person, corporation, limited liability company, partnership, joint venture, or any other organization or entity.

Plan: The health benefits plan to which this Agreement applies, but only with respect to those provisions of the health benefits plan relating to the self-funded health benefits for which Co-Administrators are providing Services, as described in the Summary Plan Description.

Plan Benefits Litigation: As defined in Section 5.13

Plan Design: The benefit structure and administrative preferences established by Plan Sponsor with respect to the Plan, as directed in writing by Plan Sponsor from time to time.

Plan Documents: For purposes of the Agreement: (i) the Plan's Summary of Benefits and Coverage, (ii) the Plan's Summary Plan Description, and (iii) the benefit grid specifying the Plan Design.

Plan Sponsor: As defined in the recitals hereto.

Plan Sponsor Confidential Information: All information disclosed or made available to (including information created by Co-Administrators or their Subcontractors or Affiliates in connection with the Services) Co-Administrators or Co-Administrators' Affiliates or Subcontractors that is marked confidential, restricted, proprietary or with a similar designation or would otherwise reasonably be understood to be confidential, restricted or proprietary based on the nature of, and circumstances surrounding, the information being made available. Plan Sponsor Confidential Information also includes the following, regardless of form or the manner in which it is furnished and regardless of whether expressly designated as confidential: (i) financial information and related pricing information, including vendor information; (ii) operating manuals, reports, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information developed by or on behalf of Plan Sponsor; (iii) eligibility and enrollment data and other Participant data; (iv) Claims Data; (v) other forms of protected health information, personal information, personally identifiable information, or personal data (each as defined by applicable Law); and (vi) the Deliverables.

Plan Sponsor Confidential Information does not include: (A) information that is or becomes generally available to the public other than as a result of a disclosure by Co-Administrators or their Affiliates or Subcontractors in violation of this Agreement or other agreement between the Parties; (B) information obtained by Co-Administrators from a third party (other than any Party to this Agreement or their respective Affiliates or Subcontractors) if Co-Administrators can demonstrate such information was lawfully obtained by the third party and by Co-Administrators from such third party and not subject to another obligation of confidentiality, or (C) information independently and lawfully developed by Co-Administrators without reference to Plan Sponsor Confidential Information and not in connection with the performance of the Co-Administrators' obligations hereunder, if Co-Administrators can demonstrate such independence through contemporaneous written records, provided, however, that notwithstanding the foregoing clauses (A), (B), and (C), information that is eligibility and enrollment data and other Participant data, Claims Data, or other forms of protected health information, personal information, personally identifiable information, or personal data (each as defined by applicable Law) shall be deemed Plan Sponsor Confidential Information regardless of whether the exceptions described in (A)-(C) of this paragraph apply.

PPB: As defined in the recitals hereto.

Proposed Adjustment: A proposed adjustment to Fees, and/or proposed amendment to the Guarantees or the terms of this Agreement arising from a Plan Sponsor-requested Plan Design modification, Insourcing Request or new Direct Contracted Provider or Customer-Specific Provider arrangement.

Renewal Term: As defined in Section 3.3.

Run-Out Period: As defined in Section 10.1.

Run-Out Services: As defined in Section 10.1.

Services: The services described in **Exhibit A** and **Exhibit B**, together with the Implementation Services, in addition to those tasks, activities, functions, and other obligations contemplated by this Agreement, specified on **Exhibit D**, or that are otherwise essential or inherently necessary in order for Co-Administrators to perform such services or appropriately manage the Plan in accordance with the provisions of this Agreement.

Service Start Date: As defined in Section 3.1.

Subcontractor: As defined in Section 11.1.

Summary Plan Description or SPD: The document(s) provided to Plan Participants describing the terms and conditions of coverage offered under the Plan.

Systems: Any software program(s) or other applications, including third party programs and applications, used or made available by a Co-Administrator to complete any component of the Services or to store Participant data or Plan Sponsor Confidential Information.

Taxes: A charge imposed, assessed, or levied by any federal, state, local, or other governmental entity.

Term: Collectively, the Implementation Period, Initial Term, and any Renewal Term.

Value-Added Services: Certain elective programs, services and functions offered by Co-Administrators that are in addition to, but not dependent on, administration of health benefits under the Negotiated Acquisition, including (i) elective specialty benefits (e.g., infertility or menopause benefits), or (ii) new Centers of Excellence ("COE") or clinical innovation programs with non-Network Providers (e.g., state-of-the-art cardiac program).

Section 2: Exhibits

As of the Effective Date, the below-listed appendices and exhibits are fully incorporated into this Agreement by reference.

Appendix A	General Provisions Governing Contracts for Consultants, Professional, Technical, Human, and Client Services, as modified by the Addendum to Appendix A January 2018 and the NYC Earned Safe and Sick Time Contract Rider.
Appendix B	Identifying Information Rider
Appendix C-1	Business Associate Agreement (Emblem)
Appendix C-2	Business Associate Agreement (UMR)
Exhibit A	Medical Benefit Administration Services
Exhibit B	Pharmacy Services
Exhibit C	Security
Exhibit D	Medical Benefit Administration Fees
Exhibit E	Guarantees
Exhibit F	Reports
Exhibit G	Sample Invoices
Exhibit H	Claims Feed Fields
Exhibit I	Network Adequacy Standards
Exhibit J	Implementation Timeline

Section 3: Term

3.1 Initial Term. Subject to the Implementation Period requirements described below, Co-Administrators' Services with respect to processing Claims corresponding to dates of service on or after January 1, 2026

shall begin on the later of (i) January 1, 2026, or (ii) the first day following completion of the Implementation Plan (the "Service Start Date") and continue through December 31, 2030 (the "Initial Term"), unless earlier terminated pursuant to Section 10.2.

3.2 Implementation Period.

(a) As of the Effective Date, Co-Administrators shall begin performance of the Implementation Services (such period between the Effective Date and the date the Implementation Services are completed, the "Implementation Period"). During the Implementation Period, Co-Administrators shall perform all services and functions necessary to accomplish the migration and transfer of the Services from Plan Sponsor's current provider(s) to Co-Administrators including the services and functions further described in one or more active work plan document(s), including communication-focused work plans, prepared and updated from time to time by Co-Administrators and Plan Sponsor in anticipation of the Service Start Date (all such work plan documents collectively, for purposes of this Agreement, the "Implementation Plan" and the Implementation Period services contemplated in this Section 3.2, Section 8 of **Exhibit A**, and the Implementation Plan, collectively, the "Implementation Services").

(b) The Implementation Period may be extended by Plan Sponsor in its sole discretion if Co-Administrators do not complete the Implementation Plan prior to the intended Service Start Date of January 1, 2026, or upon the issuance of a restraining order, injunction, or other federal or state court order that, in the reasonable estimation of Plan Sponsor, impacts or limits the ability for the Parties to effectuate a Service Start Date of January 1, 2026; provided, however, that the Parties shall negotiate in good faith to: (i) extend the Implementation Period, (ii) update the Implementation Timeline, and/or (iii) modify affected Guarantees, including the Implementation Guarantee (and any dates and scheduled items identified therein) accordingly, in the event a scheduled item set forth in the Implementation Timeline (including without limitation, the January 1, 2026 Service Start Date) is not achieved due to Plan Sponsor's (or its representatives or designees, as applicable) breach of its obligations set forth under Section 3.2(e) herein. Co-Administrators shall immediately provide written notice to Plan Sponsor if there is or will likely be a delay of the Service Start Date beyond January 1, 2026 for any reason.

(c) Each Co-Administrator will allocate sufficient staff and resources to perform their respective obligations and duties described in the Implementation Plan. Co-Administrators shall jointly appoint a representative (the "Implementation Manager") who, during the Implementation Period, shall (i) be responsible for ensuring timely completion of the Implementation Plan, and (ii) serve as the designated point of contact for Plan Sponsor with respect to the Implementation Services. The Implementation Manager shall be deemed Key Personnel, for which Plan Sponsor shall have certain rights, pursuant to Section 5.9 herein. There shall be no additional fee or charge for the Implementation Services or the services of the Implementation Manager or any other resource supporting the Implementation Services unless expressly provided for herein.

(d) Co-Administrators will complete all obligations set forth in the Implementation Plan, including the Implementation Timeline, within the timeframes specified therein (subject to any modifications as set forth in Section 3.2(b)) and acknowledge and agree that time is of the essence in fully completing the Implementation Plan to Plan Sponsor's satisfaction on or before the intended Services Start Date of January 1, 2026. During the Implementation Period, Co-Administrators shall provide regular, written updates to Plan Sponsor no less frequently than weekly on the status of the Implementation Plan, including: (i) the progress made by Co-Administrators towards completing the Implementation Services described in the Implementation Timeline by the corresponding completion date set forth therein; and (ii) advanced notice of any Customer Contingencies that are not fully satisfied or on track for completion by the due date.

(e) Plan Sponsor acknowledges and agrees that Co-Administrators' completion of certain components of the Implementation Plan is, in part, dependent on Plan Sponsor satisfying the Customer Contingencies in the Implementation Timeline. Co-Administrators shall not be responsible for Implementation Timeline dates that are delayed or not achieved to the extent such delay or non-performance is due to Plan Sponsor's (or its representatives or designee's, as applicable) failure to satisfy the corresponding Customer Contingencies.

(f) Co-Administrators acknowledge and agree that Plan Sponsor will incur substantial, real, and presently unascertainable damages if the Implementation Plan is not fully completed on or before January 1, 2026.

(g) Co-Administrators have established certain guarantees applicable to Co-Administrators' performance of the Implementation Services, as set forth in **Exhibit E**, subject to the terms and conditions set forth therein.

3.3 Renewal Terms. Upon conclusion of the Initial Term, this Agreement will thereafter automatically renew for successive one (1) year periods (each such annual renewal period, a "Renewal Term") unless Plan Sponsor provides at least thirty (30) days' prior written notice of termination ahead the conclusion of the Initial Term or then-current Renewal Term.

Section 4: Fees, Invoicing, and Claims Funding

4.1 Fees for Services.

(a) Fees for Co-Administrators' Services are described in **Exhibit A** and **Exhibit D** for Co-Administrators' medical benefit administration Services and **Exhibit B** for Co-Administrators' Pharmacy Services.

(b) If Plan Sponsor disputes any Fee due to Co-Administrators, Plan Sponsor will promptly notify Co-Administrators. Plan Sponsor agrees to meet with Co-Administrators in good faith to resolve any Fee discrepancies.

(c) Plan Sponsor may request that Co-Administrators provide Services in addition to those set forth in this Agreement and if Co-Administrators agree to provide such Services, such additional services and associated Fees shall be agreed to in an amendment to this Agreement executed by the Parties.

4.2 Bank Account.

(a) Co-Administrators and Plan Sponsor shall maintain a joint bank account with a banking institution of Plan Sponsor's choice that is not under any receivership (the "Bank Account") for the purpose of payment of: (i) Claims for Plan benefits authorized for payment by Plan Sponsor; (ii) Plan-Sponsor authorized Plan expenses (e.g., state surcharges and assessments); (iii) other Plan Sponsor financial obligations authorized for payment by Plan Sponsor; and (iv) Fees authorized by Plan Sponsor.

(b) Payments authorized by Plan Sponsor to providers for Clean Claims will be processed through the Bank Account, provided, however, that in no event shall such funds or payments be commingled with non-Plan funds or payments.

(c) When this Agreement terminates, the Bank Account funding method will remain in place for the length of the Run-Out Period, and Co-Administrator shall continue providing all applicable reporting relevant to Claims and related funding, including reports Plan Sponsor needs for the purposes of performing

escheat. Upon conclusion of the Run-Out Period, Plan Sponsor may close the Bank Account and retain all records relating thereto.

4.3 Invoicing, Payment Authorization and Payment of Fees.

(a) **General Invoicing and Payment Requirements**. During the Term, invoices for Fees for Co-Administrator's Services are generated using monthly enrollment provided by Plan Sponsor. In the event that a required invoice or funding/funding authorization date falls on a weekend or banking holiday, the invoice shall be provided or the payment made/authorized, as applicable, on the first business day thereafter. Co-Administrators' invoices for Fees will contain at least the level of detail required by the "Sample Monthly Invoice" included within **Exhibit G**. Plan Sponsor must issue a payment authorization to Co-Administrators before Co-Administrators are authorized to draw any funds from the Bank Account as payment for Fees. Upon receipt of Plan Sponsor's payment authorization, Co-Administrators may draw funds from the Bank Account in an amount equal to the authorized Fee payment amount.

(b) **Administrative Fee Invoices and Payment**: Co-Administrators will provide Plan Sponsor an invoice for administrative Fees on the last business day of every calendar month for Fees for Services performed by Co-Administrators for such calendar month. In the event that such invoice date falls on a weekend or banking holiday, the invoice shall be provided on the first business day thereafter. Within seven (7) days following Plan Sponsor's receipt of Co-Administrators' valid invoice for the Fees described in this subsection (b), Plan Sponsor shall issue a payment authorization for undisputed Fees.

(c) **Shared Savings/Out of Network Program Fee Invoices and Payment:** Co-Administrators will provide Plan Sponsor an invoice for Fees for shared savings and out of network programs on the tenth (10^{th}) day of every calendar month for Services performed by Co-Administrators in the prior month. No later than the last day of the month Plan Sponsor receives Co-Administrators' valid invoice for the Fees described in this subsection (c). Co-Administrators' invoices for such Fees will contain at least the level of detail required on the "Sample Monthly Invoice – Non-Claims" included within **Exhibit G**, Plan Sponsor shall issue a payment authorization for undisputed Fees.

(d) **Late Payment.** Subject to any applicable restrictions set forth in **Appendix A**, if undisputed amounts owed are not authorized for payment by Plan Sponsor within fifteen (15) days of their due date, Plan Sponsor will pay Co-Administrators interest on these amounts at the interest rate that Co-Administrators charge to their self-funded customers, provided that such interest rate shall not exceed the lesser of the maximum amount permitted by applicable Law or five percent (5%). Plan Sponsor shall reimburse Co-Administrators for any external costs that Co-Administrators incur to collect overdue amounts.

4.4 Claim Funding

(a) **Responsibility for Payment of Plan Benefits.** The Plan is self-funded. Plan Sponsor is solely responsible for providing funds for payment for all Plan benefits. Co-Administrators have no liability or responsibility to provide these funds.

(b) **Funding for Claims Reimbursement.** Co-Administrators will administer payments for undisputed Claims out of the Bank Account as follows:

(i) Co-Administrators shall audit and approve Claims in accordance with the requirements of the Agreement.

(ii) Co-Administrators will, no later than 10:00am ET on each business day, provide Plan Sponsor with a daily Claims funding invoice substantially in the form of the "Daily Invoice Template" included in **Exhibit G**, which will: (A) list and include supporting documentation regarding only Clean Claims audited and approved by Co-Administrators; and (B) directly correspond to the Claim funding amount requiring Plan Sponsor's authorization.

(iii) Plan Sponsor shall authorize such funding amounts by 12:00pm noon ET of the business day following the day on which the daily Claims funding invoice is issued. Upon receipt of Plan Sponsor's payment authorization, Co-Administrators will pull funds from the Bank Account in an amount equal to the amount authorized by Plan Sponsor and issue payment to the billing provider in respect of such Claims funded by Plan Sponsor.

(iv) Plan Sponsor will notify Co-Administrators of any disputed Claims and such Claims will be pended (and not funded or required to be funded) by Plan Sponsor until such time as the disputed Claim is resolved, subject to applicable Laws regarding prompt payment of claims.

(v) In the event that a required invoice or funding/funding authorization date falls on a weekend or banking holiday, the invoice shall be provided or the payment made/authorized, as applicable, on the first business day thereafter.

(c) To the extent applicable, Co-Administrators will automatically stop payment on all checks that have not been cashed within one hundred and eighty (180) days of issuance.

(d) Co-Administrators will provide Plan Sponsor with reports and funds corresponding to unclaimed payments for the purposes of performing escheat. Plan Sponsor is solely responsible for making unclaimed payee payments directly.

(e) If Plan Sponsor does not provide the required authorization for funding on a timely basis, Co-Administrators shall provide prompt notice to Plan Sponsor and Plan Sponsor must, within three (3) business days of receiving Co-Administrators' notice, correct the funding deficiency.

(f) Following the three (3) business day grace period described above, Co-Administrators may elect not make payments nor issue checks for any Claims for which there are not adequate available funds, until such time as the funding deficiency is corrected. If Plan Sponsor does not correct the funding deficiency within seven (7) business days, Co-Administrators may suspend performance of any of its other Services under this Agreement.

4.5 Late Payments due to Late Approval or Underfunding. In no event shall Co-Administrators release, or be held responsible, for issuing any funds for Claims, in the event that Plan Sponsor fails to timely (a) provide appropriate funding for such Claims, or (b) approve Claims funding amounts requiring Plan Sponsor's authorization. Co-Administrators agree to set a mutually agreeable daily funding obligation cap that will be determined prior to the Service Start Date and re-evaluated as needed. In the event Plan Sponsor's daily funding obligation is anticipated to exceed this cap for any given day during the Term, Co-Administrators will immediately notify Plan Sponsor and not fund any excess amounts until the subsequent business day. If Plan Sponsor requests that Co-Administrators cease paying Claims for up to two (2) business days, Co-Administrators agree to use best efforts to comply with Plan Sponsor's request, with the understanding that if Clean Claims are paid by Co-Administrators during such holding period, such payment will not be deemed a breach of this Agreement by Co-Administrators and Plan Sponsor will be responsible for ultimately funding such Claim payments. Plan Sponsor agrees to be responsible for any costs, fines or penalties actually incurred by Co-Administrators as a result of Co-Administrators complying with Plan Sponsor's Claims hold request.

Section 5: Co-Administrator Obligations

5.1 Standard of Care.

(a) Co-Administrators shall provide the Services to Plan Sponsor and administer Claims in accordance with the Plan Documents and all specifications set forth herein. Co-Administrators shall perform the Services and other functions, responsibilities and duties contemplated hereunder in a professional, competent and efficient manner in accordance with the professional standards similarly-situated, nationally recognized industry leaders would exercise in administering plans with a size and composition comparable to the Plan. All Services shall be performed to the satisfaction of Plan Sponsor and Co-Administrators agree to perform all aspects of the Services with full and prompt cooperation with Plan Sponsor and its designees.

(b) Each Co-Administrator shall interact with Participants and Plan Sponsor designees in accordance with the same standard of care as it deploys in performing Services directly to Plan Sponsor.

(c) Each Co-Administrator shall monitor and disclose to Plan Sponsor any direct or indirect business arrangements that potentially conflict with its ability to perform the Services and discharge its duties with respect to the Plan in accordance with this Section 5.1. Each Co-Administrator shall, promptly upon discovery, disclose to Plan Sponsor any such conflict, including details regarding the nature of any such conflict.

5.2 Management of Plan Assets.

(a) All funds and other Plan assets received or otherwise maintained by or accessible to Co-Administrators in connection with the Services shall be held in a separate, designated account by Co-Administrators and maintained, used, and/or distributed (including with respect to Fees) only as specifically permitted or contemplated by this Agreement, the Plan Documents, and applicable Law. Co-Administrators shall administer Plan assets received or otherwise maintained by or accessible to Co-Administrators fairly, honestly, in good faith and solely in the best interests of Plan Sponsor.

(b) In the event either Co-Administrator receives funds, directly or indirectly, that are attributable to or contingent on Services performed by such Co-Administrator for the Plan or its Participants from any source other than Plan Sponsor, such revenue shall be passed through to Plan Sponsor pro-rata (the amount attributable to the Services performed in respect of the Plan as a percentage of overall services connected to the source of compensation). Medical Benefit Drug Rebates and those payments specifically identified as being subject to shared savings as set forth in **Exhibit D** shall be exempt from this Section 5.2(b).

(c) Plan Sponsor shall have access to all financial and utilization information related to the Services, including information regarding funds permitted to be retained by Co-Administrators pursuant to Section 5.2(b) above.

5.3 CAA Compliance. The Parties agree that nothing in this Agreement, including any restrictions on use and disclosure of Co-Administrator Confidential Information or Plan Sponsor Confidential Information as set forth herein, shall be construed as the Parties' intent to violate Title II, Section 201 of the Consolidated Appropriations Act of 2021 and rules, subregulatory guidance and regulations promulgated thereunder, as amended or as may be amended from time to time (the "CAA"). Co-Administrators further acknowledge that in accordance with the CAA, no later than December 31st of each year, Plan Sponsor must enter into a Gag Clause Prohibition Compliance Attestation ("GCPCA") attesting compliance with applicable Law. In order for Plan Sponsor to comply with its own GCPCA obligations, Co-Administrators shall make an

annual attestation to Plan Sponsor as required by the GCPCA, and shall, on behalf of Plan Sponsor, prepare and file pharmacy benefits and drug cost reports and air ambulance claims reports as required under the CAA.

5.4 NYS General Municipal Law Compliance. Co-Administrators acknowledge that Plan Sponsor is a "public corporation" for purposes of New York General Municipal Law § 92-a. As a result, this Agreement and the Services performed hereunder are subject to the contract administration requirements mandated by New York General Municipal Law § 92-a(6), as it may be amended from time to time.

5.5 Representations and Warranties of Co-Administrators. In addition to any specific representations made by any Party in other provisions of this Agreement, including those set forth in Article 2 of **Appendix A**, each Co-Administrator represents, warrants, and covenants that as of the Effective Date and throughout the Term and the Run-Out Period (unless such other timeframe is indicated):

(a) Any and all responses, information, and other materials supplied by Co-Administrator and/or its Affiliates or intended Subcontractors in connection with the Negotiated Acquisition or this Agreement were, as of the date of submission of such materials, and, except for immaterial operational updates that shall have no bearing on Co-Administrators' ability to execute obligations under this Agreement, or other changes for which Co-Administrators shall provide notice pursuant to the terms of this Agreement, shall be, true, accurate, and complete in all material respects;

(b) Co-Administrator and each of its Affiliates involved in the delivery of Services to Plan Sponsor is a corporation duly organized, validly existing, and in good standing under the laws of its jurisdiction of incorporation, with full corporate power and authority to execute, deliver, and perform this Agreement and each obligation assumed by it hereunder;

(c) Co-Administrator possesses all authority necessary for Co-Administrator to enter into and perform its obligations under this Agreement and to bind its Affiliates to the relevant provisions of this Agreement;

(d) The execution, delivery, and performance of this Agreement (including performance resulting from Plan Sponsor's exercise of its rights hereunder) by Co-Administrator does not and will not: (i) contravene, conflict with, or result in any breach or violation of any provision of the certificate or articles of incorporation, bylaws, operating agreement, partnership agreement, or other organizational documents of Co-Administrator or of any of its Affiliates; (ii) constitute an ultra vires act or otherwise exceed the organizational powers of Co-Administrator or any of its Affiliates; (iii) violate, conflict with, or result in a breach of any term or provision of, or constitute a default under, any contract, instrument, or other legally binding arrangement to which Co-Administrator is a party;

(e) Co-Administrator is and shall be duly licensed under applicable Law and regulations to enter into this Agreement and perform the Services set forth in this Agreement including, without limitation, any services or functions which have been delegated to Co-Administrator by Plan Sponsor, and shall maintain such unrestricted license and authorization during the Term;

(f) Co-Administrator has extensive professional experience and expertise in performing the Services and sufficient quantities of qualified and skilled project staff required to render the Services in a competent, professional and timely fashion;

(g) Neither Co-Administrator nor any of its Affiliates, Subcontractors, or personnel is an Excluded Party; Co-Administrator does not employ or contract with any Person, including any Network

Provider, that employs or contracts with an Excluded Party for the provision of health care, utilization review, clinical work, or any services related thereto;

(h) Co-Administrator is not in violation of any applicable Law or Plan Sponsor policies applicable to the performance of the Services or fulfillment of its obligations hereunder;

(i) To Co-Administrators' knowledge, there are no actions, lawsuits, investigations or other proceedings pending or threatened against Co-Administrator or its Affiliates that have or would reasonably be expected to materially and adversely affect the ability of Co-Administrator or its Affiliates to perform the Services or satisfy its obligations hereunder;

(j) The collection, access, use, storage, disposal and disclosure of Participant information by Co-Administrator and its Affiliates does and will comply with HIPAA and all applicable federal and state Laws and Data Privacy and Security Requirements;

(k) The Services, the Systems, and the delivery and use thereof (including use by Plan Sponsor or its designee(s)) do not infringe upon the intellectual property rights of any third party;

(l) All arrangements between Co-Administrators, including the JV Agreement, and their respective Affiliates are in compliance with all applicable Laws, and Co-Administrator and its Affiliates have not engaged in any conduct, including any conduct in connection with the JV Agreement, in violation of such Laws;

(m) No commissions, fees, or payments will be made by Co-Administrator to any Person in connection with this Agreement or in respect of the Plan, except as explicitly permitted herein or expressly permitted by Plan Sponsor in writing. Notwithstanding the above, this subsection shall not apply to commissions, fees, or payments made by Co-Administrator to any employee of such Co-Administrator;

(n) Emblem represents and warrants that, as of the Effective Date, the Covered Emblem Affiliates are not subject to any actual or anticipated change of control described in Section 11.5; and

(o) UMR represents and warrants that, as of the Effective Date, UMR is not subject to any actual or anticipated change of control described in Section 11.6.

Each Co-Administrator further represents that Co-Administrator is solvent and possesses sufficient assets, resources, and reserves to fully perform its obligations and the Services under this Agreement. Each Co-Administrator agrees that, upon Plan Sponsor's written request at any time during the Term, Co-Administrator shall promptly provide Plan Sponsor with reasonable evidence of such solvency, which may include, but is not limited to, current financial statements, balance sheets, or other documentation as reasonably requested by Plan Sponsor. Failure to provide such evidence within a reasonable period of time, as specified by Plan Sponsor, shall constitute a material breach of this Agreement.

5.6 Guarantees; Credits; Reporting.

(a) **Guarantees.** Guarantees applicable to certain components of Co-Administrators' Services are set forth in **Exhibit E**. Unless a different Guarantee period applicable to any particular Guarantee is specifically set forth in **Exhibit E**, the first "Guarantee Period" for each Guarantee shall begin on the Service Start Date, and shall extend for the twelve (12) month period thereafter during the first year of the Agreement (Year 1), with each subsequent 12-month period thereafter constituting the relevant Guarantee Period for each subsequent contract year (Year 2, etc.) When reporting is available after the end of the respective Guarantee Period (no later than six (6) calendar months following the end of such period or such

other timeframe agreed to by Plan Sponsor), Co-Administrators will produce and deliver to Plan Sponsor a comprehensive written report detailing Co-Administrators' Performance Guarantee performance for the preceding quarter. Failure to achieve the specified Performance Guarantees will result in a penalty payment payable by (including as an offset to Co-Administrators' Fees) Co-Administrators in the amount specified for the corresponding Performance Guarantee listed on **Exhibit E**.

(b) **Plan Sponsor Payments; Credits.** Any credits or other amounts payable, reimbursable, or refunded to Plan Sponsor pursuant to any exhibit incorporated herein, including, without limitation, **Exhibit D** and **Exhibit E**, shall be either credited as an offset to Fees payable to Co-Administrators or paid to Plan Sponsor (such payment method subject to Plan Sponsor's discretion) within thirty (30) days of the date on which such payment obligation accrues, unless such other payment timeframe is specified in the applicable exhibit or requested by Plan Sponsor.

(c) **Non-Exclusive Remedies.** The guarantees established in **Exhibit E** are not an election of exclusive remedies and are compensation terms intended solely to establish specified performance and implementation commitments and the corresponding credits, adjustments, or other amounts payable, reimbursable, or refunded to Plan Sponsor by Co-Administrators in the event of a failure to achieve the guarantee requirements or standards. All such payments and adjustments shall be in addition to, and not in substitution for, any other rights or remedies that may be available to Plan Sponsor arising from or relating to a Co-Administrator or Subcontractor's breach of any requirement of this Agreement.

(d) **Reports.** Co-Administrators will provide various reports and reporting tools to Plan Sponsor and its designees during the Term, including the reports identified on **Exhibit A**, **Exhibit B**, **Exhibit F** and elsewhere within this Agreement. Co-Administrator may also request ad hoc, non-standard reports from time to time. Co-Administrators shall promptly correct any errors or inaccuracies discovered in the reports delivered under this Agreement.

5.7 Co-Administrator Joint Venture Agreement.

(a) The Parties acknowledge that Co-Administrators are the parties to that certain Amended and Restated Contractual Joint Venture Agreement entered into as of [•], 2025 (the "JV Agreement"). Pursuant to the JV Agreement, each Co-Administrator has agreed to perform certain duties and obligations intended to facilitate their performance under this Agreement. Co-Administrators agree that a complete and accurate copy of the JV Agreement and all appendices, exhibits, attachments, and other ancillary agreements or instruments related thereto have been provided to Plan Sponsor as of the Effective Date and that no other agreement or instrument exists between such parties or their respective Affiliates that relates to or otherwise impacts the relationship described thereunder or the Services to be performed hereunder. Co-Administrators further agree that the JV Agreement may not be (i) terminated or assigned during the Term without Plan Sponsor's prior written consent, which may be withheld by Plan Sponsor in its sole and absolute discretion, or (ii) materially amended or modified during the Term without providing Plan Sponsor written notice of the proposed amendments or modifications at least thirty (30) days' prior to the intended effective date of the change. During the Term, Plan Sponsor shall maintain information rights and observer rights to the Joint Operating Committee's (as defined in the JV Agreement) activities, meetings, and meeting materials and be provided notice of any Joint Operating Committee meeting at least two (2) weeks prior to the date of such meeting. For the avoidance of doubt, this Agreement, and not the JV Agreement, constitutes the entire agreement between the Parties with respect to the Services and Co-Administrator's obligations, duties, and liabilities with respect to the Plan and Plan Sponsor, and the JV Agreement shall not be deemed to control in the event of any conflict between the provisions of this Agreement and the JV Agreement.

(b) The Parties agree that references in **Appendix A** to "Contractor" shall be read to refer either to Co-Administrators or to each Co-Administrator, depending on the context of the relevant provision.

5.8 Reliance on Co-Administrator Authority. Except as expressly stated to the contrary in this Agreement or any other instrument incorporated herein by reference, Plan Sponsor is fully authorized to accept, rely upon, and act on any instruction, approval, consent, waiver, or other communication from either Co-Administrator acting alone, without any requirement for Plan Sponsor to seek confirmation from the other Co-Administrator, and any action Plan Sponsor takes in reliance on such Co-Administrator instruction, approval, consent, or communication will be considered authorized and binding on both Co-Administrators.

5.9 Staffing; Key Personnel. Co-Administrators shall recruit and maintain personnel adequately trained and skilled to perform their obligations under this Agreement and possessing at least such training, knowledge and experience as is regarded as industry standard in the provision of the tasks to which they are assigned. Co-Administrators shall honor written requests by Plan Sponsor to remove Key Personnel if Plan Sponsor reasonably believes such individual is not qualified to perform the Services, is not performing such Key Personnel's functions to Plan Sponsor's reasonable satisfaction, or does not meet appropriate professional standards. Plan Sponsor shall have the right to approve replacement Key Personnel. Co-Administrators shall take all reasonable steps to minimize the turnover of personnel, including Key Personnel, assigned to perform the Services hereunder, and shall provide at least thirty (30) days prior written notice to Plan Sponsor in advance of any changes to Key Personnel.

5.10 Communication; Issue Escalation.

(a) Co-Administrators' personnel shall acknowledge all Plan Sponsor requests and inquiries promptly and no later than the business day immediately following Co-Administrator's receipt of such requests or inquiries. Issues identified by Plan Sponsor as material or time-sensitive shall be escalated for resolution by appropriate Co-Administrator management personnel within twenty-four (24) hours of Plan Sponsor's request.

(b) Co-Administrator Key Personnel and other requested leadership team attendees will meet with Plan Sponsor and its designees on no less than a monthly basis to review Co-Administrators performance hereunder.

(c) Co-Administrators will maintain an issue log to track the status of all issues related to the Services performed hereunder. A copy of the issue log will be provided to Plan Sponsor at least three (3) business days prior to each recurring status call described in subsection (b) above, with an updated issues log provided to Plan Sponsor no later than three (3) business days following each recurring status call.

5.11 Obligations with Respect to Plan Sponsor and Participant Information. Co-Administrators shall comply, and shall ensure each Affiliate and Subcontractor complies, with all Data Privacy and Security Requirements and the requirements relating to Plan Sponsor and Participant information set forth in **Appendix B, Appendix C-1** and **Appendix C-2**, and **Exhibit C**.

5.12 Compliance with Anti-Corruption Laws. In addition to complying with the covenants of Section 4.07 of **Appendix A**, Co-Administrators will make clear to all respective Affiliates and intended Subcontractors that Co-Administrators do not condone or accept the payment of bribes (including, without limitation, "facilitation payments" or nondescript "performance bonuses"). Co-Administrators will make and keep accounts and records which accurately and fairly reflect any transactions made as part of its operations, especially as it relates to Plan Sponsor and the Plan assets. Co-Administrators will report and

provide records surrounding any financial disbursements to billing providers, rendering providers, or any third-party intermediaries or other Persons not paid in consideration for a direct service to a Participant and/or in response to a Claim. Co-Administrators will promptly notify Plan Sponsor of any request or demand for unearned financial or nonfinancial advantage of any kind made to Co-Administrators in connection with its performance of the Services or any suspected violation of applicable Law.

5.13 Plan Benefits Litigation. If a demand is asserted, or litigation or administrative proceedings are initiated by a Participant, provider, or other Person that seeks or entails payment of Plan benefits to any Person ("Plan Benefits Litigation"), the following shall apply:

(a) If Plan Benefits Litigation is commenced solely against Plan Sponsor and/or the Plan and does not name Co-Administrators or any of their respective Affiliates as a party, Plan Sponsor shall have the exclusive right to select and retain counsel in connection with such defense at Plan Sponsor's expense (subject to the indemnification provisions set forth in Section 8).

(b) If the Plan Benefits Litigation names, implicates, or threatens either Co-Administrator or any of their respective Affiliates, Co-Administrators shall: (i) promptly investigate upon advice of qualified counsel whether: (A) the Plan Benefits Litigation is properly directed to Co-Administrators or should instead be directed to Plan Sponsor; and (B) whether the Plan Benefits Litigation is based exclusively on the design or availability of Plan benefits and not Co-Administrators Services; and (ii) within two (2) business days after it is determined that the claim entails payment of Plan benefits (and with respect to such claims that substantially or exclusively pertain to design or availability of Plan benefits, as evident on the face of the claim, in no event more than ten (10) calendar days after Co-Administrators or their Affiliates are notified of the existence of the Plan Benefits Litigation), provide written notice to Plan Sponsor describing the nature of the claim, the relief sought, and the date by which a response is due, in addition to providing all pleadings, and documentation reasonably related to such Plan Benefits Litigation.

(c) If the Plan Benefits Litigation is determined to be based exclusively upon the design or availability of Plan benefits (and not Co-Administrators' Services hereunder), Co-Administrators shall, immediately upon reaching such conclusion, notify Plan Sponsor and tender the defense of the matter to Plan Sponsor (or to another Person designated in writing by Plan Sponsor). Plan Sponsor may thereafter: (i) assume full control of the defense and settlement of the Plan Benefits Litigation, or (ii) authorize Co-Administrators and their counsel to continue to represent Plan Sponsor's interests, provided that any such authorization may be conditioned, limited, or revoked at any time by written notice from Plan Sponsor.

(d) If Plan Benefits Litigation is initiated against Plan Sponsor and/or the Plan and either or both of the Co-Administrators are named as parties, and provided no conflict of interest arises between such Persons, the Parties subject to the Plan Benefits Litigation shall confer in good faith regarding joint representation. In the absence of a written agreement to joint representation executed by Plan Sponsor, each Party subject to the Plan Benefits Litigation shall retain separate counsel.

(e) If Plan Sponsor agrees that Co-Administrators will perform any function in connection with Co-Administrators' defense, settlement, or resolution of Plan Benefits Litigation outside the scope of Co-Administrators' Services—and provided that Co-Administrators are not already legally or contractually obligated to fund such amounts pursuant to this Agreement, including Section 8, the allocation of all reasonable attorneys' fees, costs, and expenses incurred by Co-Administrators in performing such functions shall be determined by a written cost-sharing arrangement approved by Plan Sponsor.

(f) In connection with defense, settlement, or resolution of any Plan Benefits Litigation, Co-Administrator(s) shall: (i) obtain Plan Sponsor's written consent prior to entering into any settlement agreement, which consent shall not be unreasonably withheld, that entails expenditure of Plan assets or

otherwise binds Plan Sponsor in any respect; (ii) cause their respective Affiliates, directors, officers, employees, agents, and Subcontractors to cooperate fully with Plan Sponsor and Plan Sponsor's counsel and provide periodic updates regarding the status of such Plan Benefits Litigation upon Plan Sponsor's request; and (iii) promptly make available to Plan Sponsor, in the manner and format requested, all documents, data, testimony, or other information in their possession, custody, or control that Plan Sponsor reasonably deems relevant to the defense or resolution of the matter.

(g) Nothing in this Section 5.13 shall be construed to limit, restrict, or waive in any respect Co-Administrators' indemnification and hold harmless obligations set forth in Section 8.

Section 6: Plan Responsibilities

6.1 Responsibility for the Plan. Co-Administrators are not the administrator of the Plan. Any references in this Agreement to Co-Administrators "administering the Plan" are descriptive only and do not confer upon Co-Administrators any responsibilities or duties beyond the duties expressly set forth herein. Except with respect to Co-Administrators' Services hereunder, Plan Sponsor is responsible for the Plan, including its benefit design, the legal sufficiency and distribution of the Plan Documents, and compliance with any Laws that apply to Plan Sponsor or the Plan. Plan Sponsor agrees that the Plan has the authority to pay from Plan assets all Fees due under this Agreement.

6.2 Plan Design and Administration.

(a) Co-Administrators will conduct all Services and shall administer all Claims in accordance with the requirements of this Agreement and the Plan Documents, as they may be amended from time to time.

(b) Co-Administrators represent and warrant that Plan Sponsor's Plan Documents made available by Plan Sponsor prior to the Effective Date can be fully administered by Plan Sponsor in accordance with all specification set forth therein and in this Agreement. Co-Administrator's Services and Claims administration practices will fully conform with the Plan Documents, delivered as of the Effective Date, in all respects and will not be impeded in any manner, including as a result of implementation errors or delays or conflicts between the initial Plan Documents and Co-Administrator's Network Provider agreements.

(c) Following the Effective Date, Plan Sponsor may modify its Plan Design at any time during the Term. Such modifications may include, but are not limited to: (i) modifications to copays, deductibles, covered services, benefit reimbursement levels (including benefit reimbursement levels applicable to services delivered by non-Network Providers); eligibility rules, and other benefit elements under the Plan; (ii) imposing pre-payment Claim audit requirements or prohibitions on Co-Administrators issuing provider reimbursement for disputed Claims; (iii) imposing custom prior authorization, utilization review, or utilization management criteria or other requirements; or (iv) any change designed to create varying cost-sharing and/or reimbursement levels for preferred and non-preferred providers/facilities.

(d) Co-Administrators will implement Plan Sponsor's requested Plan Design modifications within the timeframes requested by Plan Sponsor; provided, however, that Co-Administrators can only guarantee that Plan Sponsor's requested modifications will be incorporated within the following timeframes following Plan Sponsor's written request (subject to any Network Provider-specific limitations set forth below under Section 6.2(f)): (i) thirty (30) days' notice for changes that do not require Co-Administrators to provide any advance member notice, re-issuance of Plan materials, or Provider Network contractual changes or amendments (e.g., deductibles, cost-sharing changes); (ii) ninety (90) days' notice for changes that require advance Participant notice or re-issuance of Plan materials (including ID cards), but do not

require amendments to Network Provider agreements (e.g., changes to co-pays (which requires reissuance of ID cards)), changes to benefits (which would require advanced notice and delivery of new Plan materials to Participants, etc.); or (iii) one hundred and eighty (180) days' notice for changes that would require changes to Network Provider agreements (e.g., varying cost-sharing and/or reimbursement levels for preferred and non-preferred providers/facilities etc.), subject to any residual Network Provider agreement conflicts described in Section 6.2(f) below.

(e) Plan Sponsor shall collaborate in good faith with Co-Administrator(s) and provide all information and data reasonably necessary for Co-Administrator to effectuate such changes in a timely manner. The Parties will, as applicable, update the Plan Documents to reflect Plan Sponsor's requested Plan Design modifications.

(f) Plan Sponsor acknowledges that certain Network Provider agreements may contain provisions that conflict with Co-Administrators' ability to perform Services in accordance with Plan Design changes made by Plan Sponsor after the Effective Date. Notwithstanding the foregoing, to the extent that any Network Provider located in the Downstate Counties, or any Network Provider subject to a Material Network Provider Contract that is located outside of the Downstate Counties, has an agreement that conflicts with Co-Administrators' ability to perform Services in accordance with Plan Sponsor's required Plan Document modifications, Co-Administrators will notify Plan Sponsor of the applicable conflict pursuant to Section 6.2(g) below and discuss such conflict with Plan Sponsor during the monthly meetings described under Section 5.10, with such notice it being agreed that Co-Administrators shall, unless otherwise requested by Plan Sponsor, engage in affirmative outreach to each such applicable Network Provider with a conflicting Network Provider agreement within thirty (30) days of Plan Sponsor's Plan Design modification request, in order to seek to amend the conflicting Network Provider agreement prior to the date the Plan Design modification takes effect. Co-Administrators will resolve any Claims adjudication conflict arising as a result of the conflicting Network Provider agreement provision and the Plan Design modifications (except for those conflicts described in Section 6.3(c)) in favor of the relevant Network Provider agreement until such time as the conflicting Network Provider agreement is amended by Co-Administrators.

(g) During the thirty (30) day period following Co-Administrators' receipt of Plan Sponsor's written request for any Plan Design modification (or such other timeframe specified in Section 6.12(e)), Co-Administrators may deliver an Impact Statement to Plan Sponsor in order to communicate: (i) a listing of any applicable Network Provider agreement that will conflict with the requested Plan Design modification in accordance with Section 6.2(f), including information regarding the applicable Network Providers impacted by such conflict, and a description of the efforts Co-Administrators will undertake to remediate the conflict; and/or (ii) as applicable, any Proposed Adjustment from the requested Plan Document modification, along with documentation supporting Co-Administrators' calculation of such Proposed Adjustment. Co-Administrators agree that any Proposed Adjustment resulting from a Plan Document modification that contemplates increased Fees or negative impacts to Plan Sponsor's Guarantee position shall: (A) with respect to Fees, solely relate to additional administrative costs that Co-Administrators will incur as a result of the Insourced Services; or (B) with respect to any Guarantee, be in proportion to the actual impact of the Insourced Services to the at-issue Guarantee. Plan Sponsor shall have the right to approve the Proposed Adjustment or dispute the Proposed Adjustment in accordance with Section 6.12.

6.3 Network Provider Agreements.

(a) Within ten (10) days following the Effective Date and the date of any Plan Sponsor request thereafter, Co-Administrators shall provide Plan Sponsor a report listing (i) all Material Network Provider Contracts subject to expiration or renewal in the following eighteen (18) months, and (ii) all Material

Network Provider Contracts that Co-Administrators anticipate will otherwise be subject to negotiation, amendment, re-contracting, rate changes, or other contractual adjustments or modifications in the following eighteen (18) months, including any Network Provider agreement modifications to be negotiated by Co-Administrators in accordance with Section 6.2(f). Such report shall include the Network Providers covered by each such Material Network Provider Contract, the date any such Material Network Provider Contract will expire or terminate if not renewed, and any other information requested by Plan Sponsor that is reasonably necessary for Plan Sponsor's evaluation of any anticipated Plan impact resulting from the Network Provider agreement modifications. Co-Administrators shall provide updates to Plan Sponsor and its designees on the status of any Network Provider agreement negotiations and address any Plan Sponsor concerns related to such negotiations at the monthly meetings between the Parties, as set forth under Section 5.10(b), in addition to any Material Network Provider Contract-focused meetings requested by Plan Sponsor.

(b) Each Co-Administrator will permit Plan Sponsor to participate in contract negotiations impacting any Material Network Provider Contract and assist Plan Sponsor in preparation and negotiation of Customer-Specific Provider proposals and agreements upon request by Plan Sponsor.

(c) Co-Administrators represent and warrant that Co-Administrators have, prior to the Effective Date, provided Plan Sponsor an accurate and complete list of: (i) all Network Provider agreements covering providers located in the Downstate Counties and all Material Network Provider Contracts covering providers located outside the Downstate Counties, that will conflict with Co-Administrator's ability to perform the Services or administer Claims in accordance with, the Plan Documents; or (ii) solely with respect to Network Provider agreements covering providers located in a Downstate County or the healthcare facilities or systems known as [redacted] all Network Provider agreements that would conflict with Co-Administrator's ability to perform the Services or administer Claims in accordance with Plan Design modifications involving varying cost-sharing and/or reimbursement levels for preferred and non-preferred providers/facilities without restriction.

(d) During the Term, Co-Administrators will not, and will ensure their respective Affiliates will not, without first discussing and obtaining the verbal agreement of Plan Sponsor's authorized representatives, such agreement to be memorialized in writing, or otherwise approved by, Plan Sponsor, enter into any (i) new Network Provider agreements covering providers located in the Downstate Counties; (ii) new Network Provider agreements covering the healthcare facilities or systems known as [redacted]; or (iii) renewals of or addenda/amendments to existing Network Provider agreements covering any provider described in subsections (i)-(ii) of this subsection (d), to the extent entry into such agreement by either Co-Administrator or their respective Affiliates would limit Plan Sponsor or Co-Administrators' ability to administer the Plan in accordance with the requirements of this Agreement and Plan Sponsor's Plan Documents, or any potential Plan Design changes described in Section 6.2(c).

(e) If any agreement (i) required to be disclosed by Co-Administrators pursuant to Section 6.3(c) is not properly disclosed to Plan Sponsor; (ii) is executed, renewed, amended, or otherwise modified by Co-Administrators in violation of Section 6.3(d); or (iii) is not amended as a result of Co-Administrator's failure to affirmatively engage in outreach to amend such agreement where required pursuant to Section 6.2(f); and such agreement results in a conflict with Plan Sponsor's Plan Design, Co-Administrators shall hold Plan Sponsor harmless for any Claim funding liability in excess of the amount payable in respect of such Claim if the Claim were processed in accordance with Plan Sponsor's Plan Design.

6.4 Information Plan Sponsor Provides to Co-Administrators.

(a) Plan Sponsor shall, and, as applicable, shall ensure that the City of New York municipal sub-division/participating employers furnishing eligibility information regarding certain Eligible Individuals and Participants (each such Person, an "Affiliated Membership Administrator") shall, provide Co-Administrators, in a reasonably timely manner and on an ongoing basis throughout the Term, all eligibility and enrollment information (and any changes thereto) available to such Persons that Co-Administrators reasonably require to provide Services under this Agreement. Co-Administrators will, based upon the data provided by Plan Sponsor and any Affiliated Membership Administrator, ensure appropriate benefit coverage under the Plan to only Eligible Individuals and their dependents (including, for example, any "split contracts" in which an Eligible Individual or any of their dependents would have coverage in the City of New York's Senior Care benefit plan, while the remainder of the family would have coverage under this Plan).

(b) Co-Administrators acknowledge and agree that no aspect of the Services or Co-Administrators' performance under the Agreement is contingent upon Plan Sponsor's personnel or the availability of Plan Sponsor resources, unless specifically stated herein (such as, for example, the Customer Contingencies identified on **Exhibit J**), and except for all provisions set forth herein specifically enumerating requirements for Plan Sponsor information, materials, consent or approval, with respect to which, Plan Sponsor shall act promptly and in good faith.

6.5 Eligibility for Coverage.

(a) Plan Sponsor has the ultimate and complete authority to determine eligibility and eligibility criteria (including determination of the date of coverage eligibility and eligibility coverage classes (i.e., single/family/split contractors)) of Eligible Individuals and their dependents. Plan Sponsor and, as applicable, any Affiliated Membership Administrator shall, in an accurate and timely manner, provide Co-Administrators with eligibility information as to which Eligible Individuals and their dependents are Participants. Eligibility and enrollment updates provided by Plan Sponsor and Affiliated Membership Administrator will be loaded by Co-Administrators promptly and in no event longer than three (3) business days following receipt.

(b) Co-Administrators may rely on the most current information made available to Co-Administrators by Plan Sponsor and Affiliated Membership Administrators regarding eligibility of Participants in paying Plan benefits and providing other Services under this Agreement. In the event of an Overpayment or denial resulting from a failure by Plan Sponsor or any Affiliated Membership Administrator to provide up to date eligibility information to Co-Administrators, Co-Administrators will reprocess all Claims impacted by the eligibility issue.

(c) Plan Sponsor must provide, and ensure Affiliated Membership Administrators provide, Co-Administrators with reasonable access to eligibility-related information that is necessary for Member Administration Services, and that will enable Co-Administrators to address any eligibility-related information that is not explicitly noted (or is otherwise in conflict) in the eligibility data feeds provided to Co-Administrators (e.g., ensuring seamless eligibility when Participants are moved from the "active" membership file to the "retiree" membership file, ensuring Participants are appropriately captured in the correct benefit plan for so-called "split contracts"). As part of its Member Administration Services, Co-Administrators will identify deficiencies or conflicts in eligibility-related information and data made available to Co-Administrators, including identification of any recurring or systemic issues with respect to any particular Affiliated Membership Administrator, provided, however, that Plan Sponsor acknowledges and agrees that Co-Administrators' performance of certain Member Administration Services is necessarily dependent on: (i) provision of the eligibility information by Plan Sponsor or the Affiliated Membership

Administrators; and (ii) availability of Affiliated Membership Administrator subject matter experts to address any deficiencies or conflicts in eligibility-related information and data, in each case as described in this Section 6.5.

6.6 Plan Branding; Notices to Participants. Plan branding shall be determined by Plan Sponsor, subject to approval by Co-Administrators, such approval not to be unreasonably withheld, conditioned, or delayed. Plan Sponsor shall give Participants the information and documents they need to obtain benefits under the Plan before coverage begins. In the event this Agreement is terminated, Plan Sponsor shall be responsible for notifications to Participants that the Services Co-Administrators are providing under this Agreement are discontinued, subject to any Run-Out Services to be performed by Co-Administrators.

6.7 Unclaimed Funds; Escheat. To the extent applicable, if any check issued by either Co-Administrator or any Affiliate or Subcontractor in satisfaction of a Claim that has been funded by the Plan remains unpaid after one hundred eighty (180) days, the moneys paid by Plan in satisfaction of such Claim (if any) shall be returned to Plan Sponsor. Plan Sponsor is solely responsible for complying with all applicable abandoned property or escheat Laws, making any required payments, and filing any required reports.

6.8 State and Federal Surcharges; Mandatory Reporting.

(a) Plan Sponsor is responsible for state and Federal surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan, or on a Co-Administrator solely to the extent such Tax is imposed upon such Co-Administrator in its capacity as the Claims Administrator of the Plan, including the funding and remittance of amounts due under PPACA and PCORI (which is remitted to the government).

(b) Co-Administrators shall be responsible for ensuring that appropriate payment is made on behalf of Plan Sponsor for all such required surcharges, assessments, or similar Taxes, including those specifically described in this Section 6.8, and shall provide, on a timely basis, all information, calculations, forms, and other analyses required in order for Plan Sponsor or its designees to validate such calculations and payments. Co-Administrators shall indemnify and hold Plan Sponsor harmless for any fees, costs, assessments, or penalties payable by Co-Administrators or Plan Sponsor that are related to either Co-Administrator's failure to adhere to the obligations set forth in this Section 6.8.

(c) Co-Administrators shall be responsible for the accurate calculation of all applicable Health Care Reform Act surcharges and Covered Lives Assessments based on Claims processed under this Agreement, in accordance with the provisions of New York State Public Health Law and associated regulations. Administrator shall timely remit all such calculated surcharges, assessments, and related reports and forms to the applicable regulatory body in a timely manner as required by Law.

6.9 Non-Exclusive Services.

(a) Notwithstanding anything to the contrary in this Agreement, Plan Sponsor may perform for itself or retain any other Person to perform, without restriction: (a) any function, product, or service that is not included within the definition of "Services" as of the Effective Date; (b) any function, product, or service that is not covered by the Plan; (c) employee assistance programs, workplace health and well-being programs, and other employee wellness programs; (d) post-payment Claims audit and clinical review functions that supplement (and do not replace) Co-Administrator's Services (e.g., MedReview); (e) audit of Co-Administrators' Services pursuant to this Agreement; and (f) functions relating to Direct Contracted Provider or Customer-Specific Provider arrangements that are not performed by Co-Administrators. For avoidance of doubt, Co-Administrators acknowledge and agree that nothing herein is intended to create an

exclusive arrangement and Plan Sponsor may either: (i) supplement Co-Administrators' Services, or (ii) insource certain Services subject to the process set forth in Section 6.10 below.

(b) Nothing herein shall prohibit Co-Administrators from bidding on any function, product, service, or Services subject to an Insourcing Request to the extent that Plan Sponsor intends to engage or solicit bids for such functions, products or services from any other Person.

6.10 Insourcing.

(a) Subject to, and in accordance with, the requirements set forth in this Section 6.10, Plan Sponsor may perform for itself or engage any other Person to perform any of the Services (such Services to be self-performed or outsourced, the "Insourced Service(s)") upon at least sixty (60) days' prior notice to Co-Administrators (the "Insourcing Request"). The Insourcing Request shall describe in reasonable detail the nature and scope of the proposed Insourced Services, the reason for such Insourcing Request, Plan Sponsor's requested implementation date, and any Proposed Adjustment, if applicable.

(b) Plan Sponsor shall not insource any Core Services, or other Services, to the extent that the requested Insourced Service would render it Infeasible for Co-Administrators to continue to perform any Core Services for the Plan. For example, pre-payment Claims review activities are not Core Services, but could be determined to render performance of Co-Administrators' Access/Administration of Provider Network Services Infeasible (e.g., if Co-Administrators maintain standard Network Provider agreement provisions that require only Co-Administrators to directly perform such pre-payment Claims review activities). Co-Administrators acknowledge and agree that Plan Sponsor may insource the Pharmacy Services described in **Exhibit B**, and that insourcing of such Pharmacy Services would not render performance of any Core Services Infeasible. For the avoidance of doubt, any Impact Statement with Proposed Adjustments that result from an Insourcing Request for Pharmacy Services shall be limited to costs that will be incurred by Co-Administrator through the transition of Pharmacy Services to another vendor, or any additional function that Plan Sponsor would require to service the new Pharmacy Services vendor to perform their work efforts for Plan Sponsor.

(c) Upon receipt of any Insourcing Request, Co-Administrators shall have an affirmative obligation to work in good faith on an expedited basis with Plan Sponsor to assess whether the Insourcing Request would make performance of the Core Services Infeasible. In performing this assessment Co-Administrators shall: (i) consider those non-Fee-based, identifiable operational, contractual, technical, or regulatory factors applicable to the determination based on consistent, objective, and documented criteria; (ii) consider alternative processes or accommodations that would permit Plan Sponsor to achieve its requested changes while preserving Co-Administrators' ability to perform the Core Services; and (iii) afford Plan Sponsor the maximum practicable operational flexibility.

(d) If, after completing the assessment described in subsection (c), Co-Administrators reasonably and in good faith determine that the Insourcing Request would make performance of Core Services Infeasible, Co-Administrators shall, as soon as possible and in any event no later than thirty (30) calendar days after receipt of the Insourcing Request, deliver to Plan Sponsor an Infeasibility Notice (as defined herein).

(d) Except where an Infeasibility Notice is timely provided, Co-Administrators may, within the thirty (30) calendar day period after receipt of an Insourcing Request, furnish to Plan Sponsor an Impact Statement. The Impact Statement shall: (i) specify the earliest practicable implementation date for the requested Insourced Services, it being agreed that Co-Administrators shall use best efforts to implement the Insourced Services by the date set forth in the Insourcing Request; (ii) describe any modifications required to interfaces, file layouts, business rules, or other policies, procedures or processes; (iii) set forth,

in reasonable detail and supported by contemporaneous documentation, any Proposed Adjustments; and (iv) identify any conflict the requested Insourced Services would create with then-existing Network Provider agreements. Co-Administrators shall provide, contemporaneously with any Impact Statement, all underlying cost studies, actuarial analyses, or other materials Co-Administrators relied upon in formulating the Proposed Adjustments. Co-Administrators agree that any Proposed Adjustments resulting from an Insourcing Request shall: (A) with respect to Fees, solely relate to additional administrative costs that Co-Administrators will incur as a result of the Insourced Services; or (B) with respect to any Guarantee, be in proportion to the actual impact of the Insourced Services to the at-issue Guarantee. Plans Sponsor may dispute any Infeasibility Notice or Proposed Adjustment in accordance with Section 6.12.

(e) For all Insourced Services, Co-Administrators shall coordinate with Plan Sponsor and/or its designees and external vendors in accordance with Section 6.11 below, and, to the extent requested by Plan Sponsor, provide reasonable transition assistance and ongoing interface, data exchange, and other support services necessary to enable Plan Sponsor or its designated third party to perform the Insourced Services.

6.11 Plan Coordination. Co-Administrators agree to coordinate on an ongoing basis with Plan Sponsor and Plan Sponsor's designees and external vendors to support certain Plan-related functions or other non-Plan employee benefit plan programs, including coordination with benefit plans that Participants are enrolled in other than the Plan, Plan Sponsor's workplace wellness programs, employee assistance programs, disease management programs, and Claims post-payment review and audit functions. Co-Administrators shall, at no cost to Plan Sponsor except as expressly otherwise stated on **Exhibit D**, provide Plan Sponsor and/or Plan Sponsor's designees all Claim-related information and reports requested by Plan Sponsor and/or Plan Sponsor's designees (or Systems access or Claims feeds necessary for Plan Sponsor or Plan Sponsor's designee to directly access such information), which may include, without limitation, the itemized claim and all Claim Supporting Documentation relating to any paid Claim for specified Claim types (e.g., by CPT, DRG or NDC).

6.12 Dispute of Infeasibility Notice or Proposed Adjustment.

(a) If Plan Sponsor disputes any Infeasibility Notice or Proposed Adjustment, the Parties shall confer in good faith for up to thirty (30) calendar days to resolve the dispute.

(b) In the event that the Parties are unable to resolve the Infeasibility Notice or Proposed Adjustment dispute following the resolution timeframe described in subsection (a) above, the dispute shall be submitted to a reputable third-party consultant mutually agreed upon by the Parties, who shall have: (i) expertise regarding health benefits administration and actuarial analysis, as applicable; and (ii) professional experience involving large public sector clients ("Consultant"). If the Parties are unable to agree upon a Consultant within thirty (30) calendar days following the conclusion of any conferral period, the Parties may submit the dispute to issue-specific arbitration before a single arbitrator with appropriate subject-matter expertise, administered by the American Arbitration Association under its Commercial Arbitration Rules. For the purposes of Section 6.12(c)-(d), to the extent that a matter is escalated to arbitration, all references below to "Consultant" shall apply to the arbitrator.

(c) The Parties will submit the relevant information they deem necessary for purposes of the Consultant's determination and shall provide such additional information requested by Consultant. The Consultant's review shall be conducted on an expedited and confidential basis, either virtually or in-person, and completed within thirty (30) calendar days of the Consultant's engagement, unless the Consultant determines that good cause exists for a reasonable extension. Each Party shall bear their own fees and shall split the Consultant's fees and expenses in half, to be shared between Plan Sponsor and Co-Administrators.

(d) **Consultant Determinations**: The Consultant shall determine whether Co-Administrator's Infeasibility Notice or Proposed Adjustment, as applicable, is reasonable or unreasonable. The determination of the Consultant shall be final and binding on the Parties.

1. **Infeasibility Notice:** In the event that the Consultant determines that the Infeasibility Notice is:
   a. Reasonable, the Plan Sponsor's proposed Insourcing Request or Custom Contract Request shall not go into effect.
   b. Unreasonable, Co-Administrators may submit an Impact Statement to Plan Sponsor during the thirty (30) calendar day period following the Consultant's determination. If such Impact Statement contains a Proposed Adjustment, Plan Sponsor may accept or dispute the terms of the Proposed Adjustment, consistent with the terms set forth under this Section 6.12.
2. **Proposed Adjustment**: In the event that the Consultant determines that the Proposed Adjustment is:
   a. Reasonable, Plan Sponsor may elect whether to proceed or not proceed with the requested modification subject to the Proposed Adjustment. If Plan Sponsor elects to proceed with the requested modification, the Parties shall reflect such terms in, and execute, within fifteen (15) calendar days, an amendment to this Agreement memorializing such terms.
   b. Unreasonable, the Parties will negotiate in good faith for up to an additional fifteen (15) calendar days in an effort to agree on the terms of the Proposed Adjustment, based on feedback provided by the Consultant. If the Parties are unable to agree to the terms of a revised Proposed Adjustment:
      i. Within forty-five (45) calendar days of the Consultant's determination (i.e., thirty (30) calendar days after the Parties have negotiated in good faith following the Consultant's determination), each of: (1) Plan Sponsor on the one hand, and (2) Co-Administrators on the other, shall submit for the Consultant's review a revised Proposed Adjustment, which shall include:
         1. Each of Plan Sponsor's, on the one hand, and Co-Administrators', on the other, good faith assessment of reasonable and necessary modifications to Co-Administrators' Fees, Guarantees, or other modifications to relevant terms of the Agreement, resulting from Plan Sponsor's requested Plan Document modification, Insourcing Request, or arrangements involving Direct Contracted Providers or Customer-Specific Providers.
         2. All underlying cost studies, actuarial analyses, or other materials relied upon in formulating the Proposed Adjustments.
      ii. The Consultant shall review the Parties' Proposed Adjustments and supporting documentation and shall, within thirty (30) calendar days of submission, assess the reasonability of each Party's Proposed Adjustment and select the most reasonable proposal, based on commercially reasonable industry standards, and/or generally recognized financial and actuarial principles, as applied to the materials provided for the Consultant's review, as well as the specific matter at issue.
      iii. Following the Consultant's determination, Plan Sponsor may elect whether to proceed or not proceed with the requested modification subject to the Proposed Adjustment. If Plan Sponsor elects to proceed with the requested modification, the Parties shall reflect applicable terms in, and execute within fifteen (15) calendar days, an amendment to the Agreement memorializing such terms.

(e) If any Plan Design modification related to prior authorization is requested by Plan Sponsor upon the conclusion of the mediation process described in **Exhibit F**, the following shall apply:

1. Co-Administrators may deliver any Impact Statement described by Section 6.2(g), if applicable, to Plan Sponsor during the fifteen (15) calendar day period following receipt of Plan Sponsor's request.

2. Upon receipt of an Impact Statement from Co-Administrators, Plan Sponsor may elect to forgo the conferral period described by Section 6.12(a) and immediately submit the dispute for resolution by the Consultant consistent with the procedures described in Section 6.12(b).

3. The Parties shall mutually agree upon the Consultant within fifteen (15) calendar days of Plan Sponsor's receipt of Co-Administrators' Impact Statement instead of the thirty (30) calendar day period described in Section 6.12(c).

4. If the Consultant determines that the terms of the Proposed Adjustment are unreasonable, the procedures described in Section 6.12(d)(2)(b)(i)-(ii) shall not apply and the Consultant shall determine the appropriate Proposed Adjustment, which shall be final and binding upon the Parties.

Section 7: Records; Confidential Information; Intellectual Property

7.1 Records. Co-Administrators shall abide by the recordkeeping requirements set forth in Article 5 of **Appendix A**. In addition to the requirements and limitations set forth therein, Co-Administrators expressly acknowledge and agree that records maintained on behalf of Plan Sponsor hereunder are subject to the provisions of Article 6 of the Public Officers Law.

7.2 Use and Disclosure of Plan Sponsor Confidential Information.

(a) Each Co-Administrator shall: (i) maintain Plan Sponsor Confidential Information in confidence; (ii) protect Plan Sponsor Confidential Information from unauthorized use, access, or disclosure, in each case at least to the same extent and in substantially the same manner as such Co-Administrator protects its own confidential information and in any event at least in a reasonable manner that is appropriate for the confidential and sensitive nature of Plan Sponsor Confidential Information, subject to any more stringent requirements described in this Agreement, including all applicable Data Privacy and Security Requirements; and (iii) not access, use, disclose, release, or otherwise make Plan Sponsor Confidential Information available to third parties, including Affiliates or Subcontractors, except as specifically permitted under this Agreement.

(b) Co-Administrators are permitted to access and use Plan Sponsor Confidential Information solely to the extent such access and use is required to perform the Services or satisfy Co-Administrators' obligations under this Agreement.

(c) Co-Administrators may disclose Plan Sponsor Confidential Information: (i) as directed by Plan Sponsor; (ii) as permitted pursuant to Section 7.4; and (iii) to Co-Administrators' Subcontractors solely to the extent such Plan Sponsor Confidential Information is required for such Subcontractors to provide Services under this Agreement. Without limiting the generality of the foregoing, Co-Administrators shall not disclose Plan Sponsor Confidential Information to any Subcontractor unless such Subcontractor has agreed in writing to confidentiality, non-use, and non-disclosure terms that are no less restrictive with respect to Plan Sponsor Confidential Information than the requirements applicable to Co-Administrators

under this Agreement. Co-Administrators are permitted to disclose to any Subcontractor only that Plan Sponsor Confidential Information required for the Subcontractor to provide the subcontracted Services in accordance with this Agreement.

(d) Co-Administrator may not: (i) sell, license, or grant any other rights to Plan Sponsor Confidential Information (except as expressly contemplated herein); (ii) use Plan Sponsor Confidential Information for the creation, operation or improvement of any product, service or database for external or commercial use; or (iii) use Plan Sponsor Confidential Information to negotiate, contract with, or manage healthcare or pharmacy providers, coalitions or networks, including Co-Administrators' Affiliates.

7.3 Use and Disclosure of Co-Administrator Confidential Information.

(a) Plan Sponsor shall: (i) maintain Co-Administrator Confidential Information in confidence; (ii) protect Co-Administrator Confidential Information from unauthorized use, access, or disclosure, in each case to the same extent and in substantially the same manner as Plan Sponsor protects its own confidential information and in any event at least in a reasonable manner that is appropriate for the confidential and sensitive nature of Co-Administrator Confidential Information, subject to any more stringent requirements described in this Agreement; and (iii) not use, disclose, release, or otherwise make Co-Administrator Confidential Information available to third parties, including Affiliates or its subcontractors, except as specifically permitted under this Agreement.

(b) Plan Sponsor may use and disclose Co-Administrator Confidential Information: (i) as permitted by Section 7.4; (ii) for Plan administration and other Plan-related purposes, or in connection with the Services or its obligations hereunder, provided, however, that: (A) any Person described in (ii) of this subsection (b), other than Plan Sponsor's legal counsel, accountants, and other advisors bound by a professional obligations of confidentiality, must enter into a written confidentiality agreement with Plan Sponsor or its Affiliates that contains confidentiality, non-use, and non-disclosure restrictions applicable to disclosed Co-Administrator Confidential Information that are at least as protective of such Co-Administrator Confidential Information as the relevant provisions of this Agreement; and (B) Plan Sponsor discloses only that Co-Administrator Confidential Information necessary for the third party's purpose in receiving such Co-Administrator Confidential Information.

(c) Notwithstanding anything to the contrary in this Agreement, Plan Sponsor will not be prohibited from providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, Plan Sponsor, Participants, or individuals eligible to become Participants of the Plan. Co-Administrators agree that Plan Sponsor has no direct or indirect restrictions from: (i) accessing or maintaining raw Claims Data, provider-specific cost or quality of care data; (ii) electronically accessing Claim Data and encounter information for each Participant on a per-Claim and Claim-line level basis, including, without limitation, (A) financial information such as the allowed amount, or any other Claim-related financial obligations included in the Network Provider agreement, (B) provider information, including name and clinical designation, (C) service codes, or (D) any other Claims Data element; or (iii) sharing information described in (i) and (ii) of this subsection (c) to a business associate as defined by HIPAA.

(d) Plan Sponsor may not: (i) sell, license, or grant any other rights to Co-Administrator Confidential Information (except as expressly contemplated herein); (ii) use Co-Administrator Confidential Information for the creation, operation or improvement of any product, service or database for external or commercial use; or (iii) use Co-Administrator Confidential Information to negotiate, contract with, or manage healthcare or pharmacy providers, coalitions or networks.

7.4 Disclosure Required By Law.

(a) Except as set forth in Section 7.4(c) below or in connection with disclosures of Co-Administrator Confidential Information pursuant to **Appendix A**, if a Party is requested or required to disclose Confidential Information by subpoena, legal process, or pursuant to applicable Law, such Party shall (to the extent permitted by Law) provide the disclosing Party with immediate written notice of the request or requirement. Such Party shall reasonably cooperate in any efforts by the disclosing Party to seek an appropriate protective order or other remedy or otherwise challenge or narrow the scope of that disclosure request or requirement. If a protective order or other remedy is not obtained, the receiving Party shall furnish only that portion of the Confidential Information that is legally required.

(b) The Parties expressly agree that Claims Data and Participant information is medical information and personal data subject to an expectation of privacy that may contain personally identifiable health information, and shall therefore be treated as exempt from public disclosure under applicable law, including the New York State Freedom of Information Law, Article 6 of the New York Public Officers Law.

(c) Disclosure of Co-Administrator Confidential Information by Plan Sponsor required pursuant to applicable healthcare cost transparency Laws, including, without limitation, the CAA and New York City Local Law 78 of 2023, is expressly permitted by Co-Administrators without further action or consent required by Plan Sponsor or Co-Administrators.

Co-Administrators agree that all Claims Data or other Plan Sponsor Confidential Information will be stored in secure data centers located in the United States. Co-Administrators will not, and will ensure that their respective Affiliates and other Subcontractors will not, directly or indirectly, copy, download or store any Claims Data or other Plan Sponsor Confidential Information outside of the United States. All Services involving Participant-facing interactions or clinical decision-making functions will be performed by personnel or Subcontractors located within the United States.

7.5 Intellectual Property.

(a) Plan Sponsor shall exclusively own all right, title and interest in and to all Claims Data and other deliverables and work product produced by Co-Administrators in connection with the Services (the "Deliverables"), as well as all other Plan Sponsor Confidential Information, and all Deliverables shall be deemed to be works made for hire by Administrator for Fund, as further described in **Appendix A**. To the extent any right, title or interest in or to any Deliverables does not automatically vest in Plan Sponsor by virtue of being a work made for hire, Co-Administrators hereby irrevocably assigns all such right, title and interest to Plan Sponsor. Co-Administrators shall not incorporate into any Deliverable any element in or to which any third party owns any right, title or interest without Plan Sponsor's prior written consent in each instance.

(b) Notwithstanding any terms to the contrary, Co-Administrators own and shall retain all right, title, and interest in and to all Co-Administrator Confidential Information, including all intellectual property related thereto and, except for the rights expressly granted to Plan Sponsor pursuant to this Agreement, including Section 7.4(c) below, Plan Sponsor shall have no right, title or interest in or to Co-Administrator Confidential Information.

(c) If either: (i) any intellectual property that Co-Administrators created outside the scope of this Agreement without the use of, access to, or reference to, any Plan Sponsor Confidential Information, or that is owned by a third party; or (ii) Co-Administrator non-public Claim edits or provider discount information; is incorporated into or embedded within, or is necessary for Plan Sponsor to use or access, any

Deliverables, including Claims Data (such incorporated or embedded materials, "Embedded IP"), Co-Administrators hereby grant Plan Sponsor and its Affiliates a perpetual, worldwide, royalty-free, non-exclusive, assignable, sublicensable (through multiple tiers) license to use, copy, disclose, and reproduce such Embedded IP for Plan-related purposes, for purposes of receiving, accessing and using the Services, or any other purpose permitted by this Agreement. Plan Sponsor shall not decompile, disassemble, translate, or otherwise reverse engineer any Embedded IP for any purpose, or use the Embedded IP separate and apart from the Deliverables. Plan Sponsor shall undertake commercially reasonable efforts to protect the confidentiality of Embedded IP that constitutes Co-Administrator's non-public Claim edits or provider discount information.

(d) This Section 7.5 does not grant or otherwise give any Party ownership in or any other right, title or interest to use any of the other Parties' intellectual property, except as explicitly described herein.

7.6 Plan Sponsor Access to Claims Data. Co-Administrators shall ensure that Plan Sponsor will have continuous access to all Claims Data and other Claim-related information. Co-Administrators shall provide recurring Claims feeds in a machine-readable format to Plan Sponsor's appointed data warehouse, analytics, and/or Claims review vendor(s) that contains at least those data fields identified on **Exhibit H**. The Claims feed must include data related to all Claims, regardless of whether such Claims were paid or denied. The feed must contain Claim-line level information for all fields required by Plan Sponsor, including, without limitation, administrative coding, line-level adjudication determination codes (ex. denial reasons), as well as line-level charges, paid amounts, and patient cost-share. Such Claims feeds shall adhere to mutually agreed upon frequency (daily, weekly, or monthly), timing (date of the month or day of the week), and format (CSV, XLS, etc.) protocols. Any such transfers of information shall only occur between Business Associates (as defined under HIPAA) and as specified under the CAA. An up-to-date data dictionary must be provided alongside any data that Co-Administrators share with Plan Sponsor, upon any changes to any of the ongoing data feeds, and upon request by Plan Sponsor. The data dictionary shall include field names, format, and business descriptions of the data. Co-Administrators shall provide explanations that describe any data transformations, summaries, or simplifications that are applied to the data during the transition of data between the adjudication system and the data warehouse that serves as the source of the Claims feed. Plan Sponsor must be notified thirty (30) days in advance of any planned changes to the Claims feed (content and/or format) and fifteen (15) days in advance of any planned outage/maintenance. For any file changes, Co-Administrators will provide a complete test file thirty (30) days prior to deployment or within a mutually agreeable timeframe. In addition, upon Plan Sponsor's request, Co-Administrators will furnish Claims Data and related files or data access via secure file transfer protocol or a mutually agreeable alternative method.

7.7 Return of Data.

(a) Upon termination or expiration of this Agreement or Plan Sponsor's request during the Term, each Co-Administrator shall, and shall ensure its Affiliates and Subcontractors shall: (i) provide Plan Sponsor with any and all Claims Data and other Plan Sponsor Confidential Information in such Person's possession; and/or (ii) at Plan Sponsor's express written election, destroy Plan Sponsor's Confidential Information in its possession, subject to compliance with the record retention requirements established under this Agreement, applicable Law or as required under any Co-Administrator contract requiring retention of Plan Sponsor Confidential Information permitted by applicable Data Privacy and Security Requirements (e.g. Network Provider agreements), subject to any applicable retention requirements established by the Business Associate Agreement. Any Plan Sponsor Confidential Information permitted to be retained by Co-Administrators or any Affiliate or Subcontractor will remain subject to the confidentiality and non-disclosure requirements set forth in this Agreement and, as applicable, the Business Associate Agreement, for so long as such Party retains Plan Sponsor Confidential Information.

(b) Upon termination or expiration of this Agreement, and subject to any perpetual license or continuous Claims feed access described in this Section 7, Plan Sponsor shall: (i) provide Co-Administrators with any and all Co-Administrator Confidential Information in Plan Sponsor's possession; and/or (ii) at Co-Administrators' election, destroy Co-Administrator Confidential Information in its possession, subject to compliance with the record retention requirements established under this Agreement, applicable Law or any contract requiring retention of Co-Administrator Confidential Information permitted by applicable Data Privacy and Security Requirements. Any Co-Administrator Confidential Information permitted to be retained by Plan Sponsor will remain subject to the confidentiality and non-disclosure requirements set forth in this Agreement and, as applicable, the Business Associate Agreement, for so long as Plan Sponsor retains Co-Administrator Confidential Information.

Section 8: Co-Administrators Liability; Indemnification; Insurance; Dispute Resolution

8.1 Co-Administrator Liability; Hold Harmless. Co-Administrators expressly agree that Co-Administrators and any Affiliates and Subcontractors shall be liable to Plan Sponsor for any and all losses or damages that may result from any failure by Co-Administrators or their respective Affiliates or Subcontractors to discharge their duties hereunder, or from any improper or incorrect discharge of those duties. Co-Administrators and their respective Affiliates and Subcontractors shall save Plan Sponsor free and harmless from any and all loss occasioned by or incurred in the performance of Co-Administrators' Services under this Agreement. Plan Sponsor expressly reserves all legal rights of set-off with respect to all liabilities established hereunder.

8.2 Indemnification. The Parties agree that this Section 8.2 shall supersede Section 8.03 of **Appendix A**.

(a) To the fullest extent permitted by Law, Co-Administrators shall jointly and severally defend, indemnify, and hold harmless Plan Sponsor, including its officials and employees, against any and all direct and third party claims, losses, liabilities, penalties, fines, costs, damages, judgments, and expenses to which Plan Sponsor or its officials or employees may be subject to, including reasonable attorneys' fees and costs, to the extent arising out of, or in connection with: (i) breach of this Agreement, including any breach of the appendices and exhibits incorporated herein, by either Co-Administrator or any Co-Administrator Affiliate or Subcontractor; (ii) the negligent acts or omissions of either Co-Administrator or any Co-Administrator Affiliate or Subcontractor; (iii) claims relating to either Co-Administrator's breach, or any Co-Administrator Affiliates' breach, of any agreement with any third party; (iv) any intentional tortious act; (v) intellectual property infringement (including, without limitation, by the Services or Systems or Co-Administrators' provision or use thereof, or any other materials created or provided by Co-Administrators or any Co-Administrator Affiliate or Subcontractor); (vi) any violation of a law, rule or regulation applicable to either Co-Administrator's performance hereunder; or (vii) any breach of the Business Associate Agreement or breach of the Data Privacy and Security Requirements by Co-Administrators or any Co-Administrator Affiliate or Subcontractor . Insofar as the facts or Law relating to any of the foregoing would preclude Plan Sponsor or its officials or employees from being completely indemnified by Co-Administrators, Plan Sponsor and its officials and employees shall be partially indemnified by Co-Administrators to the fullest extent permitted by Law.

(b) Co-Administrators' obligation to indemnify, defend and hold harmless Plan Sponsor and its officials and employees shall neither be (i) limited in any way by Co-Administrators' obligations to obtain and maintain insurance under this Agreement, nor (ii) adversely affected by any failure on the part of Plan Sponsor or its officials or employees to avail themselves of the benefits of such insurance.

8.3 Insurance. Each Co-Administrator shall obtain and maintain at all times during the Term the applicable insurance coverage described in Section 7 and Schedule A of **Appendix A**. Each Co-Administrator shall separately maintain all insurance coverage required pursuant to this Agreement and the

policy limits applicable to such separate coverage may not be aggregated for purposes of meeting such Co-Administrator's obligations hereunder.

8.4 Bond. Co-Administrators shall obtain and maintain one or more surety bonds in accordance with and in an amount not less than twenty million dollars ($20,000,000) or the minimum amount required by Law, in order to secure Co-Administrators' performance under this Agreement.

8.5 Joint and Several Liability. Notwithstanding any other provision of this Agreement, Co-Administrators unconditionally and irrevocably agree to be jointly and severally liable, to the fullest extent permitted by Law, for the due performance and discharge of all obligations and liabilities of any kind, whether now existing or hereafter arising, imposed upon or accruing to either of them under this Agreement including, without limitation and notwithstanding anything therein to the contrary, **Exhibit A** and **Exhibit B** (collectively, the "Obligations"). Each Co-Administrator agrees that: (i) Plan Sponsor's failure to enforce any remedy against one Co-Administrator does not affect the liability of the other; (ii) Plan Sponsor may proceed against either or both Co-Administrators, together or separately, in any order, to enforce any right or remedy with respect to the Obligations without first exhausting any other remedy or seeking judgment against the other Co-Administrator; and (iii) the liability of each Co-Administrator is not affected by any modification or change in relationship between Co-Administrators or the JV Agreement, or the invalidity or unenforceability of any provision of this Agreement or the JV Agreement. No payment or performance by either Co-Administrator reduces or limits the liability of the other unless and until the Obligations have been indefeasibly paid and performed in full. Nothing in this Section 8.5 limits any right of contribution or subrogation either Co-Administrator may have against the other, provided such rights are subordinate to the prior indefeasible payment and performance in full of the Obligations in favor of Plan Sponsor and may not be exercised until the Obligations have been indefeasibly paid and performed in full.

8.6 Dispute Resolution. In the event of any dispute, claim, or controversy of any kind or nature between the Parties arising out of this Agreement or the Services, except for any dispute, claim, or controversy arising in connection with Section 6.12 or Section 8.7 (a "Dispute"), the disputing Party may provide written notification of the Dispute to the other Party(ies). After such notice, a senior representative from each Party shall meet in person or telephonically and make a good faith effort to resolve the Dispute. If the Dispute is not resolved within fifteen (15) days after the Parties first meet to discuss it, and either Party wishes to pursue the Dispute further, the Dispute shall be resolved in accordance with Section 12 of **Appendix A**.

8.7 Equitable Relief. The Parties expressly acknowledge and agree that the composition of Emblem and UMR's respective Networks, as well as each Co-Administrator's representations regarding compliance with the confidentiality and non-disclosure obligations described herein, were material and essential considerations for Plan Sponsor's decision to enter into this Agreement. In the event of any actual or threatened breach of the covenants set forth in Section 11.5, Section 11.6, or Section 7, (i) Plan Sponsor would suffer irreparable harm that cannot reasonably be calculated or cured via monetary damages or Plan Sponsor's exercise of any termination rights set forth herein, and (ii) Plan Sponsor shall be entitled to obtain any requested interim measures and/or equitable remedies or injunctive relief available to Plan Sponsor including, without limitation, a cease-and-desist order, specific performance, or any other form of equitable relief or ex parte injunctive relief that the court may deem proper, without prejudice as to any other available remedies Plan Sponsor may have. No bond or other form of security for the cost of such equitable relief measures shall be required to be paid by Plan Sponsor in connection with relief requested hereunder. Each Party specifically acknowledges that the covenants set forth in this Section 8.7 are reasonable, necessary, and enforceable to protect the legitimate interests of Plan Sponsor and that Plan Sponsor would not have entered into this Agreement in the absence of such covenants.

Section 9: Audit

9.1 Claims Audits.

(a) During the Term of the Agreement and for the duration of the Run-Out Period and a period of two (2) years thereafter, Plan Sponsor or its designee, including any independent certified public accountant retained by Plan Sponsor, may conduct Claims audits for purposes of determining if Co-Administrators are administering Claims in accordance with this Agreement and the Plan Documents. Plan Sponsor must notify the Co-Administrator(s) to be audited in writing of its intent to conduct a Claims audit, whereby Co-Administrators must produce Claim Supporting Documentation for a selected Claims sample or additional books and records not otherwise required to be made available to Plan Sponsor pursuant to this Agreement. Except as otherwise required by Law, all audits will be limited to information relating to the calendar year in which the audit is conducted, and the immediately preceding two (2) calendar years. The Parties will bear their own respective expenses in performance of the external audit contemplated hereunder. Plan Sponsor will provide the audited Co-Administrator(s) with copies of any audit reports within thirty (30) days after Plan Sponsor receives the audit report(s) from the auditor.

(b) In addition to the separate audit rights set forth in **Exhibit B**, the Parties agree that Plan Sponsor will generally only conduct one medical benefit Claims audit per calendar year with respect to each Co-Administrator, provided, however, that Co-Administrators acknowledge and agree that Plan Sponsor may conduct subsequent audits on a more frequent basis to the extent: (i) required by applicable Law, (ii) reasonably required by Plan Sponsor to ensure that errors found in prior audits have been corrected and are not recurring; or (iii) information becomes available to Plan Sponsor that warrants further investigation of particular Claim periods that may have already been subject to prior audit(s).

(c) Co-Administrators will not support any audits or inspections in which the audit or inspection firm is paid on a contingency basis.

(d) In addition to satisfying the external audit requirements identified above, Co-Administrators shall, at no additional cost to Plan Sponsor, maintain an internal audit program designed to ensuring accurate Claims processing in accordance with all relevant requirements identified herein. At least once every calendar quarter, Co-Administrators shall conduct an internal audit of Claims processed during the preceding quarter and prepare and deliver to Plan Sponsor a written report summarizing the audit methodology, findings, any deficiencies, and proposed corrective actions with timelines. Each report shall be delivered to Plan Sponsor promptly after completion. Co-Administrators shall meet with Plan Sponsor to review Co-Administrators' internal audit findings upon Plan Sponsor's request, and Co-Administrators shall implement corrective actions within the specified timeframes and provide Plan Sponsor written status updates until remediation is complete.

(e) Each Co-Administrator represents and warrants that it is not party to any contractual agreement or other restriction that may restrict or impair Plan Sponsor's full exercising of its audit and remediation rights hereunder.

9.2 Non-Claims Audits. Plan Sponsor or its designee may also, upon reasonable request and at least thirty (30) days' notice to the Co-Administrator(s) to be audited, conduct a targeted audit of Co-Administrators' compliance with the requirements set forth in this Agreement, including, without limitation, rebates, utilization management, accounting procedures, privacy and security controls, medical records practices, internal control procedures, Affiliate and Subcontractor processes, member appeals, member calls, clinical transactions, performance guarantees, trend guarantees, clinical programs, and Co-Administrators' compliance with Network Provider agreements. The audited Co-Administrator(s) shall provide Plan

Sponsor or its designee with access to Co-Administrator personnel, physical premises, and documentation in support of such non-Claims audit activities.

9.3 Audit Corrective Action. If an audit results in a finding that a Co-Administrator or any Affiliate or Subcontractor is not in compliance with applicable Law or any of its direct or delegated obligations hereunder or is otherwise not correctly administering Claims in accordance with the Plan Documents and the provisions of this Agreement, Co-Administrators shall have an opportunity to review and dispute any audit findings within forty-five (45) days of delivery of such findings, which Plan Sponsor or its designee shall review in good faith and not unreasonably deny. Plan Sponsor will make a final determination of audit outcomes within forty-five (45) days of receipt of such submission. With respect to any non-compliant audit findings, Co-Administrator will undertake corrective action in such timeframe necessary to ensure Co-Administrators and Plan Sponsor's compliance with Plan obligations and applicable Law. Such corrective action shall include, as applicable, immediately reimbursing Plan Sponsor, without offset or reduction, for any overpayments to Co-Administrators or overfunding of Claims attributable to Co-Administrators or any Affiliate or Subcontractor's error. Co-Administrators shall promptly provide written documentation establishing the corrective action plan to resolve such non-compliance as well as any documentation or other evidence necessary to demonstrate resolution of the non-compliance. If Co-Administrators have not corrected the non-compliance to Plan Sponsor's satisfaction, Plan Sponsor may perform an additional audit designed to ensure the non-compliance has been fully corrected. Co-Administrators will fully bear the expense of any such response. Nothing herein shall prevent Co-Administrators from recovery attempts on identified Overpayments.

9.4 General Audit. The specific audit rights set forth above shall be in addition to, and shall not diminish, Plan Sponsor's general audit and inspection rights set forth in Article 5 of **Appendix A**, provided however that Co-Administrators shall not be required to submit records for inspection in the City of New York or reimburse Plan Sponsor for out-of-City inspection in accordance with Section 5.03 of **Appendix A**, except to the extent required by applicable Law or legal order. In addition to the foregoing, Plan Sponsor reserves the right to reconcile raw Claims Data against the check register as frequently as desired. Co-Administrators will correct any unexplained anomalies discovered during this reconciliation without additional charge and within a mutually agreed upon timeframe.

Section 10: Termination

10.1 Run-Out Services. The Parties acknowledge and agree that Co-Administrators' provision of the Services under this Agreement will generally end on the date this Agreement terminates or expires. Notwithstanding the foregoing, for a period of twelve (12) months after the date this Agreement terminates or expires, unless a shorter time frame is requested by Plan Sponsor (such period, the "Run-Out Period"), Co-Administrators will continue to perform all Core Services and other functions necessary to finalize processing of Claims incurred prior to such termination or expiration date (e.g., appeals, recovery of overpayments, reporting), unless Plan Sponsor requests a more limited subset of Services (the "Run-Out Services") at no additional cost to Plan Sponsor. Claims received during the Run-Out Period that are pending or disputed at the end of the Run-Out Period will be handled to their conclusion by Co-Administrators unless otherwise requested by Plan Sponsor. The Parties agree that the terms and conditions set forth in this Agreement will continue to apply to the Run-Out Services.

10.2 Termination Events. This Agreement will terminate under the following circumstances:

(a) Upon Plan Sponsor's exercise of any partial or complete termination rights available to Plan Sponsor pursuant to Article 10 of **Appendix A**, including, without limitation, Plan Sponsor's right to terminate this Agreement at any time without cause upon thirty (30) days' prior notice to Co-Administrators;

(b) Upon at least sixty (60) days' advanced written notice by either Co-Administrator to Plan Sponsor in the event Plan Sponsor materially breaches its obligation to provide funds for payment for all Plan benefits pursuant to Section 4 of this Agreement;

(c) upon written notice by Plan Sponsor to Co-Administrator in the event of a filing by or against either Co-Administrator or any of their respective Affiliates of a petition for relief under title 11 of the United States Code;

(d) upon notice by Plan Sponsor to Co-Administrators in the timeframe specified in such notice in the event either Co-Administrators representations and warranties as set forth herein are no longer accurate; or

(e) either Co-Administrator or their respective Affiliates (as applicable) breach, or announce their intent to breach, their obligations set forth in Section 11.5 or Section 11.6.

If Plan Sponsor terminates this Agreement prior to the conclusion of the Initial Term or then-current Renewal Term, as applicable, Plan Sponsor shall have the right, at any time prior to the stated termination date specified in Plan Sponsor's notice of termination to Co-Administrators, to extend such termination date. This Agreement will remain in full force and effect and Co-Administrators will perform all Services and fulfill all obligations required hereunder until such final termination date. Notices for termination shall comply with the provisions of Section 10.05 and Section 14.04 of **Appendix A**.

10.3 Termination Assistance Services. In addition to performing the Run-Out Services, Co-Administrators shall, at no additional cost to Plan Sponsor, reasonably cooperate with Plan Sponsor or another service provider designated by Plan Sponsor in the transfer of the Services (including transfer of Plan Sponsor data and reports) to Plan Sponsor or such other service provider in order to facilitate the transfer of the Services to Plan Sponsor or such other service provider.

10.4 Survival. Sections 7, 8, 10.3, 11.3, 11.9, 11.11, 11.12 will survive the termination of this Agreement, in addition to any provision of any exhibit or appendix incorporated or specifically referenced herein which, by its nature, is intended to continue beyond the termination of this Agreement.

Section 11: Miscellaneous

11.1 Subcontractors; Affiliates.

(a) The Parties agree that the terms and conditions set forth in this Section 11.1 shall supersede the following provisions of **Appendix A** in their entirety: subsections (A), (B), (D), (E), (F) of Section 3.02, and subsections (B)(7), B(8), and D(4) of Section 4.05.

(b) Co-Administrators may rely on certain Co-Administrator Affiliates or subcontractors to perform or support Co-Administrators' Services under this Agreement as permitted by this Section 11.1 and subject to the applicable restrictions set forth in **Appendix A**, including Section 3.02 of **Appendix A**.

(c) Plan Sponsor's consent is required prior to either Co-Administrator engaging any subcontractor, third party support contractor, supplier, service provider, outsourced vendor, or other non-Affiliate third party to whom Co-Administrators grant access to Plan Sponsor's Confidential Information or otherwise uses in connection with the Services (each such third party, a "Subcontractor"), Co-Administrators shall submit a written statement to the Plan Sponsor giving the name and address of the proposed Subcontractor, the portion of the work and materials that the Subcontractor is to perform and

furnish, identify any access the Subcontractor will have to Plan Sponsor's information systems, data, or Confidential Information. Such approval shall not be unreasonably conditioned, delayed or withheld.

(d) Co-Administrators shall cause all Affiliates and Subcontractors to adhere to all relevant requirements of this Agreement and **Appendix A**, including, without limitation: (i) the requirements for timely and accessible use of information upon demand by an authorized Person; (ii) Plan Sponsor Confidential Information; (iii) audits and access to books and records; (iv) guarding against improper information modification or destruction, including ensuring that sensitive data has not been modified or deleted in an unauthorized and undetected manner; and (v) protecting data from unauthorized (accidental or intentional) modification, destruction, or disclosure, and Safeguards no less stringent than those provided in this Agreement. Co-Administrators will be responsible for the proper, timely and faithful performance of the Services performed by any Affiliate or Subcontractor to the same extent that Co-Administrators would have been responsible had Co-Administrators performed those Services without the use of such Affiliate or Subcontractor.

(e) Plan Sponsor is fully authorized to accept, rely upon, and act on any instruction, approval, consent, waiver, or other communication made or issued by any Affiliate performing any material portion of the Services or otherwise delegated any function or obligation incident thereto as if such instruction, approval, consent, waiver, or other communication were issued by Co-Administrators with respect to such Services, function, or obligation subcontracted or delegated to the Affiliate.

(f) Plan Sponsor may, at any time, request replacement of any Subcontractor by providing written notice to Co-Administrators. Co-Administrators will replace a Subcontractor, subject to Plan Sponsor's review and approval, with another Subcontractor(s) with the same or greater skill set in a reasonable amount of time, pursuant to a replacement plan that includes analysis of disruption of the Plan, after having received Plan Sponsor's written notice of request to replace.

11.2 Entire Agreement. This Agreement, including any exhibits and appendices incorporated herein, constitutes the entire agreement between the Parties with respect to the subject matter hereof. This Agreement replaces and supersedes any prior written or oral agreements between the Parties relating to the subject matter hereof.

11.3 Order of Precedence. In the event of any express or implied conflict between the provisions of this Agreement, inclusive of all exhibits incorporated herein, and the appendices incorporated herein, the following order of priority shall govern, as applicable: (1) the terms contained in **Appendix B**, **Appendix C-**1, and **Appendix C-2**, as applicable (solely with respect to the subject matter explicitly contemplated therein); (2) the body and exhibits of this Agreement; (3) **Appendix A**, provided, however, that any provision present in a lower-priority document but absent from a higher-priority document shall not be considered a conflict.

11.4 Amendment. Except as may otherwise expressly specified in this Agreement, this Agreement, including any appendices or exhibits incorporated herein, may be amended only by all Parties agreeing to the amendment in writing pursuant to Article 9 of **Appendix A**, provided, however, that this Agreement shall be automatically amended to the extent necessary to permit the Parties to comply with NYS General Municipal Law Section 92–a.

11.5 Change of Control Impacting Emblem.

(a) For the first two (2) years after the Service Start Date, Emblem, EmblemHealth, Inc., and Health Insurance Plan of Greater New York (each of the foregoing Persons, a "Covered Emblem Affiliate") shall not, without obtaining Plan Sponsor's prior written consent, which may be granted or withheld in Plan

Sponsor's sole and absolute discretion, enter into any agreement to consummate, undergo or permit, and shall not consummate, undergo or permit a "change of control" (as defined below). For purposes of this Section 11.5, a "change of control" includes the following: (i) consolidation or merger of a Covered Emblem Affiliate with or into any Person where such Covered Emblem Affiliate is not the surviving Person; (ii) sale, transfer or other disposition of all or substantially all of the assets of a Covered Emblem Affiliate; (iii) acquisition by any Person, or group of Persons acting in concert, of beneficial ownership of fifty percent (50%) or more (or such lesser percentage that constitutes control) of a Covered Emblem Affiliate; (iv) any change in the composition of the governing board(s) or control group(s) of a Covered Emblem Affiliate such that within a period of twelve (12) consecutive months, a majority of the members of the governing board(s) or control group(s) of such Covered Emblem Affiliate are replaced by Persons whose appointment or election was not approved by a majority of the members of the governing board(s) or control group(s) in place immediately prior to such appointment or election; or (v) any transaction or series of transactions that results in a change in the identity of the persons or entities having the power to appoint or elect a majority of the members of the governing board, or otherwise having the power to direct or cause the direction of the management and policies of a Covered Emblem Affiliate; provided, that, with respect to any of the foregoing scenarios described in (i)-(v) of this subsection (a), a "change of control" shall not include: (A) the sale, transfer or other disposition of assets that do not relate to or will not impact administration of the Plan or other City benefit plans; or (B) any sale, conveyance, assignment, or transfer of assets or power, merger, consolidation, or any other transaction or combination or change of beneficial ownership between a Covered Emblem Affiliate or any of their respective Affiliates as of the Effective Date that is not related to or a result of a change of control between any Emblem Affiliate and any non-Affiliate Person. In the event of any change resulting in AdvantageCare Physicians, P.C. ("ACPNY") no longer being financially consolidated with the Covered Emblem Affiliate group in the first two (2) years after the Service Start Date (which change, for the avoidance of doubt, shall not require Plan Sponsor consent), Emblem shall ensure that ACPNY shall use commercially reasonable best efforts to continue its rate structure then in effect, as applicable to ACPNY Services provided to Participants under the Plan for the remainder of such two (2)-year period.

(b) During the Initial Term, in the event of a change of control impacting Emblem, Emblem shall, unless otherwise requested or consented to by Plan Sponsor, continue to perform the Services and its obligations set forth herein in all respects, including the provision of access to the Network and Network Providers in the Downstate Counties, as a distinct legal entity.

11.6 Change of Control Impacting UMR.

(a) Co-Administrators shall provide written notice to Plan Sponsor of: (i) the consolidation or merger of UMR with or into any Person; (ii) sale transfer or other disposition of all or substantially all of the assets of UMR; or (iii) acquisition by any Person, or group of Persons acting in concert, of beneficial ownership of fifty percent (50%) or more (or such lesser percentage that constitutes control) of UMR; provided that, Co-Administrators shall not be required to provide written notice to Plan Sponsor of any sale, conveyance, assignment, or transfer of assets or power, merger, consolidation, or any other transaction or combination or change of beneficial ownership between UMR or any Person who is a UMR Affiliate as of the Effective Date.

(b) Any notice required to be provided to Plan Sponsor pursuant to subsection (a) above shall be provided within thirty (30) days of UMR or any of its Affiliates entering into any definitive agreement in anticipation of the change prompting notice to Plan Sponsor, and in any event no later than sixty (60) days prior to the consummation of such change.

11.7 Assignment. In addition to the provisions set forth in Section 3.01 of **Appendix A**, except as otherwise permitted pursuant to Section 11.1, neither this Agreement nor any of the rights, interests, or

obligations hereunder may be assigned, delegated, transferred, pledged, encumbered, or otherwise disposed of by Co-Administrators, in whole or in part, whether voluntarily, involuntarily, by operation of law, or otherwise, without the prior written consent of Plan Sponsor, which consent may be granted or withheld in Plan Sponsor's sole and absolute discretion. Any attempted or purported assignment in violation of this Section 11.7 shall be null, void, and of no force or effect. Subject to the foregoing, this Agreement shall be binding upon, and inure to the benefit of, the Parties hereto and their respective permitted successors and assigns.

11.8 Use of Name. Except as permitted herein, the Parties agree not to use each other's name, logo, service marks, trademarks, or other identifying information without the written permission of Co-Administrators (with respect to Plan Sponsor's use) or Plan Sponsor (with respect to Co-Administrators' use).

11.9 Compliance with Laws and Regulations. Each Party agrees to comply with all applicable Laws in its performance under this Agreement.

11.10 Interpretation. The Parties acknowledge that they have read this Agreement, have had the opportunity to review it with legal counsel, and have agreed to all its terms.

11.11 Counterparts; Electronic Signatures. This Agreement may be executed in any number of counterparts (including any form of electronic communication) and all such counterparts taken together shall be deemed to constitute one and the same instrument. The Parties may rely upon delivery of an executed facsimile or similar executed electronic copy of this Agreement (including by means of an electronic signature), and such facsimile or similar executed electronic copy will be legally effective to create a valid and binding agreement between the Parties.

11.12 Notice. All notices and other communications required or permitted by this Agreement shall be given in accordance with Section 14.04 of **Appendix A**.

[Signature Page Follows]

By signing below, each Party, by and through its authorized representatives set forth below, hereby agrees to the terms of this Agreement as of the Effective Date.

UMR, Inc.

By: _____

Authorized Signature

Print Name: _____

Print Title: _____

Date: _____

EmblemHealth Plan, Inc.

By: _____

Authorized Signature

Print Name: _____

Print Title: _____

Date: _____

City of New York acting through the Mayor's Office of Labor Relations – Employee Benefits Program

By: _____

Authorized Signature

Print Name: Renee Campion

Print Title: OLR Commissioner

Date: _____

NEW YORK CITY LAW DEPARTMENT
Approved as to Form and Certified
as to Legal Authority

By:

Date:

EXHIBIT A

Medical Benefit Administration Services

Section 1: Network

Network Access, Management and Administration. Co-Administrators will provide access to Networks and Network Providers, as well as related Services including physician (and other health care professional) relations, clinical profiling, contracting, credentialing, network analysis, and system development consistent with the Network Adequacy Standards. In the event that any material changes or reductions to the Networks are anticipated, Co-Administrators shall provide notice as soon as possible and in any event no later than thirty (30) days prior to that date on which such changes are to take effect, provided, however, that the Network Adequacy Standards must be maintained by Co-Administrators at all times during the Term.

On a monthly basis, each Co-Administrator will provide reports of Network Provider system and facility-level additions and deletions. For purposes of this Network Access, Management, and Administration section, "material changes or reductions" means resulting changes in the Network status of Network Provider(s) that have, individually or in the aggregate, either: (i) rendered services to five hundred (500) or more Participants within the prior twelve (12) months, or (ii) received at least one million dollars ($1,000,000) in reimbursement for Claims within the prior twelve (12) months.

Network Provider agreements shall not permit providers to opt out of participation solely with respect to the Plan.

Co-Administrator will comply with their respective Network Adequacy standards as set forth in Exhibit I.

Some Network Providers are affiliated with Co-Administrators, however they are not Co-Administrators' agents or partners. Otherwise, Network Providers participate in Networks only as independent contractors. Network Providers and the Participants are solely responsible for any health care services rendered to Participants. For purposes of this Agreement, Co-Administrators are not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services, including Network pharmacies and services provided through Co-Administrators' Affiliates' networks for the payment of Claims, provided, however, that Co-Administrators shall be responsible for performing Network Provider credentialing and re-credentialing for their respective Networks in accordance with standards established pursuant to applicable Law and accreditation requirements. Co-Administrators shall contract, and shall ensure their Affiliates contract, with only those health care professionals and individuals who: (i) are duly licensed, certified and/or continuously registered and qualified to practice within their given operational specialty/profession in the relevant jurisdiction (if applicable); and (ii) are not Excluded Parties. Co-Administrators shall notify Plan Sponsor within thirty (30) days of any exclusion findings that will result in the removal of any such Excluded Parties from the Plan's network.

Section 2: Provider Programs

Value-Based Contracting Program.

The Parties acknowledge that as of the Service Start Date of this Agreement, the Value-Based Contracting Program shall not apply to the Plan. After the Service Start Date, should Plan Sponsor agree to any Value-Based Contracting Program made available to the Plan, Co-Administrators agree that Value Based Payments payable by the Plan will be designated as Claims paid under Plan benefits, and not Fees. Only

the initial Claims-based reimbursement to Network Providers will be subject to the Participant's copayment, coinsurance, or deductible requirements. Plan Sponsor will pay the Network Provider the full amount earned or attributable to its Participants (subject to meeting the applicable Value-Based Payment program requirements established by Co-Administrators), without a reduction for copayments or deductibles, and agrees that there will be no impact from these payments on the calculation of the Participant's satisfaction of their annual deductible amount.

In addition, in the event that Value-Based Contracting Programs are agreed to by Plan Sponsor during the Term, the below-listed terms shall apply to each of UMR and Emblem's respective Value-Based Contracting Programs:

Emblem Value-Based Contracting:

Emblem engages in value-based provider contracts aimed at enhancing care quality and reducing costs. These contracts may include shared savings, shared risk, capitation, or pay-for-performance models. Providers may be compensated through financial risk-sharing and performance-based incentives. Plan Sponsor consents to the use of de-identified claims, utilization, and quality data in accordance with HIPAA to the extent necessary to support the arrangements Plan Sponsor participates in. Emblem may implement clinical programs and population health initiatives, such as care management, chronic condition support, and transition of care services, as part of its value-based care strategy. Provider reimbursement may vary based on quality performance, patient satisfaction, and efficiency metrics, which may affect network participation or member cost-sharing. All value-based arrangements shall comply with applicable Laws, including HIPAA, and ERISA where applicable.

UMR Value-Based Contracting:

UMR Affiliate contracts with some Network Providers in the UMR Provider Network service area may include withholds, incentives, and/or additional payments that may be earned by meeting standards relating to utilization, quality of care, efficiency measures (including better contract rates), compliance with UMR policies or initiatives, or other clinical integration or practice transformation standards.

- Attribution Methodology
    - UMR emphasizes a quality-driven, value-based, and collaborative approach to care, supported by a vast national network of over 1.7 million providers and advanced digital capabilities. UMR's value-based programs/value-based care currently encompasses approximately ten (10%) percent of its national commercial network, driving improved outcomes, cost efficiency, and enhanced member and provider experiences.
    - UMR employs a standardized attribution methodology across its commercial Accountable Care Organization (ACO) arrangements to align members with a designated Primary Care Provider (PCP) participating in a Performance-Based Contract (PBC) within an ACO. Attribution is determined using 24 months of historical claims data. A Participant is attributed to a PCP if a claim has been paid to that provider within the lookback period, with precedence given to the most recent visit over frequency of visits.
    - Upon the commencement of Services, Co-Administrators will analyze the first six months of claims to determine participants that may qualify for attribution to an ACO. Thereafter, claim data will be continually analyzed to determine additional members that could be attributed to ACOs based on current Claim activity.

- Plan Sponsor's Financial Responsibility (if any)

    - Each ACO contract is unique and contains unique payment terms and measures. Upon completion of the analysis referenced above, UMR will provide Plan Sponsor reporting that will (1) identify the participants that qualify for an ACO; (2) the ACO to which each participant qualifies; (3) the financial terms of those ACOs; and (4) the expected savings should Plan Sponsor elect to utilize the Value Based Contracting Program for any particular ACO contract.

    - ACO attribution and payments (in accordance with Plan Sponsor's Plan) shall only be made after said reports are provided to Plan Sponsor and Plan Sponsor approves of the attribution(s) in writing.

Direct Contracted Provider and Customer-Specific Provider Arrangements. Co-Administrators acknowledge and agree that nothing herein shall be construed to limit Plan Sponsor's right to contract (either as a Direct Contracted Provider or Customer-Specific Provider) with Network Providers in lieu of either Co-Administrator's Network Provider agreement with such Network Provider, nor shall Plan Sponsor be prohibited from engaging in discussions, proposals, or negotiations with Network Providers, either in connection with any potential Direct Contracted Provider or Customer-Specific Provider arrangement or otherwise. Plan benefits for health care services rendered by any Direct Contracted Provider or Customer-Specific Provider will be equal to the amounts such provider agreed to accept in the contractual arrangements governing such provider's agreement with respect to reimbursement by the Plan. In the event of a conflict or rate schedule conflict between the contractual arrangement governing the Plan-specific relationship with a Direct Contracted Provider or Customer-Specific Provider and such provider's Network Provider agreement with either Co-Administrator, the conflict will be resolved in accordance with Plan Sponsor's selected agreement with such provider. With respect to any Direct Contracted Provider, Plan Sponsor will provide Co-Administrators with the applicable rate schedule, and Plan Sponsor will notify Co-Administrators thirty (30) days in advance of any rate change to Plan Sponsor's contractual arrangements. Co-Administrators shall apply Plan Sponsor's contracted rates until Co-Administrators receive written instructions from Plan Sponsor to cease administering the Direct Contracted Provider arrangement. Plan Sponsor is responsible for the resolution of any Dispute specifically related to Plan Sponsor's contractual arrangement with any Direct Contracted Providers.

If, after completing a good-faith assessment of the feasibility of providing Services under any new Direct Contracted Provider arrangement, Co-Administrators conclude that a component of the proposed contract with the Direct Contracted Provider would make performance of the Core Services Infeasible, Co-Administrators shall, within thirty (30) calendar days after receipt of Plan Sponsor's notice of any new Direct Contracted Provider arrangement, deliver to Plan Sponsor an Infeasibility Notice.

In the event that Co-Administrators determine that any Direct Contracted Provider or Customer-Specific Provider arrangement contains terms that vary materially from Co-Administrators' Network Provider Agreements, such that the arrangement will increase Co-Administrators' costs or impact Co-Administrators ability to meet Performance Guarantees, Co-Administrators may, within thirty (30) calendar days after receipt of notice from Plan Sponsor of such new arrangement, furnish to Plan Sponsor an Impact Statement. Any Impact Statement delivered to Plan Sponsor shall: (i) describe any modifications required to interfaces, file layouts, business rules, or other processes, if applicable; (ii) set forth, in reasonable detail and supported by contemporaneous documentation, any Proposed Adjustments; and (iii) identify the specific material variance between the requested Direct- or Customer-Specific Contracted Provider arrangement and the then-existing Network Provider agreement that requires the Proposed Adjustment. For any Impact Statement proposing increased Fees or negative impacts to Plan Sponsor's Guarantees, Co-Administrators

shall provide, contemporaneously with the Impact Statement, all underlying cost studies, actuarial analyses, or other materials Co-Administrators relied upon in formulating the Proposed Adjustments. Co-Administrators agree that any Proposed Adjustments resulting from the circumstances described in this paragraph shall solely relate to additional costs that Co-Administrators will incur as a result of the new Direct Contracted Provider or Customer-Specific Provider arrangement. Plan Sponsor may dispute any Infeasibility Notice or Proposed Adjustment in accordance with Section 6.12.

Section 3: Prevention and Recovery Services

Co-Administrators will provide prevention and recovery Services for Overpayments and other Plan recovery and savings opportunities as described herein.

Overpayments. Co-Administrators will recover Overpayments by employing appropriate outreach to Participants and/or providers, as applicable, to demand reimbursement. If an Overpayment is the result of the errors or omissions of either Co-Administrator or any Affiliate or Subcontractor, an amount equal to the overpaid amount will be fully credited to Plan Sponsor on a dollar-for-dollar basis without offset for Co-Administrators' or any Affiliate, Subcontractor or collection agency expenses and regardless of the outcome of Plan Sponsor's recovery process.

Payment Integrity Services. Co-Administrators will undertake best efforts to prevent, identify, and resolve irregular Claims and to ensure Co-Administrators only make payment to providers for Clean Claims eligible for reimbursement under the Plan ("Payment Integrity Services"). The Payment Integrity Services help guard against potential errors, fraud, waste and abuse by reviewing Claims on a pre- or post-adjudicated basis.

The Payment Integrity Services processes will be based upon Co-Administrators' proprietary and confidential procedures, modes of analysis, and investigations. Payment Integrity Services include all work to identify recovery and savings opportunities, research, data analysis, investigation, and initiation of all Recovery Processes set forth below.

Recovery Process – Non-Class Action Recoveries. Plan Sponsor delegates to Co-Administrators the discretion and authority to develop and use standards and procedures for any non-class action Overpayment recovery opportunity, including but not limited to, whether or not to seek recovery, what steps to take if Co-Administrators decide to seek recovery, whether to initiate litigation or arbitration, the scope of such litigation or arbitration, which legal theories to pursue in such litigation or arbitration, and all decisions relating to such litigation or arbitration, including but not limited to, whether to compromise or settle any litigation or arbitration, and the circumstances under which a Claim may be compromised or settled for less than the full amount of the potential recovery. In all instances where Co-Administrators pursue recovery through litigation or arbitration, Plan Sponsor, on behalf of itself and on behalf of its Plan(s), will be deemed to have granted Co-Administrators an assignment of all ownership, title and legal rights and interests in and to any and all Claims that are the subject matter of the litigation or arbitration, subject to Co-Administrators' obligation to allocate recovered Overpayment amounts to Plan Sponsor in accordance with this Agreement.

Plan Sponsor acknowledges that use of Co-Administrators' standards and procedures may not result in full or partial recovery for any particular Claim. Co-Administrators will not pursue any recovery if it is not permitted by Law, or if recovery would be impractical, as determined in Co-Administrator's discretion. While Co-Administrators may initiate litigation or arbitration to facilitate a recovery, Co-Administrators have no obligation to do so; however, Plan Sponsor may request Co-Administrators to undertake or abandon litigation or arbitration with respect to any particular Claim(s), which Co-Administrators shall not

unreasonably deny. If Co-Administrators initiate litigation or arbitration, Plan Sponsor will use reasonable efforts to cooperate with Co-Administrators in the litigation or arbitration.

If this Agreement terminates, in whole or in part, Co-Administrators shall continue recovery activities for any Claims paid when the Agreement was in effect pursuant to the terms of this Section 3 and successful recoveries will be credited to Plan Sponsor.

Recovery Process – Class Action Recoveries. Where a class action purports to affect Plan Sponsor's (or the Plan(s) it sponsors or administers) right to and interest in any Overpayment, Co-Administrators have the right to determine whether to seek recovery of the Overpayment on Plan Sponsor's (or the plan(s) it sponsors or administers, including the Plan) behalf through litigation, arbitration, or settlement. If Co-Administrators elect to seek recovery of such an Overpayment that is at issue in a class action, Co-Administrators will provide written notice to Plan Sponsor of such intention. If Plan Sponsor does not want Co-Administrators to seek recovery of the Overpayment, Plan Sponsor shall notify Co-Administrators in writing within thirty (30) days of receiving notice from Co-Administrators. If Plan Sponsor does not so notify Co-Administrators, Plan Sponsor, on behalf of itself and on behalf of the Plan(s) it sponsors and administers, assigns to Co-Administrators all ownership, title and legal rights and interests in and to any and all Overpayments that are the subject matter of the class action. In such cases, Plan Sponsor will cooperate with Co-Administrators in any resulting litigation or arbitration that Co-Administrators may file to pursue the Overpayments.

If Plan Sponsor provides Co-Administrators with written notice that it does not want Co-Administrators to seek recovery of an Overpayment related to a class action (whether putative or certified) then, pursuant to its standard procedures, Co-Administrators will provide Plan Sponsor with related Overpayment Claims information, at Plan Sponsor's request. Plan Sponsor is then solely responsible for determining whether it will participate in the class action (whether putative or certified), participate in any class action settlement, pursue recovery of the relevant Overpayment outside of the class action, or take any other action with respect to any cause of action Plan Sponsor might have.

If this Agreement terminates, in whole or in part, Co-Administrators can continue recovery activities for any Claims paid when the Agreement was in effect pursuant to the terms of this Section 3 and successful recoveries will be credited to Plan Sponsor.

Offsetting Process. Recovery of Overpayments may occur by offsetting the Overpayment against future Plan payments to the provider. In effectuating Overpayment recoveries through offset, Co-Administrators will follow its established Overpayment recovery rules, subject to the limitations established in this paragraph, which include, among other things, prioritizing Overpayment credits based on: (1) the age of the Overpayment for electronic payments and (2) the funding type and the age of the Overpayment for check payments. Co-Administrators may recover the Overpayment by offsetting, in whole or in part, against future benefits that are payable under the Plan in connection with Services provided to any Participants. Reallocations pursuant to this process do not impact the decision as to whether or not a benefit is payable under the Plan. For the avoidance of doubt, Co-Administrators are not permitted to recover an Overpayment made to a provider by the Plan by reducing payments owed to that provider under a different plan. Co-Administrators shall hold Plan Sponsor and its Affiliates harmless for any and all losses and liabilities associated with Co-Administrators' offsetting processes.

In Co-Administrators' application of Overpayment recovery through offset, timing differences may arise in the processing of Claims payments, disbursement of provider checks, and the recovery of Overpayments. As a result, the Plan may in some instances receive the benefit of an Overpayment recovery before Co-Administrators actually receive the funds from the provider. Conversely, Co-Administrators may receive

the funds before the Plan receives the credit for the Overpayment. It is hereby understood that the Parties may retain any interest that accrues as a result of these timing differences. Details associated with Overpayment recoveries made on behalf of the Plan through offset will be identified in the monthly reconciliation report provided to Plan Sponsor.

Recovery Fees. Except as otherwise provided in this Agreement, Plan Sponsor will be charged a Fee for the Overpayment Recovery Services described in this Section 3. No Fees will be charged: (a) if the Overpayment is the result of the negligence of either Co-Administrator or any Affiliate or Subcontractor performing duties on Co-Administrators' behalf that caused the Overpayment; or (b) for recoveries obtained through a class action where Co-Administrators do not file an opt-out case on behalf of Plan Sponsor. Co-Administrators will not be responsible for reimbursement of any unrecovered Overpayment nor attorneys' fees and costs related to litigation or arbitration associated with recoveries except to the extent an arbitrator, arbitration panel, or court of competent jurisdiction determines that the Overpayment was due to the negligence of either Co-Administrator or any Affiliate or Subcontractor performing duties on Co-Administrators; behalf that caused the Overpayment.

Section 4: Fees for Medical Benefit Services

Fees. As consideration for Co-Administrators' performance of the Services described in this **Exhibit A** and effective as of the Service Start Date, Plan Sponsor shall pay Co-Administrators the Fees set forth in **Exhibit D** hereto. Plan Sponsor's payment for the Services provided under this Agreement shall be made only after the Services are rendered by Co-Administrators. Fees will be calculated on a pro-rated basis for any partial month of performance by Co-Administrators.

Changes in Fees Upon Renewal. Co-Administrators may change the Fees upon the expiration of any applicable multi-year Fee term as set forth in **Exhibit D**. For the avoidance of doubt, the current multi-year Fee term will expire after December 31, 2030.

Co-Administrators will provide Plan Sponsor with one hundred and eighty (180) days prior written notice of the revised Fees for each subsequent Renewal Term following the current multi-year Fee term, and such Fees will be effective the first day of such Renewal Term. Co-Administrators will provide Plan Sponsor with a new proposed **Exhibit D** that will replace the existing **Exhibit D**.

Other Changes in Fees. In addition to any Proposed Adjustments set forth under an Impact Statement and accepted by Plan Sponsor (as set forth in this Agreement), Co-Administrators may propose modifications to the Fees upon at least ninety (90) days' prior written notice to Plan Sponsor if any of the below-listed conditions change or occur, as applicable, during the Term, provided, however, that proposed Fee modifications may only be duly incorporated pursuant to an amendment to **Exhibit D** mutually agreed upon by all the Parties.

(a) If the total number of enrolled Participants varies by twenty percent (20%) or more (such variation excluding individuals enrolled in another plan administered by Co-Administrators) from the total number of enrolled Participants as of one (1) month following the Service Start Date

(b) Fees proposed are based on the plan of benefits as submitted but does not assume duplication of benefits or provisions. Fees proposed assume Plan Sponsor's Plan Design is a standard PPO plan design with no referral administration and no primary care physician tracking. Proposal assumes that the benefit plans will meet the steerage requirements of the networks proposed or will be

changed to meet the requirements, including but not limited to; deductible, out of pocket, coinsurance and plan limitations.

(c) In the event: (i) of any changes in federal, state or other applicable legislation or regulation impacting Co-Administrator's cost of Service delivery; (ii) in the event of any changes in Plan Design or procedures required by the applicable regulatory authority or by Plan Sponsor; (iii) any taxes, surcharges, assessments or similar changes being imposed by a governmental entity on the Plan or Co-Administrators in relation to the Services to Plan Sponsor.

(d) In the event of (i) any changes in federal, state or other applicable Law or rules; (ii) changes in Plan Design required by the applicable regulatory authority (e.g. mandated benefits) or by the customer; or (iii) any taxes, surcharges, assessments or similar charges being imposed by a governmental entity on the Plan or Co-Administrators.

(e) Fees proposed by either Co-Administrator assume one billing, reporting, eligibility feed, and banking arrangement.

(f) If the Average Contract Size (calculated as the total number of enrolled Participants divided by the total number of enrolled Employees), decreases or increases by fifteen percent (15%) or more from the assumed average contract size. As of the Effective Date, the assumed average contract size under this Agreement is 2.43.

Section 5: Medical Benefit Drug Rebate Allocation and Payment

Co-Administrators or a Subcontractor may negotiate with drug manufacturers, or an Administrative Services Organization (ASO) as an aggregator, regarding the payment of Medical Benefit Drug Rebates. Between Plan Sponsor and Co-Administrators, Co-Administrators will retain the entire value, inclusive of Manufacturer Administrative Fee (MAF) which are available within the agreement within the manufacturer, or between Co-Administrator and Co-Administrator, Medical Benefit Drug Rebates received by Co-Administrators or their Subcontractors.

Plan Sponsor agrees that during the Term of this Agreement, subject to any permitted insourcing pursuant to Section 6.10 of the Agreement, neither Plan Sponsor nor the Plan will negotiate or arrange or contract in any way for Medical Benefit Drug Rebates under the Plan's medical benefit outpatient drugs.

Section 6: Claim Determinations and Appeals

Initial Benefit Determinations and First Level Appeals. Co-Administrators shall establish and maintain all necessary procedures and controls to ensure that any payments made by Co-Administrators pursuant to this Agreement are only made with proper authorization in accordance with the relevant provisions of this Agreement and the Plan Documents. Plan Sponsor appoints each Co-Administrator a named fiduciary under the Plan with respect to (i) performing initial benefit determinations and payment, and (ii) performing the fair and impartial review of first level internal appeals. As such, Plan Sponsor delegates to each Co-Administrator the discretionary authority to (i) construe and interpret the terms of the Plan, and (ii) determine the validity of charges submitted to Co-Administrators under the Plan. If Co-Administrators deny a Claim, in whole or in part, Co-Administrators shall notify the claimant of the adverse benefit determination and the claimant will have the appeal rights set forth in the Summary Plan Description and those which are required under Law.

Each Co-Administrator agrees that it has a duty under this Agreement to safeguard against unnecessary utilization of services reimbursable as Plan benefits. In fulfillment of this duty, Co-Administrators shall establish parameters, informed by accepted standards of industry practice, and shall review each Claim to ensure that such Claim is a Clean Claim and that the services subject to such Claim have been performed in accordance with applicable Plan and Co-Administrator requirements.

Co-Administrators shall ensure that any use of artificial intelligence, algorithms or other software complies with applicable Law, including that Claims be consistently decided and that all clinical support tools are based on sound and generally acceptable logic and rules.

Second Level Appeals. Unless otherwise elected by Plan Sponsor, Co-Administrators shall perform the fair and impartial review of second level internal appeals and shall make final, binding determinations concerning the availability of Plan benefits under the Plan's internal appeal process, all in compliance with applicable Law. Co-Administrators shall notify the claimant of the outcome of the final internal appeal. The appeal determination will be final and binding on the claimant and all other interested parties, except as to a claimant's right to an appeal under the external review program.

External Review Program. In order for Plan Sponsor to meet its regulatory obligations with respect to Claim appeals or other applicable external review regulations, Plan Sponsor shall provide an external review program to claimants. Plan Sponsor may utilize Co-Administrators' external review program. In such case, the following will apply:

(a) The Fees for external review set forth in **Exhibit D** may apply;

(b) Plan Sponsor acknowledges that the independent review organizations are not Co-Administrators' Subcontractors; and

(c) Co-Administrators will cooperate fully in supporting Plan Sponsor in any review process but it is not responsible for the decisions of the independent review organizations.

Notwithstanding the foregoing provisions of this Section 6, Plan Sponsor retains full discretion to determine the outcome of any dispute regarding the interpretation of its Plan Documents or any Plan Design issue arising therefrom, provided, however, that such determination may not be applied retroactively to an appeal for which an adverse determination has been rendered.

Section 7: Systems Access

Access. Each Co-Administrator hereby grants Plan Sponsor the nonexclusive, nontransferable (except as set forth in this Section 7) right to access and use the functionalities contained within the Systems as mutually agreed upon by the Parties. Plan Sponsor must obtain and maintain, at no expense to Co-Administrators, internet connectivity required for Plan Sponsor to access the Systems. Plan Sponsor shall not:

(a) Access the Systems or use, copy, reproduce, modify, or excerpt any Systems documentation provided by Co-Administrators for purposes other than for Plan-related purposes or as expressly permitted under this Agreement.

(b) share, transfer or lease Plan Sponsor's right to access and use the Systems, to any other Person other than personnel of Plan Sponsor or its Affiliates, provided, however, Plan Sponsor may designate one or more third parties to access those Systems necessary for such third parties to access Claims Data and other Claims- or Plan-related information in connection with this Agreement or other Plan-related

purposes, provided the third party complies with the terms and conditions of such Systems access set forth herein and is subject to: (i) confidentiality restrictions at least as protective of Co-Administrator Confidential Information made available in the Systems as the relevant requirements of Section 7.3 of the Agreement; and (ii) any other contractual provisions required pursuant to applicable Data Privacy and Security Requirements.

Security Procedures. With respect to the Systems access described above, Plan Sponsor shall:

(a) use commercially reasonable physical and software-based measures to protect the passwords and user IDs provided by Co-Administrators;

(b) use commercially reasonable anti-virus software, intrusion detection and prevention system, secure file transfer and connectivity protocols to protect any email and confidential communications provided to Co-Administrators;

(c) maintain appropriate logs and monitoring of system activity; and

(d) notify Co-Administrators within a reasonable timeframe of Plan Sponsor becoming aware of any (i) unauthorized access or damage, including damage caused by computer viruses resulting from direct access connection, and (ii) misuse or unauthorized disclosure of passwords and user IDs provided by Co-Administrators.

Termination of Systems Access. Co-Administrators may terminate Plan Sponsor's System access and deactivate Plan Sponsor's identification numbers and passwords upon the later of two (2) years following the termination of this Agreement or two (2) years following the expiration of the Run-Out Period.

Section 8: Schedule of Services

[Attached Below]

EXHIBIT A

Schedule of Medical Benefit Services

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
Implementation of Plan.	Timely deployment of the Plan in coordination with Plan Sponsor, as defined in the Implementation Timeline (**Exhibit J**), including but not limited to: - Coordination with OLR for NYCAPS and Affiliated Membership Administrators for non-NYCAPS systems modifications - Receipt and processing of Plan Sponsor enrollment information, for the purpose of creating/sending welcome kits and enrollment onboarding - Eligibility files intake and loading - Communication to Plan Sponsor on implementation deliverables	Jointly managed and delivered by Emblem and UMR	
Ongoing maintenance and servicing of Plan,	Ongoing maintenance and servicing of the Plan, including but not limited to: - Monthly JLMC (Joint Labor Management Committee) meetings (in-person meetings scheduled in accordance with Section 5.10 of the Agreement) - Banking and billing support Reporting on clinical, savings programs and total cost of care (Optum Benefits Analytic Manager, etc.)	Jointly managed and delivered by Emblem and UMR	
Enrollment meetings and support.	Co-Administrators will hold virtual and in-person meetings with unions/welfare funds, agencies, and other current or prospective Participants to ensure that Participants are educated and informed on the Plan.	Jointly managed and delivered by Emblem and UMR	
NYCE PPO enrollment materials (for implementation and ongoing, upon new enrollment).	New Plan Implementation: Creation, printing, and mailing of the Welcome Packet to all eligible individuals: • Customized NYCE PPO Welcome Packet: -Announcement Letter -New Plan Description Brochure (subject to review and approval of the Plan Sponsor)	Enrollment material design and branding will be collaborative across both organizations.	Enrollment material design and branding will be collaborative across both organizations. UMR will distribute enrollment materials to Participants, whether through mailings, posting

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	-SBC All materials will be co-branded as UnitedHealthcare and Emblem On-Going Plan Enrollment Material Support: Creation, printing, and mailing of the enrollment materials, to all newly enrolled Participants, including the following: • ID Card (with QR code to Participant website with benefit details, Welcome Kit, SBC, and FAQs). • Member flyer (with links to Participant website). • All materials will be co-branded as UnitedHealthcare and Emblem.		materials to member portal, or otherwise, in accordance with applicable Laws and the terms of the Agreement
NYCE PPO Plan ID Card production and issuance.	Creation, printing and distribution/mailing of custom member ID cards to all Participants within required timelines. Ongoing printing (or re-printing), distribution/mailing and management of member ID cards will occur as needed. • ID Card will bear City of New York logo • ID Card will be co-branded as UnitedHealthcare and Emblem Union print shop	Design and branding will be collaborative across both organizations.	UMR will print and distribute ID cards in accordance with applicable Laws and terms of the Agreement.
Membership Administration Services	Membership Administration Services shall include: • Processing, handling and updating of Participant enrollment and related eligibility information • Formatting, storing and providing eligibility data for Plan Sponsor and vendors • Managing issues related to Participant enrollment and membership, including the creation, distribution and updates to Participant ID cards Plan Sponsor (or its designee or other authorized party) shall share information regarding which Eligible	Plan Sponsor (or its designee) will provide eligibility data to Emblem. Emblem will and transmit data to UMR for uploading and processing. Emblem will share eligibility data with UMR: • Full Files: Monthly • Daily Change Files: Daily (Monday-Friday)	UMR will load eligibility data into the UMR system. UMR with send Emblem standard email confirming files have been received and processed along with summary results.

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	Individuals and their dependents are Participants, including enrollment and disenrollment information. Co-Administrators will load such eligibility data electronically, for the purpose of determining eligibility for benefits and payments under the Plan. Co-Administrators will ensure that mapping of all coverage classes (individual, family, and split contracts), is processed correctly based on the eligibility file.		
Electronic billing, Claims funding and Fee payments.	• Payment of Monthly administrative fees is subject to the review and approval by Plan Sponsor of Administrative Fee invoice - as defined - "Sample Monthly Invoice" included within **Exhibit G** provided by Co-Administrators after confirmation by Plan Sponsor which shall occur within the timelines specified herein. • Payment of daily claims (is subject to the review and approval by Plan Sponsor of Daily Claims File as defined - "Daily Invoice Template" included in **Exhibit G** provided by Co-Administrators • **Monthly payment of fees associated with claims is** subject to the review and approval by Plan Sponsor which shall occur within the timelines specified herein Co-Administrators will provide a monthly summary of all Fees, Payments and related reconciliation on a monthly basis.	Emblem to draw down Fees and Claims fundings from Plan Sponsor bank account, based on the eligibility reconciliation and City, subject to confirmation by Plan Sponsor within the timelines specified herein. Fees and funded Claim amounts drawn from Plan Sponsor will be distributed between UMR and Emblem's respective bank accounts, subject to prior approval by Plan Sponsor.	
Online administration services accessed through Plan Sponsor employer portal, made available by Co-Administrators.	Online administrative services via Plan Sponsor employer portal to enable the City to view information including the following: • Online Participant eligibility maintenance • Claim status inquiry and online reporting Plan Sponsor is provided a designated number of users who are eligible to use the website. Co-Administrators reserve the right, from time to time, to change the	Emblem to maintain and provide access to the employer portal to City and welfare fund designated individuals.	

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	content, format and/or type of Co-Administrators reports, provided that such reports must continue to contain the minimum specifications required pursuant to the terms of this Agreement or otherwise reasonably required by Plan Sponsor. Co-Administrators will promptly deliver all non-standard or ad hoc reports (or standard reports at a non-standard frequency) that are requested by Plan Sponsor. Co-Administrators will designate a dedicated reporting analyst who will respond to all Plan Sponsor reporting requests.		
Financial Support Services	▪ Basic Claim projections using book of business assumptions for reserves and trend ▪ Basic benefit design changes & financial impact ▪ Basic premium-equivalent rate calculations		
Report Preparation and Filings.	Prepare and file (as applicable): • Pharmacy cost benefits and drug cost reports as required under the CAA • Provide language to support Plan Sponsor's annual CAA anti-gag clause attestation requirement • Air ambulance Claims reports as required under the CAA • Medicare Secondary Payer Reporting as required by the Medicare Secondary Payer Mandatory Reporting Provisions (the Reporting Requirements) in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007. • Annual government filings of 1099 reports to the IRS regarding payments made to physicians and other health care professionals and issuance of 1099s to providers • Provide required data necessary to enable Plan Sponsor to file Form 5500 (as applicable) • Non-certified reserve estimates • All other filings as required by applicable Law.	Emblem to provide support as needed. For pharmacy benefits, Emblem will submit (or ensure submission of) benefits and drug cost reports for pharmacy drug benefits.	UMR will issue annual anti-gag clause attestation. UMR will submit benefits and drug cost reports for medical drug benefits; Upon release of final rules governing air ambulance Claims reporting, UMR will provide reports.

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	○ Prescription Drug Data Collection by June 1 (annual) ○ MA1099HC reporting by January 31 (MA, only annual) ○ CMS Section 111 reporting (quarterly) ○ State assessments/surcharges (based on state requirements), including: ▪ Alaska Vaccine Assessment (quarterly) ▪ Connecticut Childhood Immunization Assessment (annual) ▪ Idaho Immunization Assessment (annual) ▪ Maine Guaranteed Access Reinsurance Assessment (quarterly) ▪ Maine Vaccine Assessment (quarterly) ▪ Massachusetts Payor Assessment (monthly) ▪ New Hampshire Vaccine Association Assessment (quarterly) ▪ New Hampshire Health Plan Assessment (quarterly) ▪ New Mexico Vaccine Assessment (quarterly) ▪ New York Health Care Reform Act (HCRA) Surcharge / Patient Services Surcharge (monthly) ▪ New York Covered Lives Assessment (monthly) ▪ Rhode Island Vaccine Assessment Program (quarterly) ▪ Rhode Island Children's Health Account (quarterly)		

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	▪ Vermont Health Care Claim Assessment (annual) ▪ Vermont Vaccine Assessment (quarterly) ▪ Washington Provider Access Line (WA PAL) (quarterly) o Provide assistance with preparing and filing PCORI fees. All draft filings, reports, information, data, and other materials in support of the reports and filings described above will be provided for Plan Sponsor's review and approval at least thirty (30) days prior to the applicable filing or reporting deadline.		
Summary Program Description Assistance	At least annually Co-Administrators will prepare a customized draft of the Plan's SPD, subject to review and approval by Plan Sponsor. The approved version of Plan SPD will be made available electronically on the Co-Administrator microsite and the OLR Health Benefits Program website. Plan Sponsor shall provide Co-Administrators with a copy of the NYCE PPO Plan section of the NYC SPD for Co-Administrators' review in a timely manner (no later than thirty (30) days prior to the date Plan Sponsor plan to send its open enrollment announcement letter) to ensure consistency with Co-Administrators' administration of the Plan under this Agreement and the Plan SPD. The Plan SPD will be in English with translated versions available upon Plan Sponsor request at an additional cost. If the Plan SPD is not finalized in advance of the Service Start Date, Co-Administrators will (i) utilize the summary of Plan benefits and exclusions document that Co-Administrators create based on Co-Administrators' understanding of Plan Sponsor's Plan design and which Plan Sponsor has reviewed and approved or (ii) create, at Co-Administrators' discretion, an operational Plan SPD which will be based upon the Plan benefits and exclusions that Plan Sponsor has reviewed and	Plan Sponsor will work with Emblem and UMR to customize the NYCE PPO Plan section of the SPD.	Plan Sponsor will work with UMR and Emblem to customize the NYCE PPO Plan section of the SPD.

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	approved. Co-Administrators will administer Claims and otherwise provide the Services in accordance with the above until a final Plan SPD is approved by Plan Sponsor. Co-administrators will provide an initial draft of the Plan SPD 30 days prior to open enrollment for new plan implementation. All customization is the responsibility of the Plan Sponsor.		
Summary of Benefits and Coverage ("SBC")	Annual SBC provided electronically in Co-Administrators' standard format, subject to Plan Sponsor's review and approval. Co-Administrators will make changes to the SBC at the direction of Plan Sponsor. All changes made to plan benefits will be posted on Plan Sponsor's portal.	Emblem is responsible for customization and additional SBCs outside the UMR standard agreement, including PBM information (to be added to SBC prepared by UMR).	UMR will create SBCs. SBCs will be in UMR's standard layout and provided in Word format; any customization would need to be handled by Emblem or the Plan Sponsor. SBCs will contain both medical and PBM information. UMR will distribute plan documents, SBCs, etc. to members electronically or in writing, as required by applicable law.
NYCE PPO Plan Microsite, Member Portal, and Mobile App	Co-Administrators shall create and maintain the NYCE PPO Plan microsite, member portal, and mobile app for all Participants. All applications must be in compliance with local, state, and federal regulations regarding cybersecurity and must be ADA compliant. Participants must be able to securely access their member eligibility and claim information, including all EOBs and plan materials.	Co-Administrators are responsible for customization and creation of microsite, member portal, and mobile app.	
Provider Services	Co-Administrators shall provide a toll-free phone number/point of contact for all provider services. Co-Administrators shall internally route all provider inquiries, appeals, requests or other communications to the appropriate internal teams at the respective Co-Administrator businesses, as set forth herein.	Emblem will address provider contract disputes related to its provider contracts.	UMR shall maintain the toll-free provider number and triage as appropriate based on the nature of the provider call and location. Provider disputes that involve Emblem provider contracts will be routed back to Emblem for resolution. UMR will address

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
			provider contract disputes related to its provider contracts.
Member Services	Co-Administrators shall maintain and operate a single phone number/point of contact for all member/Participant services, which will be printed on all Participant ID cards, as well as other Participant enrollment materials. Co-Administrators shall internally route all Participant inquiries, in-patient admissions, pre-certifications, appeals, requests or other communications to the appropriate internal teams at the respective Co-Administrator businesses, as set forth herein.	Emblem staff will answer member calls using UMR's telephony system. Phone number will be the current NYC member number. Emblem will access the United Advocacy Tool (UMR's Plan Advisor Dashboard) to manage calls.	Calls will be answered using UMR's telephony system. UMR will provide the United Advocacy Tool (UMR's Plan Advisory Dashboard)
Member Communications	City of New York facing member communications	Member Communications related to promotion and engagement will come from Emblem. This includes documents customized for specific populations or programs.	UMR's systems will be used to send systemic/auto-generated communications such as EOBs as noted above.
Claims Adjudication and Claims Payment Services	Claims Adjudication activities, including: • Pricing, re-pricing and payment of Clean Claims; • Auto and manual adjudication using proprietary software, and • Pending and subsequent Claim review. Provide an Explanation of Benefits (EOB) notice to Participants and Remittance Advice (RA) statement to providers Claims for Plan benefits must be submitted by providers or Participants in a form that is satisfactory to Co-Administrators in order for Co-Administrators to determine whether a benefit is payable under the Plan. Co-Administrators will only issue payment in response to Clean Claims from providers/Participants. Except as set forth in this Agreement or otherwise specified by Plan Sponsor, Plan Sponsor delegates to Co-	*Emblem will not perform any Claims Adjudication services; all Claims Adjudication will be conducted by UMR.* To enable UMR to conduct Claims Adjudication for Claims for Plan benefits for services delivered in the Downstate Counties, Emblem shall provide pricing information to UMR in standard 837 files for Claims originating from the Downstate Counties (excluding Behavioral Health Services).	UMR will be responsible for all Claims Adjudication, including: new day claims, adjustments, correspondence, processing from all mediums received from Participants and providers, file intake, distribution of electronic and paper payments, EOBs, EOPs, maintaining reporting data, access for providers (and processing of standard 837 file from Emblem for Downstate County Claims) UMR will have responsibility for monitoring and managing Claim performance, including but not limited to inventory and aging.

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	Administrators the discretion and authority to use Co-Administrators' Claim procedures and standards for Claim determinations.		
Pre-payment review/Payment Integrity	Claims shall not be Paid and will pend for cost control purposes until pre-payment Payment Integrity activities are completed (including but not limited to): - Prospective fraud, waste and abuse (FWA) review - Pre-payment subrogation - Administrative Claims review - Out of network program strategy - Coordination of benefits - Large claim team review (more than $25,000) - Advanced Claim Review (targeted cost containment review of high-cost Claims and records) - SIU (Special Investigation Unit) activities	Emblem will collaborate with UMR on any escalated SIU investigations in the downstate 13 counties.	UMR will be responsible for all pre-payment Payment Integrity service, regardless of geography. UMR will report volumes and findings on a monthly basis.
Post-payment review/ Payment Integrity and Recovery.	Co-Administrators shall use best efforts to monitor patterns of Network Providers who may be contributing to overutilization of Plan benefits, including a comprehensive remediation plan to investigate and remediate questionable Claim billing and benefit utilization practices. Plan Sponsor or its designee shall have the right to review and request further information, including the itemized claim form and all Claim Supporting Documentation, relating to any paid Claim, including on a recurring basis for specified Claim types (e.g. by CPT, DRG or NDC). Such information shall be made available to Plan Sponsor or its designee promptly upon Plan Sponsor's request. If Plan Sponsor or its designee identify an issue with any paid Claim resulting in an anticipated or actual Overpayment, such Overpayment will be resolved by Co-Administrators in accordance with Section 3 of this **Exhibit A** above.		UMR to implement a program that identifies Claim Overpayments and pursues recovery in accordance to state regulations and provider contracts (special handling providers). UMR monitors and reports recoveries and outstanding balances. To the extent Overpayments are identified and eligible for recovery, UMR will offset such Overpayments against future Plan payments made to the provider to the extent consistent with the provider contract (subject to limitations on offsetting against payments from other plan other than the Plan described in Exhibit A).

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
			UMR's subrogation vendor will send letters, as applicable, for those claims that are identified for post-payment review based on diagnosis and dollar threshold.
Prior Authorization Medical Necessity/Utilization Management (UM) Review	Review of pre-service requests (i.e., prior authorization for clinical services) to ensure the provision of medically necessary and appropriate services, including site of service. Co-Administrators shall provide Prior Authorization, First Level Appeal and Second Level Appeal (including Peer-to-Peer review) services for Pre-Service Utilization Management reviews, as fiduciary. Co-Administrators adhere to state law for utilization management turnaround times, defaulting to URAC guidelines when state law is silent.	Emblem will handle UM, including prior authorization, pre-determination, pre-service appeals and peer-to-peer review, for medical services in the Downstate Counties, with the exception of any: (i) advanced imaging services, (ii) genetic testing, (ii) physical therapy (PT); (iii) occupational therapy (OT); (iv) speech therapy (ST); and (v) Behavioral Health/Substance Abuse Disorder (BH/SUD). *UMR will serve as the primary point of contact and interface with providers and Participants on all appeals*. In the event of any pre-service medical UM appeals in the Downstate Counties (with the exception of any: (i) advanced imaging services, (ii) genetic testing, (ii) physical therapy (PT); (iii) occupational therapy (OT); (iv) speech therapy (ST); and (v) Behavioral Health/Substance Abuse Disorder (BH/SUD).), Emblem may work with UMR behind the scenes to resolve. Emblem will utilize UMR systems and follow UMR	UMR will handle UM, including prior authorization pre-determination, pre-service appeals and peer-to-peer review, for all services outside of the Downstate Counties. UMR will also handle all such UM services for (i) advanced imaging services, (ii) genetic testing, (ii) physical therapy (PT); (iii) occupational therapy (OT); (iv) speech therapy (ST); and (v) Behavioral Health/Substance Abuse Disorder (BH/SUD), regardless of the geographic area. For the purpose of any appeals (including both 1st and 2nd level appeals) relating to prior service UM, UMR shall be the primary point of contact and interface with providers and Participants, and shall provide systems access, data, letter fulfillment and related support. *To the extent that any such appeals relate to medical services in the Downstate Counties, Emblem and UMR shall coordinate internally*.

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
		protocols for the provision of UM services.	
Claims Review, Denials and Appeals and Retrospective UM Determinations	Review of Claims that are partially or fully denied (adverse benefit determinations), for reasons including: investigational and experimental, cosmetic, not medically necessary, no prior authorization, global/inclusive to another procedure. Co-Administrators shall provide Initial Benefit Determinations, First Level Appeal and Second Level Appeal Services for Claims in accordance with the requirements of Section 6 of this **Exhibit A**.	*UMR will serve as the primary point of contact and interface with providers and Participants on all appeals*. In the event of any post-service appeals of Claim denials based on UM in the Downstate Counties (with the exception of any: (i) advanced imaging services, (ii) genetic testing, (ii) physical therapy (PT); (iii) occupational therapy (OT); (iv) speech therapy (ST); and (v) Behavioral Health/Substance Abuse Disorder (BH/SUD).), Emblem may work with UMR behind the scenes to resolve.	UMR will handle all post-service appeals regardless of geographic area. For the purpose of any post-service Claims appeals, UMR shall be the primary point of contact and interface with providers and Participants, and shall provide systems access, data, letter fulfillment and related support.
Administrative Review, Denials and Appeals	Review of claims for services or items partially or fully denied for not being in accordance with the SPD. Co-Administrator shall provide initial benefit determination, First Level and Second Level Appeals for claims denied for not being in accordance with the SPD. Co-Administrators will notify Plan Sponsor and provide copies of denials as part of its fiduciary responsibility.	*UMR will serve as the primary point of contact and interface with providers and Participants on all appeals*. In the event of any post-service appeals of Claim denials based on UM in the Downstate Counties (with the exception of any: (i) advanced imaging services, (ii) genetic testing, (ii) physical therapy (PT); (iii) occupational therapy (OT); (iv) speech therapy (ST); and (v) Behavioral Health/Substance Abuse Disorder (BH/SUD).), Emblem may work with UMR and Plan Sponsor behind the scenes to resolve.	For the purpose of any post-service Claims appeals, UMR shall be the primary point of contact and interface with providers and Participants, and shall provide systems access, data, letter fulfillment and related support. UMR may work with the Plan Sponsor behind the scenes to resolve.
Peer-to-Peer Review	Clinical discussion(s) conducted between the requesting or treating provider and a licensed physician (or other appropriate clinician) of the same or similar specialty.	In the event of any post-service requests for peer-to-peer review relating to Claim denials based on	For the purpose of any requests for peer-to-peer review relating to a post-service Claim denial, UMR

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	The purpose of the Peer-to-Peer Review is to allow the provider an opportunity to present additional clinical information or discuss the medical necessity of a requested service prior to issuance of a final adverse determination.	UM in the Downstate Counties (other than for the above exempt services), Emblem may work with UMR behind the scenes to resolve such requests.	shall be the primary point of contact and interface with providers and Participants, and shall provide systems access, data, letter fulfillment and related support. *To the extent that any such requests for peer-to-peer review relating to Claims denials of medical services in the Downstate Counties relating to UM, Emblem and UMR shall coordinate internally.* UMR will handle all peer-to-peer reviews for post-service Claims denials outside of the Downstate Counties, and for Claims relating to (i) advanced imaging services, (ii) genetic testing, (ii) PT; (iii) OT; (iv) ST; or (v) BH/SUD, regardless of the geographic area.
Grievances and Complaints	Intake, track and respond, within required timelines, to all Participant and provider grievances and complaints. Co-Administrators shall provide Plan Sponsor with a summary of grievances and complaints on a weekly basis.	*UMR will serve as the primary point of contact and interface with providers and Participants for all grievances and complaints.* In the event of any grievance or complaints relating to medical services in the Downstate Counties (with the exception of any: (i) advanced imaging services, (ii) genetic testing, (ii) physical therapy (PT); (iii) occupational therapy (OT); (iv) speech therapy (ST); and (v) Behavioral Health/Substance Abuse Disorder (BH/SUD).), Emblem may work with UMR behind the scenes to resolve.	For the purpose of any grievances or complaints, UMR shall be the primary point of contact and interface with providers and Participants, and shall provide systems access, data, letter fulfillment and related support. *To the extent that any such appeals relate to concerns or questions about medical services in the Downstate Counties, Emblem and UMR shall coordinate internally*. Refer to ASA for additional details.

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
Provider Network Disputes	Intake, track and respond, within required timelines, to Provider disputes related to participation and reimbursement. Co-Administrators shall provide Plan Sponsor monthly report of material disputes.	Emblem will handle all Provider contract disputes relative to the application of the Emblem contract with Emblem Network Providers within the Emblem service area. A contractual dispute shall mean any dispute related to a contractual provision; a Claim dispute shall mean the accuracy of Claims processing.	UMR shall be the primary point of contact and interface with providers for intake of all provider disputes. To the extent that any disputes relate to Emblem's contracted network, UMR will assign such dispute to Emblem for resolution. All other provider disputes will be handled by UMR.
Coordination of benefits.	Coordination of benefits for all applicable medical and BH/SUD Claims including ACA and diabetic supplies that meets the requirements for COB processing.		UMR will manage the coordination of medical and BH/SUD benefits.
Production and distribution of explanation of benefits.	- Print and distribute EOBs to members, in addition to making EOBs available on the member portal. - Design and draft content for EOBs including inserts that address Federal and State regulations, subject to review and approval by Plan Sponsor	Design and template for EOBs will be collaborative across both organizations.	UMR will print and send out EOBs, and make EOBs available on the member portal. Design and template for EOBs will be collaborative across both organizations.
Network access, management, and administration.	Ongoing management of and provision of access to Co-Administrator facility and professional networks, including but not limited to contracting, credentialing and recredentialing, maintenance of provider directories, etc. Includes Value Based Contracting where relevant.	Emblem will provide access to its Provider Network for services delivered in the Downstate Counties. *Does not include BH/SUD services.*	UMR will provide access to its national network (Choice Plus) in all geographies except the Downstate Counties. UMR will provide access to its national Behavioral Health Network in all geographies. UMR will support and provide access to UnitedHealth Network (UHN) providers in Puerto Rico.
Out of network programs	For all out-of-network claims (excluding Inadvertent Services - defined by the No Surprises Act of the 2021 Consolidated Appropriations Act), Plan Sponsor has chosen a reimbursement level based on 100% of Medicare as of the Effective Date unless a different level is established by Plan Sponsor. Reductions are applied		UMR will be responsible for administering the OON programs regardless of geography. UMR will provide monthly reports for OON utilization and savings.

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	according to Medicare's cost-based methodology or gap fill methodology if no Medicare value is available. UMR will utilize CRS Non-Par Cost Containment (NPC2): For Inadvertent Services - defined by the No Surprises Act of the 2021 (Consolidated Appropriations Act). CRS will determine a Qualified Payment Amount that would be the proposed allowed reimbursement for an Inadvertent Service. Provider disputes are settled through negotiations or Independent Dispute Resolutions according to this federal regulation. Members are held harmless for inadvertent services but are responsible for participant cost-sharing and balance billing for all other OON claims.		
Federal No Surprises Act ("NSA") medical billing and the Independent Dispute Resolution ("IDR")	(1) Co-Administrators will determine if a Claim is subject to the NSA billing protections. (2) If Co-Administrators and a provider are unable to come to an agreement within the prescribed negotiation period for a Claim subject to the NSA billing protections, Co-Administrators will manage, direct, and make decisions and submissions to support the IDR for Plan Sponsor. (3) Co-Administrators will not use third party provider networks for services covered by the NSA. (4) The Fees for programs in which the parties share in the savings achieved off a provider's billed charge will continue to apply to all services covered under the NSA. (5) Plan Sponsor shall fund all settlement amounts and payments required as a result of any IDR process decision through the Bank Account. (6) Plan Sponsor shall fund the IDR administration fee and all IDR arbitrator fees through the Bank Account		UMR will handle all "No Surprise Act" negotiations with out-of-network providers regardless of the provider's location including any associated appeals that go through independent dispute resolution.
Catastrophic Events.	During such time a state or government agency declares a state of emergency or otherwise invokes emergency procedures with respect to Participants who may be	All activities in the description will be jointly managed by Emblem and UMR as needed and we will partner closely with Plan Sponsor and unions/welfare funds to ensure delivery.	

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	affected by severe weather or other catastrophic events (a "Catastrophic Event Timeframe") impacting public health or access to healthcare, Plan Sponsor directs Co-Administrators to implement certain mutually agreed upon changes and processes in Co-Administrators' Claim procedures for affected Participants, including, for example: (a) exemption from the application of prior authorization requirements and/or penalties; (b) waiver of out-of-network restrictions (e.g., out-of-network providers paid at the Network Provider level); (c) extension of time frames for claims filing and/or appeals; (d) early replacement of lost or damaged durable medical equipment; and (e) other protocols reasonably required to provide Participants with access to health and pharmacy benefits, as applicable. Such protocols are applicable to Participants residing within impacted areas of the Catastrophic Event, and for dates of service that fall within the Catastrophic Event Timeframe.		
Health Plan Transparency in Coverage Rule ("TiC").	Co-Administrators will support Plan Sponsor's compliance by providing (1) machine-readable files (MRF) that are accessible via a publicly available website, which Plan Sponsor will be able to access and link to Plan Sponsor's own website, and (2) a cost estimator tool available online for Plan Participants for the items and services as required each year.	*Emblem will not perform any Claims Adjudication services; all Claims Adjudication will be conducted by UMR*. Emblem will return Claim pricing (for Emblem participating and non-participating providers) for medical services in the Downstate Counties to UMR via EDI in a standard 837 file format UMR will be responsible for the process of applying clinical edits to the Emblem Claims. Emblem will send required provider data and MRF data in a mutually agreed upon format for the Downstate Counties to UMR using UMR's required naming	UMR will route medical Claims from the Downstate Counties (other than for excluded services described above) to Emblem for Claim pricing in a standard 837 file format. Emblem provider data and rates, in addition to UHC Choice Network provider data and rates will be fed to UMR's consumer cost transparency tool (CPPT). BH/SUD provider data and rates will also be made accessible through United's consumer cost transparency tool (CPPT) . UMR will make the cost transparency tool (CPPT) available to Participants on the member

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
		convention, refreshed minimum of weekly. Emblem will continue to have accountability for MRF/Cost Transparency tool for Pharmacy and making available to Participants.	portal, which includes details for UMR and Emblem providers. UMR establish and update an online provider directory accessible by Participants.
Mental Health Parity Non-Quantitative Treatment Limitations ("NQTL").	Provide a comparative analysis of the Plan's NQTLs applicable to medical/surgical and mental health/substance use benefits in compliance with the CAA. Provide an analysis of the Plan's QTLs applicable to medical/surgical and mental health/substance use benefits. Provide support requested by Plan Sponsor related to Mental Health Parity NQTL audits initiated by the U.S. Department of Labor, U.S. Department of Health and Human Services, or the U.S. Department of Treasury.	All activities in the description will be jointly managed by Emblem and UMR. Co-Administrators will partner closely with Plan Sponsor to ensure delivery.	
Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") Services.	Standard federal COBRA Services include an administration manual, member services, reporting, conversion, requests for review, eligibility updates, review of disability extension requests, and termination processing. Co-Administrators will provide the first and second level of review and communicate the decision. On a quarterly basis, Co-Administrators will return all amounts collected from qualified beneficiaries to Plan Sponsor, less any amounts owed by Plan Sponsor to Co-Administrators as it relates to COBRA. In the event a qualified beneficiary's coverage terminates prior to the maximum continuation of coverage period (including termination for non-payment), Co-Administrators will provide the qualified beneficiary with a written notice of early termination. Plan Sponsor must provide Co-Administrators with written notice of any changes in monthly contribution rates pursuant to federally mandated COBRA time	*Jointly managed. Work flows to follow.*	*Jointly managed. Work flows to follow.*

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	frames. Co-Administrators may accept partial payment amounts sent by qualified beneficiaries. Plan Sponsor has final authority to decide all COBRA questions, including matters of clerical error concerning qualified beneficiaries' eligibility for continued coverage under the Plan. Plan Sponsor is responsible for compliance with COBRA, including establishing the amount the qualified beneficiary must contribute to continue coverage under the Plan. Specific to COBRA Services, the Prevention and Recovery Services section of this Agreement does not apply to the administration of the COBRA Services which shall be separate and apart from COBRA Claims processing. UMR will apply fraud, waste, and abuse programs for COBRA claims as outlined in Section 3 of this Exhibit A above.		
Telemedicine Services from Teladoc.	Standard telemedicine services include Participant access to a telehealth network with telephonic and web-based video medical consultations or other online provider access, as allowed by state law provided by Teladoc.	Emblem will maintain the contract with Teladoc and provide timely updates to UMR, ensuring the contract allows Teladoc to submit claims and obtain benefit eligibility, and accumulator information from UMR. Reporting will come to Emblem directly from Teladoc; however claims data will be housed in UMR's InfoPort. Marketing information for Teladoc will be supplied by Emblem. Emblem will be responsible for performance management and oversight of Teladoc.	UMR will perform Claims Adjudication for Teladoc Claims according to the Emblem contract with Teladoc.
Case Management	Case Management services handled by licensed nurses who serve as Case Managers.	Emblem will handle all High Risk Case Management (CM) for all	UMR will handle all BH/SUD Case Management.

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	- Lead program design and conduct case/care management capabilities - Implement and maintain care management platform - Conduct and tracking all member assessments 1. Identify individuals for Case Management through the following: Prior authorization data for early identification to proactively reach out to Participants before treatment begins including certain elective procedures and services. All inpatient cases are outreached for Care Management Services for support with discharge needs and transition of care; 2. Claims data for indicators of a complex condition (e.g., cancer, organ transplant, complicated pregnancy) 3. Referrals from Other UMR Programs or External resources: o Participants may be referred from other CARE or external solutions such as: ▪ Maternity CARE ▪ EAP ▪ Wellness ▪ Employer referrals ▪ Provider referrals ▪ Advocacy 4. High-Risk Case Identification 5. Reporting: CARE reporting provides actionable insights into health engagement, clinical risk management, and cost containment strategies. These reports include detailed breakdowns of prior authorization activity, outreach effectiveness, and care coordination. They are designed to help identify trends, optimize service utilization, and demonstrate the impact of our programs on both member outcomes and financial performance. Plan Sponsor will receive Utilization Management (Prior Authorization data), Emerging CARE, Complex Condition CARE, and Maternity CARE reporting. These	Participants, except for services relating to BH/SUD. High risk cases are those for which accumulated Claim costs reach a certain threshold (e.g., 50% of a predefined limit), indicating potential complexity. Emblem will use UMR systems to perform Case Management and documentation. Emblem will provide ongoing training with support from UMR.	

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
	reports are made available monthly, quarterly, or annually. 6. Member Appeals: Pre Service & Post Service - Member Appeals – 30 calendar days, Federal Appeals – 4 Months		
Emerging CARE and Maternity CARE	Condition management including: - Maternity care - Frequent ER visits - Behavioral Health / Substance Use Disorders - Pre- admission counseling - LGBTQ+ support - Discharge support - Medical specialty medications - Denial and appeal support - Fertility		UMR will handle Maternity Management and moderate risk management programs for all members.
Diabetes Management	Diabetes management and diabetes reversal programs including: - Continue to operate the existing A1chieve program for members with Diabetes - Type 2 diabetes reversal program aimed to decrease or eliminate the need for diabetes medication	EH will handle diabetes management programs for all members.	
Wellness Program	On-demand health coaching for Participants and access to the WellSpark Digital Platform, which includes an online web application and website that offers Participants tools for: (i) activity tracking, (ii) personalized health assessments, (iii) on-demand webinars and health content; and (iv) on-demand interactive health education courses.	Emblem will provide all Wellness Program services.	
Subrogation	Oversight & Authority: The Plan Sponsor may guide whether cases are pursued or settled ensuring appropriate oversight of plan assets. Process & Reporting: Member questionnaires are used to gather details, and reporting is provided to the Plan Sponsor to track subrogation activity and case status.	Emblem to assist with coordination and resolution of existing subrogation cases.	UMR's subrogation vendor will identify claims with subrogation opportunity based on diagnosis code and dollar threshold. Outreach will be made to Participants, as needed, to collect accident details and will pursue viable sources of recovery

Service	Description	Emblem Responsibilities/ Resources *(if applicable)*	UMR Responsibilities/ Resources *(if applicable)*
			on behalf of the health plan. Monthly activity reporting will be sent to the designated contact via secure email.
Pharmacy Services	Pharmacy services through Prime Therapeutics.	Emblem will be responsible for providing Pharmacy Services as outlined in Exhibit B. Emblem will be responsible for performance management and oversight of Prime.	

APPENDIX A

GENERAL PROVISIONS GOVERNING CONTRACTS FOR CONSULTANTS, PROFESSIONAL, TECHNICAL, HUMAN, AND CLIENT SERVICES

ARTICLE 1 - DEFINITIONS

Section 1.01 Definitions

The following words and expressions, or pronouns used in their stead, shall, wherever they appear in this Agreement, be construed as follows, unless a different meaning is clear from the context:

A. "Agency Chief Contracting Officer" or "ACCO" means the position delegated authority by the Agency Head to organize and supervise the procurement activity of subordinate Agency staff in conjunction with the City Chief Procurement Officer.

B. "Agreement" means the various documents, including this Appendix A, that constitute the contract between the Contractor and the City.

C. "City" means the City of New York.

D. "City Chief Procurement Officer" or "CCPO" means the position delegated authority by the Mayor to coordinate and oversee the procurement activity of Mayoral agency staff, including the ACCOs.

E. "Commissioner" or "Agency Head" means the head of the Department or his or her duly authorized representative. The term "duly authorized representative" shall include any person or persons acting within the limits of his or her authority.

F. "Comptroller" means the Comptroller of the City of New York.

G. "Contractor" means the entity entering into this Agreement with the City.

H. "Days" means calendar days unless otherwise specifically noted to mean business days.

I. "Department" or "Agency" means the City agency or office through which the City has entered into this Agreement.

J. "Law" or "Laws" means the New York City Charter ("Charter"), the New York City Administrative Code ("Admin. Code"), a local rule of the City of New York, the Constitutions of the United States and the State of New York, a statute of the United States or of the State of New York and any ordinance, rule or regulation having the force of law and adopted pursuant thereto, as amended, and common law.

K. "Procurement Policy Board" or "PPB" means the board established pursuant to Charter § 311 whose function is to establish comprehensive and consistent procurement policies and rules that have broad application throughout the City.

L. "PPB Rules" means the rules of the Procurement Policy Board as set forth in Title 9 of the Rules of the City of New York ("RCNY"), § 1-01 *et seq*.

M. "SBS" means the New York City Department of Small Business Services.

N. "State" means the State of New York.

ARTICLE 2 – REPRESENTATIONS, WARRANTIES, CERTIFICATIONS, AND DISCLOSURES

Section 2.01 Procurement of Agreement

A. The Contractor represents and warrants that, with respect to securing or soliciting this Agreement, the Contractor is in compliance with the requirements of the New York State Lobbying Law (Legislative Law §§ 1-a *et seq*.). The Contractor makes such representation and warranty to induce the City to enter into this Agreement and the City relies upon such representation and warranty in the execution of this Agreement.

B. For any breach or violation of the representation and warranty set forth in Paragraph A above, the Commissioner shall have the right to annul this Agreement without liability, entitling the City to recover all monies paid to the Contractor; and the Contractor shall not make claim for, or be entitled to recover, any sum or sums due under this Agreement. The rights and remedies of the City provided in this Section 2.01(B) are not exclusive and are in addition to all other rights and remedies allowed by Law or under this Agreement.

Section 2.02 Conflicts of Interest

A. The Contractor represents and warrants that neither it nor any of its directors, officers, members, partners or employees, has any interest nor shall they acquire any interest, directly or indirectly, which conflicts in any manner or degree with the performance of this Agreement. The Contractor further represents and warrants that no person having such interest or possible interest shall be employed by or connected with the Contractor in the performance of this Agreement.

B. Consistent with Charter § 2604 and other related provisions of the Charter, the Admin. Code and the New York State Penal Law, no elected official or other officer or employee of the City, nor any person whose salary is payable, in whole or in part, from the City Treasury, shall participate in any decision relating to this Agreement which affects his or her personal interest or the interest of any corporation, partnership or other entity in which he or she is, directly or indirectly, interested; nor shall any such official, officer, employee, or person have any interest in, or in the proceeds of, this Agreement. This Section 2.02(B) shall not prevent directors, officers, members, partners, or employees of the Contractor from participating in decisions relating to this Agreement where their sole personal interest is in the Contractor.

C. The Contractor shall not employ a person or permit a person to serve as a member of the Board of Directors or as an officer of the Contractor if such employment or service would violate Chapter 68 of the Charter.

Section 2.03 Certification Relating to Fair Practices

A. The Contractor and each person signing on its behalf certifies, under penalties of perjury, that to the best of its, his or her knowledge and belief:

1. The prices and other material terms set forth in this Agreement have been arrived at independently, without collusion, consultation, communication, or agreement with any other bidder or proposer or with any competitor as to any matter relating to such prices or terms for the purpose of restricting competition;

2. Unless otherwise required by Law or where a schedule of rates or prices is uniformly established by a government agency through regulation, policy, or directive, the prices and other material terms set forth in this Agreement that have been quoted in this Agreement and on the bid or proposal submitted by the Contractor have not been knowingly disclosed by the Contractor, directly or indirectly, to any other bidder or proposer or to any competitor prior to the bid or proposal opening; and

3. No attempt has been made or will be made by the Contractor to induce any other person or entity to submit or not to submit a bid or proposal for the purpose of restricting competition.

B. The fact that the Contractor (i) has published price lists, rates, or tariffs covering items being procured, (ii) has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or (iii) has sold the same items to other customers at the same prices and/or terms being bid or proposed, does not constitute, without more, a disclosure within the meaning of this Section 2.03.

Section 2.04 Disclosures Relating to Vendor Responsibility

The Contractor represents and warrants that it has duly executed and filed all disclosures as applicable, in accordance with Admin. Code § 6-116.2, PPB Rule § 2-08, and the policies and procedures of the Mayor's Office of Contract Services. The Contractor acknowledges that the Department's reliance on the completeness and veracity of the information stated therein is a material condition to the execution of this Agreement, and the Contractor represents and warrants that the information it and its principals have provided is accurate and complete.

Section 2.05 Disclosure Relating to Bankruptcy and Reorganization

If the Contractor files for bankruptcy or reorganization under Chapter Seven or Chapter Eleven of the United States Bankruptcy Code, the Contractor shall disclose such action to the Department within seven days of filing.

Section 2.06 Authority to Execute Agreement

The Contractor represents and warrants that: (i) its execution, delivery and performance of this Agreement have been duly authorized by all necessary corporate action on its part; (ii) it has all necessary power and authority to execute, deliver and perform its obligations under this Agreement; and (iii) once executed and delivered, this Agreement will constitute its legal, valid and binding obligation, enforceable in accordance with its terms.

ARTICLE 3 - ASSIGNMENT AND SUBCONTRACTING

Section 3.01 Assignment

A. The Contractor shall not assign, transfer, convey, or otherwise dispose of this Agreement, or the right to execute it, or the right, title, or interest in or to it or any part of it, or assign, by power of attorney or otherwise, any of the monies due or to become due under this Agreement, without the prior written consent of the Commissioner. The giving of any such consent to a particular assignment shall not dispense with the necessity of such consent to any further or other assignments. Any such assignment, transfer, conveyance, or other disposition without such written consent shall be void.

B. Before entering into any such assignment, transfer, conveyance, or other disposal of this Agreement, the Contractor shall submit a written request for approval to the Department giving the name and address of the proposed assignee. The proposed assignee's disclosure that is required by PPB Rule § 2-08(e) must be submitted within 30 Days after the ACCO has granted preliminary written approval of the proposed assignee, if required. Upon the request of the Department, the Contractor shall provide any other information demonstrating that the proposed assignee has the necessary facilities, skill, integrity, past experience, and financial resources to perform the specified services in accordance with the terms and conditions of this Agreement. The Department shall make a final determination in writing approving or disapproving the assignee after receiving all requested information.

C. Failure to obtain the prior written consent to such an assignment, transfer, conveyance, or other disposition may result in the revocation and annulment of this Agreement, at the option of the Commissioner. The City shall thereupon be relieved and discharged from any further liability and obligation to the Contractor, its assignees, or transferees, who shall forfeit all monies earned under this Agreement, except so much as may be necessary to pay the Contractor's employees.

D. The provisions of this Section 3.01 shall not hinder, prevent, or affect an assignment by the Contractor for the benefit of its creditors made pursuant to the Laws of the State.

E. This Agreement may be assigned, in whole or in part, by the City to any corporation, agency, or instrumentality having authority to accept such assignment. The City shall provide the Contractor with written notice of any such assignment.

Section 3.02 Subcontracting

A. In accordance with PPB Rule § 4-13, all subcontractors must be approved by the Department prior to commencing work under a subcontract.

1. *Approval when subcontract is $20,000 or less.* The Department hereby grants approval for all subcontractors providing services covered by this Agreement pursuant to a subcontract in an amount that does not exceed $20,000.00. The Contractor must submit monthly reports to the Department listing all such subcontractors and shall list the subcontractor in the City's Payee Information Portal (www.nyc.gov/pip).

2. Approval when subcontract is greater than $20,000.

a. The Contractor shall not enter into any subcontract for an amount greater than $20,000.00 without the prior approval by the Department of the subcontractor.

b. Prior to entering into any subcontract for an amount greater than $20,000.00, the Contractor shall submit a written request for the approval of the proposed subcontractor to the Department giving the name and address of the proposed subcontractor, the portion of the work and materials that it is to perform and furnish, and the estimated cost of the subcontract. If the subcontractor is providing professional services under this Agreement for which professional liability insurance or errors and omissions insurance is reasonably commercially available, the Contractor shall submit proof of professional liability insurance in the amount required by Article 7. In addition, the Contractor shall list the proposed subcontractor in the City's Payee Information Portal (www.nyc.gov/pip) and provide the following information: maximum subcontract value, description of subcontractor work, start and end date of the subcontract, and the subcontractor's industry.[1]

c. Upon receipt the information required above, the Department in its discretion may grant or deny preliminary approval for the Contractor to contract with the subcontractor.

d. The Department shall notify the Contractor within 30 Days whether preliminary approval has been granted. If preliminary approval is granted, the Contractor shall provide such documentation as may be requested by the

[1] Assistance establishing a Payee Information Portal account and using the system may be obtained by emailing the Financial Information Services Agency Help Desk at pip@fisa.nyc.gov.

Department to show that the proposed subcontractor has the necessary facilities, skill, integrity, past experience and financial resources to perform the required work, including, the proposed subcontract and/or any of the items listed in PPB Rule 4-13(d)(3).

e. Upon receipt of all relevant documentation, the Department shall notify the Contractor in writing whether the proposed subcontractor is approved. If the proposed subcontractor is not approved, the Contractor may submit another proposed subcontractor unless the Contractor decides to do the work. No subcontractor shall be permitted to perform work unless approved by the Department.

f. For proposed subcontracts that do not exceed $25,000.00, the Department's approval shall be deemed granted if the Department does not issue a written approval or disapproval within 45 Days of the Department's receipt of the written request for approval or, if PPB Rule 2-08(e) is applicable, within 45 Days of the Department's acknowledged receipt of fully completed disclosures for the subcontractor.

B. All subcontracts must be in writing. All subcontracts shall contain provisions specifying that:

1. The work performed by the subcontractor must be in accordance with the terms of the Agreement between the City and the Contractor;

2. Nothing contained in the agreement between the Contractor and the subcontractor shall impair the rights of the City;

3. Nothing contained in the agreement between the Contractor and the subcontractor, or under the Agreement between the City and the Contractor, shall create any contractual relation between the subcontractor and the City; and

4. The subcontractor specifically agrees to be bound by Section 4.05(D) and Article 5 of this Appendix A and specifically agrees that the City may enforce such provisions directly against the subcontractor as if the City were a party to the subcontract.

C. The Contractor agrees that it is as fully responsible to the Department for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by such subcontractors as it is for the acts and omissions of any person directly employed by it.

D. For determining the value of a subcontract, all subcontracts with the same subcontractor shall be aggregated.

E. The Department may revoke the approval of a subcontractor granted or deemed granted pursuant to Section 3.02(A) if revocation is deemed to be in the interest of the City in

writing on no less than 10 Days' notice unless a shorter period is warranted by considerations of health, safety, integrity issues, or other similar factors. Upon the effective date of such revocation, the Contractor shall cause the subcontractor to cease all work under the Agreement. The City shall not incur any further obligation for services performed by such subcontractor pursuant to this Agreement beyond the effective date of the revocation. The City shall pay for services provided by the subcontractor in accordance with this Agreement prior to the effective date of revocation.

F. The Department's approval of a subcontractor shall not relieve the Contractor of any of its responsibilities, duties, and liabilities under this Agreement. At the request of the Department, the Contractor shall provide the Department a copy of any subcontract.

G. Individual employer-employee contracts are not subcontracts subject to the requirements of this Section 3.02.

H. The Contractor shall report in the City's Payee Information Portal payments made to each subcontractor within 30 days of making the payment. If any of the information provided in accordance with Section 3.02(A)(2)(b) changes during the term of this Agreement, the Contractor shall update the information in such Portal accordingly. Failure of the Contractor to list a subcontractor and/or to report subcontractor payments in a timely fashion may result in the Department declaring the Contractor in default of the Agreement and will subject Contractor to liquidated damages in the amount of $100 per day for each day that the Contractor fails to identify a subcontractor along with the required information about the subcontractor and/or fails to report payments to a subcontractor, beyond the time frames set forth herein or in the notice from the City.

ARTICLE 4 - LABOR PROVISIONS

Section 4.01 Independent Contractor Status

The Contractor and the City agree that the Contractor is an independent contractor and not an employee, subsidiary, affiliate, division, department, agency, office, or unit of the City. Accordingly, the Contractor and its employees, officers, and agents shall not, by reason of this Agreement or any performance pursuant to or in connection with this Agreement, assert the existence of any relationship or status on the part of the Contractor, with respect to the City, that differs from or is inconsistent with that of an independent contractor.

Section 4.02 Employees and Subcontractors

All persons who are employed by the Contractor and all the Contractor's subcontractors (including without limitation, consultants and independent contractors) that are retained to perform services under or in connection with this Agreement are neither employees of the City nor under contract with the City. The Contractor, and not the City, is responsible for their work, direction, compensation, and personal conduct while the Contractor is engaged under this Agreement. Nothing in this Agreement, and no entity or person's performance pursuant to or in connection

with this Agreement, shall create any relationship between the City and the Contractor's employees, agents, subcontractors, or subcontractor's employees or agents (including without limitation, a contractual relationship, employer-employee relationship, or quasi-employer/quasi-employee relationship) or impose any liability or duty on the City (i) for or on account of the acts, omissions, liabilities, rights or obligations of the Contractor, its employees or agents, its subcontractors, or its subcontractor's employees or agents (including without limitation, obligations set forth in any collective bargaining agreement); or (ii) for taxes of any nature; or (iii) for any right or benefit applicable to an official or employee of the City or to any officer, agent, or employee of the Contractor or any other entity (including without limitation, Workers' Compensation coverage, Employers' Liability coverage, Disability Benefits coverage, Unemployment Insurance benefits, Social Security coverage, employee health and welfare benefits or employee retirement benefits, membership or credit). The Contractor and its employees, officers, and agents shall not, by reason of this Agreement or any performance pursuant to or in connection with this Agreement, (i) hold themselves out as, or claim to be, officials or employees of the City, including any department, agency, office, or unit of the City, or (ii) make or support in any way on behalf of or for the benefit of the Contractor, its employees, officers, or agents any demand, application, or claim upon or against the City for any right or benefit applicable to an official or employee of the City or to any officer, agent, or employee of the Contractor or any other entity. Except as specifically stated in this Agreement, nothing in the Agreement and no performance pursuant to or in connection with the Agreement shall impose any liability or duty on the City to any person or entity whatsoever.

Section 4.03 Removal of Individuals Performing Work

The Contractor shall not have anyone perform work under this Agreement who is not competent, faithful, and skilled in the work for which he or she shall be employed. Whenever the Commissioner shall inform the Contractor, in writing, that any individual is, in his or her opinion, incompetent, unfaithful, or unskilled, such individual shall no longer perform work under this Agreement. Prior to making a determination to direct a Contractor that an individual shall no longer perform work under this Agreement, the Commissioner shall provide the Contractor an opportunity to be heard on no less than five Days' written notice. The Commissioner may direct the Contractor to prohibit the individual from performing work under the Agreement pending the opportunity to be heard and the Commissioner's determination.

Section 4.04 Minimum Wage; Living Wage

A. Except for those employees whose minimum wage is required to be fixed in accordance with N.Y. Labor Law §§ 220 or 230 or by Admin. Code § 6-109, all persons employed by the Contractor in the performance of this Agreement shall be paid, without subsequent deduction or rebate, unless expressly authorized by Law, not less than the minimum wage as prescribed by Law. Any breach of this Section 4.04 shall be deemed a material breach of this Agreement.

B. If this Agreement involves the provision of homecare services, day care services, head start services, services to persons with cerebral palsy, building services, food services, or temporary services, as those services are defined in Admin. Code § 6-109 ("Section 6-109"), in accordance with Section 6-109, the Contractor agrees as follows:

1. The Contractor shall comply with the requirements of Section 6-109, including, where applicable, the payment of either a prevailing wage or a living wage, as those terms are defined in Section 6-109.

2. The Contractor shall not retaliate, discharge, demote, suspend, take adverse employment action in the terms and conditions of employment or otherwise discriminate against any employee for reporting or asserting a violation of Section 6-109, for seeking or communicating information regarding rights conferred by Section 6-109, for exercising any other rights protected under Section 6-109, or for participating in any investigatory or court proceeding relating to Section 6-109. This protection shall also apply to any employee or his or her representative who in good faith alleges a violation of Section 6-109, or who seeks or communicates information regarding rights conferred by Section 6-109 in circumstances where he or she in good faith believes it applies.

3. The Contractor shall maintain original payroll records for each of its covered employees reflecting the days and hours worked on contracts, projects, or assignments that are subject to the requirements of Section 6-109, and the wages paid and benefits provided for such hours worked. The Contractor shall maintain these records for the duration of the term of this Agreement and shall retain them for a period of four years after completion of this Agreement. For contracts involving building services, food services, or temporary services, the Contractor shall submit copies of payroll records, certified by the Contractor under penalty of perjury to be true and accurate, to the Department with every requisition for payment. For contracts involving homecare, day care, head start or services to persons with cerebral palsy, the Contractor shall submit either certified payroll records or categorical information about the wages, benefits, and job classifications of covered employees of the Contractor, and of any subcontractors, which shall be the substantial equivalent of the information required in Section 6-109(2)(a)(iii).

4. The Contractor and all subcontractors shall pay all covered employees by check and shall provide employees check stubs or other documentation at least once each month containing information sufficient to document compliance with the requirements of the Living Wage Law concerning living wages, prevailing wages, supplements, and health benefits. In addition, if this Agreement is for an amount greater than $1,000,000.00, checks issued by the Contractor to covered employees shall be generated by a payroll service or automated payroll system (an in-house system may be used if approved by the Department). For any subcontract for an amount greater than $750,000.00, checks issued by a subcontractor to covered employees shall be generated by a payroll service or automated payroll system (an in-house system may be used if approved by the Department).

5. The Department will provide written notices to the Contractor, prepared by the Comptroller, detailing the wages, benefits, and other protections to which covered employees are entitled under Section 6-109. Such notices will be provided in English, Spanish and other languages spoken by ten percent or more of a covered employer's covered employees. Throughout the term of this Agreement, the Contractor shall post in a prominent and accessible place at every work site and provide each covered employee a copy of the written notices provided by the Department. The Contractor shall provide the notices to its subcontractors and require them to be posted and provided to each covered employee.

6. The Contractor shall ensure that its subcontractors comply with the requirements of Section 6-109, and shall provide written notification to its subcontractors of those requirements. All subcontracts made by the Contractor shall be in writing and shall include provisions relating to the wages, supplements, and health benefits required by Section 6-109. No work may be performed by a subcontractor employing covered employees prior to the Contractor entering into a written subcontract with the subcontractor.

7. Each year throughout the term of the Agreement and whenever requesting the Department's approval of a subcontractor, the Contractor shall submit to the Department an updated certification, as required by Section 6-109 and in the form of the certification attached to this Agreement, identifying any changes to the current certification.

8. Failure to comply with the requirements of Section 6-109 may, in the discretion of the Department, constitute a material breach by the Contractor of the terms of this Agreement. If the Contractor and/or subcontractor receives written notice of such a breach and fails to cure such breach within 30 Days, the City shall have the right to pursue any rights or remedies available under this Agreement or under applicable law, including termination of the Agreement. If the Contractor fails to perform in accordance with any of the requirements of Section 6-109 and fails to cure such failure in accordance with the preceding sentence, and there is a continued need for the service, the City may obtain from another source the required service as specified in the original Agreement, or any part thereof, and may charge the Contractor for any difference in price resulting from the alternative arrangements, and may, as appropriate, invoke such other sanctions as are available under the Agreement and applicable law. In addition, the Contractor agrees to pay for all costs incurred by the City in enforcing the requirements of Section 6-109, including the cost of any investigation conducted by or on behalf of the Department or the Comptroller, where the City discovers that the Contractor or its subcontractor(s) failed to comply with the requirements of this Section 4.04(B) or of Section 6-109. The Contractor also agrees, that should it fail or refuse to pay for any such investigation, the Department is hereby authorized to deduct from a Contractor's account an amount equal to the cost of such investigation.

Section 4.05 Non-Discrimination in Employment

A. General Prohibition. To the extent required by law, the Contractor shall not unlawfully discriminate against any employee or applicant for employment because of actual or perceived age, religion, religious practice, creed, sex, gender, gender identity or gender expression, sexual orientation, status as a victim of domestic violence, stalking, and sex offenses, familial status, partnership status, marital status, caregiver status, pregnancy, childbirth or related medical condition, disability, presence of a service animal, predisposing genetic characteristics, race, color, national origin (including ancestry), alienage, citizenship status, political activities or recreational activities as defined in N.Y. Labor Law 201-d, arrest or conviction record, credit history, military status, uniformed service, unemployment status, salary history, or any other protected class of individuals as defined by City, State or Federal laws, rules or regulations. The Contractor shall comply with all statutory and regulatory obligations to provide reasonable accommodations to individuals with disabilities, due to pregnancy, childbirth, or a related medical condition, due to status as a victim of domestic violence, stalking, or sex offenses, or due to religion.

B. N.Y. Labor Law § 220-e. If this Agreement is for the construction, alteration or repair of any public building or public work or for the manufacture, sale, or distribution of materials, equipment, or supplies, the Contractor agrees, as required by N.Y. Labor Law § 220-e, that:

1. In the hiring of employees for the performance of work under this Agreement or any subcontract hereunder, neither the Contractor, subcontractor, nor any person acting on behalf of such Contractor or subcontractor, shall by reason of race, creed, color, disability, sex or national origin discriminate against any citizen of the State of New York who is qualified and available to perform the work to which the employment relates;

2. Neither the Contractor, subcontractor, nor any person on his or her behalf shall, in any manner, discriminate against or intimidate any employee hired for the performance of work under this Agreement on account of race, creed, color, disability, sex or national origin;

3. There may be deducted from the amount payable to the Contractor by the City under this Agreement a penalty of $50.00 for each person for each calendar day during which such person was discriminated against or intimidated in violation of the provisions of this Agreement; and

4. This Agreement may be terminated by the City, and all monies due or to become due hereunder may be forfeited, for a second or any subsequent violation of the terms or conditions of this Section 4.05.

The provisions of this Section 4.05(B) shall be limited to operations performed within the territorial limits of the State of New York.

C. Admin. Code § 6-108. If this Agreement is for the construction, alteration or repair of buildings or the construction or repair of streets or highways, or for the manufacture, sale, or distribution of materials, equipment or supplies, the Contractor agrees, as required by Admin. Code § 6-108, that:

1. It shall be unlawful for any person engaged in the construction, alteration or repair of buildings or engaged in the construction or repair of streets or highways pursuant to a contract with the City or engaged in the manufacture, sale or distribution of materials, equipment or supplies pursuant to a contract with the City to refuse to employ or to refuse to continue in any employment any person on account of the race, color or creed of such person.

2. It shall be unlawful for any person or any servant, agent or employee of any person, described in Section 4.05(C)(1) above, to ask, indicate or transmit, orally or in writing, directly or indirectly, the race, color, creed or religious affiliation of any person employed or seeking employment from such person, firm or corporation.

Breach of the foregoing provisions shall be deemed a breach of a material provision of this Agreement.

Any person, or the employee, manager or owner of or officer of such firm or corporation who shall violate any of the provisions of this Section 4.05(C) shall, upon conviction thereof, be punished by a fine of not more than $100.00 or by imprisonment for not more than 30 Days, or both.

D. E.O. 50 -- Equal Employment Opportunity

1. This Agreement is subject to the requirements of City Executive Order No. 50 (1980) ("E.O. 50"), as revised, and the rules set forth at 66 RCNY §§ 10-01 *et seq.* No agreement will be awarded unless and until these requirements have been complied with in their entirety. The Contractor agrees that it:

a. Will not discriminate unlawfully against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability, marital status, sexual orientation or citizenship status with respect to all employment decisions including, but not limited to, recruitment, hiring, upgrading, demotion, downgrading, transfer, training, rates of pay or other forms of compensation, layoff, termination, and all other terms and conditions of employment;

b. Will not discriminate unlawfully in the selection of subcontractors on the basis of the owners', partners' or shareholders' race, color, creed, national origin, sex, age, disability, marital status, sexual orientation, or citizenship status;

c. Will state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that all qualified applicants will receive consideration for employment without unlawful discrimination based on race, color, creed,

national origin, sex, age, disability, marital status, sexual orientation or citizenship status, and that it is an equal employment opportunity employer;

d. Will send to each labor organization or representative of workers with which it has a collective bargaining agreement or other contract or memorandum of understanding, written notification of its equal employment opportunity commitments under E.O. 50 and the rules and regulations promulgated thereunder;

e. Will furnish before this Agreement is awarded all information and reports including an Employment Report which are required by E.O. 50, the rules and regulations promulgated thereunder, and orders of the SBS, Division of Labor Services ("DLS"); and

f. Will permit DLS to have access to all relevant books, records, and accounts for the purposes of investigation to ascertain compliance with such rules, regulations, and orders.

2. The Contractor understands that in the event of its noncompliance with the nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, such noncompliance shall constitute a material breach of this Agreement and noncompliance with E.O. 50 and the rules and regulations promulgated thereunder. After a hearing held pursuant to the rules of DLS, the Director of DLS may direct the Commissioner to impose any or all of the following sanctions:

a. Disapproval of the Contractor; and/or

b. Suspension or termination of the Agreement; and/or

c. Declaring the Contractor in default; and/or

d. In lieu of any of the foregoing sanctions, imposition of an employment program.

3. Failure to comply with E.O. 50 and the rules and regulations promulgated thereunder in one or more instances may result in the Department declaring the Contractor to be non-responsible.

4. The Contractor agrees to include the provisions of the foregoing Sections 4.05(D)(1)-(3) in every subcontract or purchase order in excess of $100,000.00 to which it becomes a party unless exempted by E.O. 50 and the rules and regulations promulgated thereunder, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as may be directed by the Director of DLS as a means of enforcing such provisions including sanctions for noncompliance. A supplier of unfinished products to the Contractor needed

to produce the item contracted for shall not be considered a subcontractor or vendor for purposes of this Section 4.05(D)(4).

5. The Contractor further agrees that it will refrain from entering into any subcontract or modification thereof subject to E.O. 50 and the rules and regulations promulgated thereunder with a subcontractor who is not in compliance with the requirements of E.O. 50 and the rules and regulations promulgated thereunder. A supplier of unfinished products to the Contractor needed to produce the item contracted for shall not be considered a subcontractor for purposes of this Section 4.05(D)(5).

6. Nothing contained in this Section 4.05(D) shall be construed to bar any religious or denominational institution or organization, or any organization operated for charitable or educational purposes, that is operated, supervised or controlled by or in connection with a religious organization, from lawfully limiting employment or lawfully giving preference to persons of the same religion or denomination or from lawfully making such selection as is calculated by such organization to promote the religious principles for which it is established or maintained.

Section 4.06 Paid Sick Leave Law

A. *Introduction and General Provisions.*

1. The Earned Sick Time Act, also known as the Paid Sick Leave Law ("PSLL"), requires covered employees who annually perform more than 80 hours of work in New York City to be provided with paid sick time.[2] Contractors of the City or of other governmental entities may be required to provide sick time pursuant to the PSLL.

2. The PSLL became effective on April 1, 2014, and is codified at Title 20, Chapter 8, of the Admin. Code. It is administered by the City's Department of Consumer Affairs ("DCA"). DCA's rules promulgated under the PSLL are codified at Chapter 7 of Title 6 of the Rules of the City of New York ("Rules").

3. The Contractor agrees to comply in all respects with the PSLL and the Rules, and as amended, if applicable, in the performance of this Agreement. The Contractor further acknowledges that such compliance is a material term of this Agreement and that failure to comply with the PSLL in performance of this Agreement may result in its termination.

[2] Pursuant to the PSLL, if fewer than five employees work for the same employer, as determined pursuant Admin. Code § 20-912(g), such employer has the option of providing such employees uncompensated sick time.

4. The Contractor must notify the ACCO in writing within 10 Days of receipt of a complaint (whether oral or written) regarding the PSLL involving the performance of this Agreement. Additionally, the Contractor must cooperate with DCA's education efforts and must comply with DCA's subpoenas and other document demands as set forth in the PSLL and Rules.

5. The PSLL is summarized below for the convenience of the Contractor. The Contractor is advised to review the PSLL and Rules in their entirety. On the website www.nyc.gov/PaidSickLeave there are links to the PSLL and the associated Rules as well as additional resources for employers, such as Frequently Asked Questions, timekeeping tools and model forms, and an event calendar of upcoming presentations and webinars at which the Contractor can get more information about how to comply with the PSLL. The Contractor acknowledges that it is responsible for compliance with the PSLL notwithstanding any inconsistent language contained herein.

B. *Pursuant to the PSLL and the Rules: Applicability, Accrual, and Use.*

1. An employee who works within the City of New York for more than eighty hours in any consecutive 12-month period designated by the employer as its "calendar year" pursuant to the PSLL ("Year") must be provided sick time. Employers must provide a minimum of one hour of sick time for every 30 hours worked by an employee and compensation for such sick time must be provided at the greater of the employee's regular hourly rate or the minimum wage. Employers are not required to provide more than 40 hours of sick time to an employee in any Year.

2. An employee has the right to determine how much sick time he or she will use, provided that employers may set a reasonable minimum increment for the use of sick time not to exceed four hours per Day. In addition, an employee may carry over up to 40 hours of unused sick time to the following Year, provided that no employer is required to allow the use of more than 40 hours of sick time in a Year or carry over unused paid sick time if the employee is paid for such unused sick time and the employer provides the employee with at least the legally required amount of paid sick time for such employee for the immediately subsequent Year on the first Day of such Year.

3. An employee entitled to sick time pursuant to the PSLL may use sick time for any of the following:

a. such employee's mental illness, physical illness, injury, or health condition or the care of such illness, injury, or condition or such employee's need for medical diagnosis or preventive medical care;

b. such employee's care of a family member (an employee's child, spouse, domestic partner, parent, sibling, grandchild, or grandparent, or the child or parent of an employee's spouse or domestic partner) who has a mental illness, physical

illness, injury or health condition or who has a need for medical diagnosis or preventive medical care;

c. closure of such employee's place of business by order of a public official due to a public health emergency; or

d. such employee's need to care for a child whose school or childcare provider has been closed due to a public health emergency.

4. An employer must not require an employee, as a condition of taking sick time, to search for a replacement. However, an employer may require an employee to provide: reasonable notice of the need to use sick time; reasonable documentation that the use of sick time was needed for a reason above if for an absence of more than three consecutive work days; and/or written confirmation that an employee used sick time pursuant to the PSLL. However, an employer may not require documentation specifying the nature of a medical condition or otherwise require disclosure of the details of a medical condition as a condition of providing sick time and health information obtained solely due to an employee's use of sick time pursuant to the PSLL must be treated by the employer as confidential.

5. If an employer chooses to impose any permissible discretionary requirement as a condition of using sick time, it must provide to all employees a written policy containing those requirements, using a delivery method that reasonably ensures that employees receive the policy. If such employer has not provided its written policy, it may not deny sick time to an employee because of non-compliance with such a policy.

6. Sick time to which an employee is entitled must be paid no later than the payday for the next regular payroll period beginning after the sick time was used.

C. *Exemptions and Exceptions*. Notwithstanding the above, the PSLL does not apply to any of the following:

1. an independent contractor who does not meet the definition of employee under N.Y. Labor Law § 190(2);

2. an employee covered by a valid collective bargaining agreement in effect on April 1, 2014, until the termination of such agreement;

3. an employee in the construction or grocery industry covered by a valid collective bargaining agreement if the provisions of the PSLL are expressly waived in such collective bargaining agreement;

4. an employee covered by another valid collective bargaining agreement if such provisions are expressly waived in such agreement and such agreement provides a benefit comparable to that provided by the PSLL for such employee;

5. an audiologist, occupational therapist, physical therapist, or speech language pathologist who is licensed by the New York State Department of Education and who calls in for work assignments at will, determines his or her own schedule, has the ability to reject or accept any assignment referred to him or her, and is paid an average hourly wage that is at least four times the federal minimum wage;

6. an employee in a work study program under Section 2753 of Chapter 42 of the United States Code;

7. an employee whose work is compensated by a qualified scholarship program as that term is defined in the Internal Revenue Code, Section 117 of Chapter 20 of the United States Code; or

8. a participant in a Work Experience Program (WEP) under N.Y. Social Services Law § 336-c.

D. *Retaliation Prohibited.* An employer may not threaten or engage in retaliation against an employee for exercising or attempting in good faith to exercise any right provided by the PSLL. In addition, an employer may not interfere with any investigation, proceeding, or hearing pursuant to the PSLL.

E. *Notice of Rights.*

1. An employer must provide its employees with written notice of their rights pursuant to the PSLL. Such notice must be in English and the primary language spoken by an employee, provided that DCA has made available a translation into such language. Downloadable notices are available on DCA's website at http://www.nyc.gov/html/dca/html/law/PaidSickLeave.shtml.

2. Any person or entity that willfully violates these notice requirements is subject to a civil penalty in an amount not to exceed $50.00 for each employee who was not given appropriate notice.

F. *Records*. An employer must retain records documenting its compliance with the PSLL for a period of at least three years, and must allow DCA to access such records in furtherance of an investigation related to an alleged violation of the PSLL.

G. *Enforcement and Penalties.*

1. Upon receiving a complaint alleging a violation of the PSLL, DCA has the right to investigate such complaint and attempt to resolve it through mediation. Within 30 Days of written notification of a complaint by DCA, or sooner in certain circumstances, the employer must provide DCA with a written response and such other information as

DCA may request. If DCA believes that a violation of the PSLL has occurred, it has the right to issue a notice of violation to the employer.

2. DCA has the power to grant an employee or former employee all appropriate relief as set forth in Admin. Code § 20-924(d). Such relief may include, among other remedies, treble damages for the wages that should have been paid, damages for unlawful retaliation, and damages and reinstatement for unlawful discharge. In addition, DCA may impose on an employer found to have violated the PSLL civil penalties not to exceed $500.00 for a first violation, $750.00 for a second violation within two years of the first violation, and $1,000.00 for each succeeding violation within two years of the previous violation.

H. *More Generous Polices and Other Legal Requirements.* Nothing in the PSLL is intended to discourage, prohibit, diminish, or impair the adoption or retention of a more generous sick time policy, or the obligation of an employer to comply with any contract, collective bargaining agreement, employment benefit plan or other agreement providing more generous sick time. The PSLL provides minimum requirements pertaining to sick time and does not preempt, limit, or otherwise affect the applicability of any other law, regulation, rule, requirement, policy or standard that provides for greater accrual or use by employees of sick leave or time, whether paid or unpaid, or that extends other protections to employees. The PSLL may not be construed as creating or imposing any requirement in conflict with any federal or state law, rule, or regulation.

Section 4.07 Whistleblower Protection Expansion Act

A. In accordance with Local Laws 30 and 33 of 2012, codified at Admin. Code §§ 6-132 and 12-113, respectively,

1. Contractor shall not take an adverse personnel action with respect to an officer or employee in retaliation for such officer or employee making a report of information concerning conduct which such officer or employee knows or reasonably believes to involve corruption, criminal activity, conflict of interest, gross mismanagement or abuse of authority by any officer or employee relating to this Agreement to (i) the Commissioner of the Department of Investigation, (ii) a member of the New York City Council, the Public Advocate, or the Comptroller, or (iii) the City Chief Procurement Officer, ACCO, Agency head, or Commissioner.

2. If any of Contractor's officers or employees believes that he or she has been the subject of an adverse personnel action in violation of this Section 4.07, he or she shall be entitled to bring a cause of action against Contractor to recover all relief necessary to make him or her whole. Such relief may include but is not limited to: (i) an injunction to restrain continued retaliation, (ii) reinstatement to the position such employee would have had but for the retaliation or to an equivalent position, (iii) reinstatement of full fringe benefits and seniority rights, (iv) payment of two times back pay, plus interest, and (v) compensation for any special damages sustained as a result of the retaliation, including litigation costs and reasonable attorney's fees.

3. Contractor shall post a notice provided by the City (attached hereto) in a prominent and accessible place on any site where work pursuant to the Agreement is performed that contains information about:

a. how its employees can report to the New York City Department of Investigation allegations of fraud, false claims, criminality or corruption arising out of or in connection with the Agreement; and

b. the rights and remedies afforded to its employees under Admin. Code §§ 7-805 (the New York City False Claims Act) and 12-113 (the Whistleblower Protection Expansion Act) for lawful acts taken in connection with the reporting of allegations of fraud, false claims, criminality or corruption in connection with the Agreement.

4. For the purposes of this Section 4.07, "adverse personnel action" includes dismissal, demotion, suspension, disciplinary action, negative performance evaluation, any action resulting in loss of staff, office space, equipment or other benefit, failure to appoint, failure to promote, or any transfer or assignment or failure to transfer or assign against the wishes of the affected officer or employee.

5. This Section 4.07 is applicable to all of Contractor's subcontractors having subcontracts with a value in excess of $100,000.00; accordingly, Contractor shall include this Section 4.07 in all subcontracts with a value in excess of $100,000.00.

B. Section 4.07 is not applicable to this Agreement if it is valued at $100,000.00 or less. Sections 4.07(A)(1), (2), (4), and (5) are not applicable to this Agreement if it was solicited pursuant to a finding of an emergency. Section 4.07(A)(3) is neither applicable to this Agreement if it was solicited prior to October 18, 2012 nor if it is a renewal of a contract executed prior to October 18, 2012.

ARTICLE 5 - RECORDS, AUDITS, REPORTS, AND INVESTIGATIONS

Section 5.01 Books and Records

The Contractor agrees to maintain separate and accurate books, records, documents, and other evidence, and to utilize appropriate accounting procedures and practices that sufficiently and properly reflect all direct and indirect costs of any nature expended in the performance of this Agreement.

Section 5.02 Retention of Records

The Contractor agrees to retain all books, records, documents, other evidence relevant to this Agreement, including those required pursuant to Section 5.01, for six years after the final payment or expiration or termination of this Agreement, or for a period otherwise prescribed by

Law, whichever is later. In addition, if any litigation, claim, or audit concerning this Agreement has commenced before the expiration of the six-year period, the books, records, documents, and other evidence must be retained until the completion of such litigation, claim, or audit. Any books, records, documents, and other evidence that are created in an electronic format in the regular course of business may be retained in an electronic format. Any books, records, documents, or other evidence that are created in the regular course of business as a paper copy may be retained in an electronic format provided that they satisfy the requirements of N.Y. Civil Practice Law and Rules ("CPLR") 4539(b), including the requirement that the reproduction is created in a manner "which does not permit additions, deletions, or changes without leaving a record of such additions, deletions, or changes." Furthermore, the Contractor agrees to waive any objection to the admissibility of any such books, records, documents, or other evidence on the grounds that such documents do not satisfy CPLR 4539(b).

Section 5.03 Inspection

A. At any time during the Agreement or during the record retention period set forth in Section 5.02, the City, including the Department and the Department's Office of the Inspector General, as well as City, State, and federal auditors and any other persons duly authorized by the City shall, upon reasonable notice, have full access to and the right to examine and copy all books, records, documents, and other evidence maintained or retained by or on behalf of the Contractor pursuant to this Article 5. Notwithstanding any provision herein regarding notice of inspection, all books, records, documents, and other evidence of the Contractor kept pursuant to this Agreement shall be subject to immediate inspection, review, and copying by the Department's Office of the Inspector General, the Comptroller, and/or federal auditors without prior notice and at no additional cost to the City. The Contractor shall make such books, records documents, and other evidence available for inspection in the City of New York or shall reimburse the City for expenses associated with the out-of-City inspection.

B. The Department shall have the right to have representatives of the Department or of the City, State or federal government present to observe the services being performed. If observation of particular services or activity would constitute a waiver of a legal privilege or violate the Law or an ethical obligation under the New York Rules of Professional Conduct for attorneys, National Association of Social Workers Code of Ethics or other similar code governing the provision of a profession's services in New York State, the Contractor shall promptly inform the Department or other entity seeking to observe such work or activity. Such restriction shall not act to prevent government representatives from inspecting the provision of services in a manner that allows the representatives to ensure that services are being performed in accordance with this Agreement.

C. The Contractor shall not be entitled to final payment until the Contractor has complied with any request for inspection or access given under this Section 5.03.

Section 5.04 Audit

A. This Agreement and all books, records, documents, and other evidence required to be maintained or retained pursuant to this Agreement, including all vouchers or invoices presented for payment and the books, records, and other documents upon which such vouchers or invoices are based (e.g., reports, cancelled checks, accounts, and all other similar material), are subject to audit by (i) the City, including the Comptroller, the Department, and the Department's Office of the Inspector General, (ii) the State, (iii) the federal government, and (iv) other persons duly authorized by the City. Such audits may include examination and review of the source and application of all funds whether from the City, the State, the federal government, private sources, or otherwise.

B. Audits by the City, including the Comptroller, the Department, and the Department's Office of the Inspector General, are performed pursuant to the powers and responsibilities conferred by the Charter and the Admin. Code, as well as all orders, rules, and regulations promulgated pursuant to the Charter and Admin. Code.

C. The Contractor shall submit any and all documentation and justification in support of expenditures or fees under this Agreement as may be required by the Department and by the Comptroller in the exercise of his/her powers under Law.

D. The Contractor shall not be entitled to final payment until the Contractor has complied with the requirements of this Section 5.04.

Section 5.05 No Removal of Records from Premises

Where performance of this Agreement involves use by the Contractor of any City books, records, documents, or data (in hard copy, or electronic or other format now known or developed in the future) at City facilities or offices, the Contractor shall not remove any such items or material (in the format in which it originally existed, or in any other converted or derived format) from such facility or office without the prior written approval of the Department's designated official. Upon the request by the Department at any time during the Agreement or after the Agreement has expired or terminated, the Contractor shall return to the Department any City books, records, documents, or data that has been removed from City premises.

Section 5.06 Electronic Records

As used in this Appendix A, the terms "books," "records," "documents," and "other evidence" refer to electronic versions as well as hard copy versions.

Section 5.07 Investigations Clause

A. The Contractor agrees to cooperate fully and faithfully with any investigation, audit or inquiry conducted by a State or City agency or authority that is empowered directly or by designation to compel the attendance of witnesses and to examine witnesses under oath, or conducted by the Inspector General of a governmental agency that is a party in interest to the

transaction, submitted bid, submitted proposal, contract, lease, permit, or license that is the subject of the investigation, audit or inquiry.

B.

1. If any person who has been advised that his or her statement, and any information from such statement, will not be used against him or her in any subsequent criminal proceeding refuses to testify before a grand jury or other governmental agency or authority empowered directly or by designation to compel the attendance of witnesses and to examine witnesses under oath concerning the award of or performance under any transaction, agreement, lease, permit, contract, or license entered into with the City, or State, or any political subdivision or public authority thereof, or the Port Authority of New York and New Jersey, or any local development corporation within the City, or any public benefit corporation organized under the Laws of the State, or;

2. If any person refuses to testify for a reason other than the assertion of his or her privilege against self-incrimination in an investigation, audit or inquiry conducted by a City or State governmental agency or authority empowered directly or by designation to compel the attendance of witnesses and to take testimony under oath, or by the Inspector General of the governmental agency that is a party in interest in, and is seeking testimony concerning the award of, or performance under, any transaction, agreement, lease, permit, contract, or license entered into with the City, the State, or any political subdivision thereof or any local development corporation within the City, then;

C.

6. The Commissioner or Agency Head whose agency is a party in interest to the transaction, submitted bid, submitted proposal, contract, lease, permit, or license shall convene a hearing, upon not less than five (5) Days written notice to the parties involved to determine if any penalties should attach for the failure of a person to testify.

7. If any non-governmental party to the hearing requests an adjournment, the Commissioner or Agency Head who convened the hearing may, upon granting the adjournment, suspend any contract, lease, permit, or license pending the final determination pursuant to Paragraph E below without the City incurring any penalty or damages for delay or otherwise.

D. The penalties that may attach after a final determination by the Commissioner or Agency Head may include but shall not exceed:

1. The disqualification for a period not to exceed five years from the date of an adverse determination for any person, or any entity of which such person was a member at the time the testimony was sought, from submitting bids for, or transacting business with, or entering into or obtaining any contract, lease, permit or license with or from the City; and/or

2. The cancellation or termination of any and all such existing City contracts, leases, permits or licenses that the refusal to testify concerns and that have not been assigned as permitted under this Agreement, nor the proceeds of which pledged, to an unaffiliated and unrelated institutional lender for fair value prior to the issuance of the notice scheduling the hearing, without the City incurring any penalty or damages on account of such cancellation or termination; monies lawfully due for goods delivered, work done, rentals, or fees accrued prior to the cancellation or termination shall be paid by the City.

E. The Commissioner or Agency Head shall consider and address in reaching his or her determination and in assessing an appropriate penalty the factors in Paragraphs (1) and (2) below. He or she may also consider, if relevant and appropriate, the criteria established in Paragraphs (3) and (4) below, in addition to any other information that may be relevant and appropriate:

1. The party's good faith endeavors or lack thereof to cooperate fully and faithfully with any governmental investigation or audit, including but not limited to the discipline, discharge, or disassociation of any person failing to testify, the production of accurate and complete books and records, and the forthcoming testimony of all other members, agents, assignees or fiduciaries whose testimony is sought.

2. The relationship of the person who refused to testify to any entity that is a party to the hearing, including, but not limited to, whether the person whose testimony is sought has an ownership interest in the entity and/or the degree of authority and responsibility the person has within the entity.

3. The nexus of the testimony sought to the subject entity and its contracts, leases, permits or licenses with the City.

4. The effect a penalty may have on an unaffiliated and unrelated party or entity that has a significant interest in an entity subject to penalties under Paragraph D above, provided that the party or entity has given actual notice to the Commissioner or Agency Head upon the acquisition of the interest, or at the hearing called for in Paragraph (C)(1) above gives notice and proves that such interest was previously acquired. Under either circumstance, the party or entity must present evidence at the hearing demonstrating the potential adverse impact a penalty will have on such person or entity.

F. Definitions

1. The term "license" or "permit" as used in this Section shall be defined as a license, permit, franchise, or concession not granted as a matter of right.

2. The term "person" as used in this Section shall be defined as any natural person doing business alone or associated with another person or entity as a partner, director, officer, principal or employee.

3. The term "entity" as used in this Section shall be defined as any firm, partnership, corporation, association, or person that receives monies, benefits, licenses, leases, or permits from or through the City, or otherwise transacts business with the City.

4. The term "member" as used in this Section shall be defined as any person associated with another person or entity as a partner, director, officer, principal, or employee.

G. In addition to and notwithstanding any other provision of this Agreement, the Commissioner or Agency Head may in his or her sole discretion terminate this Agreement upon not less than three (3) Days written notice in the event the Contractor fails to promptly report in writing to the City Commissioner of Investigation any solicitation of money, goods, requests for future employment or other benefits or thing of value, by or on behalf of any employee of the City or other person or entity for any purpose that may be related to the procurement or obtaining of this Agreement by the Contractor, or affecting the performance of this Agreement.

Section 5.08 Confidentiality

A. The Contractor agrees to hold confidential, both during and after the completion or termination of this Agreement, all of the reports, information, or data, furnished to, or prepared, assembled or used by, the Contractor under this Agreement. The Contractor agrees to maintain the confidentiality of such reports, information, or data by using a reasonable degree of care, and using at least the same degree of care that the Contractor uses to preserve the confidentiality of its own confidential information. The Contractor agrees that such reports, information, or data shall not be made available to any person or entity without the prior written approval of the Department. The obligation under this Section 5.08 to hold reports, information or data confidential shall not apply where the Contractor is legally required to disclose such reports, information or data, by virtue of a subpoena, court order or otherwise ("disclosure demand"), provided that the Contractor complies with the following: (1) the Contractor shall provide advance notice to the Commissioner, in writing or by e-mail, that it received a disclosure demand for to disclose such reports, information or data and (2) if requested by the Department, the Contractor shall not disclose such reports, information, or data until the City has exhausted its legal rights, if any, to prevent disclosure of all or a portion of such reports, information or data. The previous sentence shall not apply if the Contractor is prohibited by law from disclosing to the Department the disclosure demand for such reports, information or data.

B. The Contractor shall provide notice to the Department within three days of the discovery by the Contractor of any breach of security, as defined in Admin. Code § 10-501(b), of any data, encrypted or otherwise, in use by the Contractor that contains social security numbers or other personal identifying information as defined in Admin. Code § 10-501 ("Personal Identifying Information"), where such breach of security arises out of the acts or omissions of the Contractor

or its employees, subcontractors, or agents. Upon the discovery of such security breach, the Contractor shall take reasonable steps to remediate the cause or causes of such breach, and shall provide notice to the Department of such steps. In the event of such breach of security, without limiting any other right of the City, the City shall have the right to withhold further payments under this Agreement for the purpose of set-off in sufficient sums to cover the costs of notifications and/or other actions mandated by any Law, or administrative or judicial order, to address the breach, and including any fines or disallowances imposed by the State or federal government as a result of the disclosure. The City shall also have the right to withhold further payments hereunder for the purpose of set-off in sufficient sums to cover the costs of credit monitoring services for the victims of such a breach of security by a national credit reporting agency, and/or any other commercially reasonable preventive measure. The Department shall provide the Contractor with written notice and an opportunity to comment on such measures prior to implementation. Alternatively, at the City's discretion, or if monies remaining to be earned or paid under this Agreement are insufficient to cover the costs detailed above, the Contractor shall pay directly for the costs, detailed above, if any.

C. The Contractor shall restrict access to confidential information to persons who have a legitimate work related purpose to access such information. The Contractor agrees that it will instruct its officers, employees, and agents to maintain the confidentiality of any and all information required to be kept confidential by this Agreement.

D. The Contractor, and its officers, employees, and agents shall notify the Department, at any time either during or after completion or termination of this Agreement, of any intended statement to the press or any intended issuing of any material for publication in any media of communication (print, news, television, radio, Internet, etc.) regarding the services provided or the data collected pursuant to this Agreement at least 24 hours prior to any statement to the press or at least five business days prior to the submission of the material for publication, or such shorter periods as are reasonable under the circumstances. The Contractor may not issue any statement or submit any material for publication that includes confidential information as prohibited by this Section 5.08.

E. At the request of the Department, the Contractor shall return to the Department any and all confidential information in the possession of the Contractor or its subcontractors. If the Contractor or its subcontractors are legally required to retain any confidential information, the Contractor shall notify the Department in writing and set forth the confidential information that it intends to retain and the reasons why it is legally required to retain such information. The Contractor shall confer with the Department, in good faith, regarding any issues that arise from the Contractor retaining such confidential information. If the Department does not request such information or the Law does not require otherwise, such information shall be maintained in accordance with the requirements set forth in Section 5.02.

F. A breach of this Section 5.08 shall constitute a material breach of this Agreement for which the Department may terminate this Agreement pursuant to Article 10. The Department reserves any and all other rights and remedies in the event of unauthorized disclosure.

ARTICLE 6 - COPYRIGHTS, PATENTS, INVENTIONS, AND ANTITRUST

Section 6.01 Copyrights and Ownership of Work Product

A. Any reports, documents, data, photographs, deliverables, and/or other materials produced pursuant to this Agreement, and any and all drafts and/or other preliminary materials in any format related to such items produced pursuant to this Agreement, shall upon their creation become the exclusive property of the City.

B. Any reports, documents, data, photographs, deliverables, and/or other materials provided pursuant to this Agreement ("Copyrightable Materials") shall be considered "work-made-for-hire" within the meaning and purview of Section 101 of the United States Copyright Act, 17 U.S.C. § 101, and the City shall be the copyright owner thereof and of all aspects, elements, and components thereof in which copyright protection might exist. To the extent that the Copyrightable Materials do not qualify as "work-made-for-hire," the Contractor hereby irrevocably transfers, assigns and conveys exclusive copyright ownership in and to the Copyrightable Materials to the City, free and clear of any liens, claims, or other encumbrances. The Contractor shall retain no copyright or intellectual property interest in the Copyrightable Materials. The Copyrightable Materials shall be used by the Contractor for no purpose other than in the performance of this Agreement without the prior written permission of the City. The Department may grant the Contractor a license to use the Copyrightable Materials on such terms as determined by the Department and set forth in the license.

C. The Contractor acknowledges that the City may, in its sole discretion, register copyright in the Copyrightable Materials with the United States Copyright Office or any other government agency authorized to grant copyright registrations. The Contractor shall fully cooperate in this effort, and agrees to provide any and all documentation necessary to accomplish this.

D. The Contractor represents and warrants that the Copyrightable Materials: (i) are wholly original material not published elsewhere (except for material that is in the public domain); (ii) do not violate any copyright Law; (iii) do not constitute defamation or invasion of the right of privacy or publicity; and (iv) are not an infringement, of any kind, of the rights of any third party. To the extent that the Copyrightable Materials incorporate any non-original material, the Contractor has obtained all necessary permissions and clearances, in writing, for the use of such non-original material under this Agreement, copies of which shall be provided to the City upon execution of this Agreement.

E. If the services under this Agreement are supported by a federal grant of funds, the federal and State government reserves a royalty-free, non-exclusive irrevocable license to reproduce, publish, or otherwise use and to authorize others to use, for federal or State government purposes, the copyright in any Copyrightable Materials developed under this Agreement.

F. If the Contractor publishes a work dealing with any aspect of performance under this Agreement, or with the results of such performance, the City shall have a royalty-free, non-exclusive irrevocable license to reproduce, publish, or otherwise use such work for City governmental purposes.

Section 6.02 Patents and Inventions

The Contractor shall promptly and fully report to the Department any discovery or invention arising out of or developed in the course of performance of this Agreement. If the services under this Agreement are supported by a federal grant of funds, the Contractor shall promptly and fully report to the federal government for the federal government to make a determination as to whether patent protection on such invention shall be sought and how the rights in the invention or discovery, including rights under any patent issued thereon, shall be disposed of and administered in order to protect the public interest.

Section 6.03 Pre-existing Rights

In no case shall Sections 6.01 and 6.02 apply to, or prevent the Contractor from asserting or protecting its rights in any discovery, invention, report, document, data, photograph, deliverable, or other material in connection with or produced pursuant to this Agreement that existed prior to or was developed or discovered independently from the activities directly related to this Agreement.

Section 6.04 Antitrust

The Contractor hereby assigns, sells, and transfers to the City all right, title, and interest in and to any claims and causes of action arising under the antitrust laws of the State or of the United States relating to the particular goods or services procured by the City under this Agreement.

ARTICLE 7 - INSURANCE

Section 7.01 Agreement to Insure

The Contractor shall maintain the following types of insurance if and as indicated in Schedule A (with the minimum limits and special conditions specified in Schedule A) throughout the term of this Agreement, including any applicable guaranty period. All insurance shall meet the requirements set forth in this Article 7. Wherever this Article 7 requires that insurance coverage be "at least as broad" as a specified form (including all ISO forms), there is no obligation that the form itself be used, provided that the Contractor can demonstrate that the alternative form or endorsement contained in its policy provides coverage at least as broad as the specified form.

Section 7.02 Workers' Compensation, Disability Benefits, and Employers' Liability Insurance

A. The Contractor shall maintain workers' compensation insurance, employers' liability insurance, and disability benefits insurance, in accordance with Law on behalf of, or in regard to, all employees providing services under this Agreement

B. Within 10 Days of award of this Agreement or as otherwise specified by the Department, and as required by N.Y. Workers' Compensation Law §§ 57 and 220(8), the Contractor shall submit proof of Contractor's workers' compensation insurance and disability benefits insurance (or proof of a legal exemption) to the Department in a form acceptable to the New York State Workers' Compensation Board. ACORD forms are not acceptable proof of such insurance. The following forms are acceptable:

1. Form C-105.2, *Certificate of Workers' Compensation Insurance*;

2. Form U-26.3, *State Insurance Fund Certificate of Workers' Compensation Insurance*;

3. Form SI-12, *Certificate of Workers' Compensation Self-Insurance*;

4. Form GSI-105.2, *Certificate of Participation in Worker's Compensation Group Self-Insurance*;

5. Form DB-120.1, *Certificate of Disability Benefits Insurance*;

6. Form DB-155, *Certificate of Disability Benefits Self-Insurance*;

7. Form CE-200 – *Affidavit of Exemption*;

8. Other forms approved by the New York State Workers' Compensation Board; or

9. Other proof of insurance in a form acceptable to the City.

Section 7.03 Other Insurance

A. *Commercial General Liability Insurance.* The Contractor shall maintain commercial general liability insurance in the amounts specified in Schedule A covering operations under this Agreement. Coverage must be at least as broad as the coverage provided by the most recently issued ISO Form CG 00 01, primary and non-contributory, and "occurrence" based rather than "claims-made." Such coverage shall list the City, together with its officials and employees, and any other entity that may be listed on Schedule A as an additional insured with coverage at least as broad as the most recently issued ISO Form CG 20 10 or CG 20 26 and, if construction is performed as part of the services, ISO Form CG 20 37.

B. *Commercial Automobile Liability Insurance.* If indicated in Schedule A and/or if vehicles are used in the provision of services under this Agreement, the Contractor shall maintain commercial automobile liability insurance for liability arising out of ownership, maintenance or

use of any owned, non-owned, or hired vehicles to be used in connection with this Agreement. Coverage shall be at least as broad as the most recently issued ISO Form CA 00 01. If vehicles are used for transporting hazardous materials, the commercial automobile liability insurance shall be endorsed to provide pollution liability broadened coverage for covered vehicles (endorsement CA 99 48) as well as proof of MCS-90.

C. *Professional Liability Insurance.*

1. If indicated in Schedule A, the Contractor shall maintain and submit evidence of professional liability insurance or errors and omissions insurance appropriate to the type(s) of such services to be provided under this Agreement. The policy or policies shall cover the liability assumed by the Contractor under this Agreement arising out of the negligent performance of professional services or caused by an error, omission, or negligent act of the Contractor or anyone employed by the Contractor.

2. All subcontractors of the Contractor providing professional services under this Agreement for which professional liability insurance or errors and omissions insurance is reasonably commercially available shall also maintain such insurance in the amount specified in Schedule A. At the time of the request for subcontractor approval, the Contractor shall provide to the Department, evidence of such professional liability insurance on a form acceptable to the Department.

3. Claims-made policies will be accepted for professional liability insurance. All such policies shall have an extended reporting period option or automatic coverage of not less than two years. If available as an option, the Contractor shall purchase extended reporting period coverage effective on cancellation or termination of such insurance unless a new policy is secured with a retroactive date, including at least the last policy year.

D. *Crime Insurance.* If indicated in Schedule A, the Contractor shall maintain crime insurance during the term of the Agreement in the minimum amounts listed in Schedule A. Such insurance shall include coverage, without limitation, for any and all acts of employee theft including employee theft of client property, forgery or alteration, inside the premises (theft of money and securities), inside the premises (robbery or safe burglary of other property), outside the premises, computer fraud, funds transfer fraud, and money orders and counterfeit money. The policy shall name the Contractor as named insured and shall list the City as loss payee as its interests may appear.

E. *Cyber Liability Insurance.* If indicated in Schedule A, the Contractor shall maintain cyber liability insurance covering losses arising from operations under this Agreement in the amounts listed in Schedule A. The City shall approve the policy (including exclusions therein), coverage amounts, deductibles or self-insured retentions, and premiums, as well as the types of losses covered, which may include but not be limited to: notification costs, security monitoring costs, losses resulting from identity theft, and other injury to third parties. If additional insured status is commercially available under the Contractor's cyber liability insurance, the insurance shall cover the City, together with its respective officials and employees, as additional insured.

F. *Other Insurance.* The Contractor shall provide such other types of insurance in the amounts specified in Schedule A.

Section 7.04 General Requirements for Insurance Coverage and Policies

A. Unless otherwise stated, all insurance required by Section 7.03 of this Agreement must:

1. be provided by companies that may lawfully issue such policies;

2. have an A.M. Best rating of at least A- / VII, a Standard & Poor's rating of at least A, a Moody's Investors Service rating of at least A3, a Fitch Ratings rating of at least A- or a similar rating by any other nationally recognized statistical rating organization acceptable to the New York City Law Department unless prior written approval is obtained from the New York City Law Department; and

3. be primary (and non-contributing) to any insurance or self-insurance maintained by the City (not applicable to professional liability insurance/errors and omissions insurance) and any other entity listed as an additional insured in Schedule A.

B. The Contractor shall be solely responsible for the payment of all premiums for all required insurance policies and all deductibles or self-insured retentions to which such policies are subject, whether or not the City is an insured under the policy.

C. There shall be no self-insurance program, including a self-insurance retention, exceeding $10,000.00, with regard to any insurance required under Section 7.03 unless approved in writing by the Commissioner. Any such self-insurance program shall provide the City and any other additional insured listed on Schedule A with all rights that would be provided by traditional insurance required under this Article 7, including but not limited to the defense obligations that insurers are required to undertake in liability policies.

D. The limits of coverage for all types of insurance for the City, including its officials and employees, and any other additional insured listed on Schedule A that must be provided to such additional insured(s) shall be the greater of (i) the minimum limits set forth in Schedule A or (ii) the limits provided to the Contractor as named insured under all primary, excess, and umbrella policies of that type of coverage.

Section 7.05 Proof of Insurance

A. For each policy required under Section 7.03 and Schedule A of this Agreement, the Contractor shall file proof of insurance and, where applicable, proof that the City, including its officials and employees, is an additional insured with the Department within ten Days of award of this Agreement. The following proof is acceptable:

1. A certificate of insurance accompanied by a completed certification of insurance broker or agent (included in Schedule A of this Agreement) and any endorsements by which the City, including its officials and employees, have been made an additional insured; or

2. A copy of the insurance policy, including declarations and endorsements, certified by an authorized representative of the issuing insurance carrier.

B. Proof of insurance confirming renewals of insurance required under Section 7.03 must be submitted to the Department prior to the expiration date of the coverage. Such proof must meet the requirements of Section 7.05(A).

C. The Contractor shall provide the City with a copy of any policy required under this Article 7 upon the demand for such policy by the Commissioner or the New York City Law Department.

D. Acceptance by the Commissioner of a certificate or a policy does not excuse the Contractor from maintaining policies consistent with all provisions of this Article 7 (and ensuring that subcontractors maintain such policies) or from any liability arising from its failure to do so.

E. If the Contractor receives notice, from an insurance company or other person, that any insurance policy required under this Article 7 shall expire or be cancelled or terminated for any reason, the Contractor shall immediately forward a copy of such notice to both the address referred to in Section 14.04 and Schedule A and to the New York City Comptroller, Attn: Office of Contract Administration, Municipal Building, One Centre Street, Room 1005, New York, New York 10007.

Section 7.06 Miscellaneous

A. Whenever notice of loss, damage, occurrence, accident, claim, or suit is required under a policy required by Section 7.03 and Schedule A, the Contractor shall provide the insurer with timely notice thereof on behalf of the City. Such notice shall be given even where the Contractor may not be covered under such policy if this Agreement requires that the City be an additional insured (for example, where one of Contractor's employees was injured). Such notice shall expressly specify that "this notice is being given on behalf of the City of New York, including its officials and employees, as additional insured" (such notice shall also include the name of any other entity listed as an additional insured on Schedule A) and contain the following information to the extent known: the number of the insurance policy; the name of the named insured; the date and location of the damage, occurrence, or accident; the identity of the persons or things injured, damaged, or lost; and the title of the claim or suit, if applicable. The Contractor shall simultaneously send a copy of such notice to the City of New York c/o Insurance Claims Specialist, Affirmative Litigation Division, New York City Law Department, 100 Church Street, New York, New York 10007. If the Contractor fails to comply with the requirements of this paragraph, the Contractor shall indemnify the City, together with its officials and employees, and any other entity listed as an additional insured on Schedule A for all losses, judgments, settlements and expenses,

including reasonable attorneys' fees, arising from an insurer's disclaimer of coverage citing late notice by or on behalf of the City together with its officials and employees, and any other entity listed as an additional insured on Schedule A.

B. The Contractor's failure to maintain any of the insurance required by this Article 7 and Schedule A shall constitute a material breach of this Agreement. Such breach shall not be waived or otherwise excused by any action or inaction by the City at any time.

C. Insurance coverage in the minimum amounts required in this Article 7 shall not relieve the Contractor or its subcontractors of any liability under this Agreement, nor shall it preclude the City from exercising any rights or taking such other actions as are available to it under any other provisions of this Agreement or Law.

D. With respect to insurance required by Section 7.03 and Schedule A (but not including professional liability/errors and omissions insurance), the Contractor waives all rights against the City, including its officials and employees, and any other entity listed as an additional insured on Schedule A for any damages or losses that are covered under any insurance required under this Article 7 (whether or not such insurance is actually procured or claims are paid thereunder) or any other insurance applicable to the operations of the Contractor and/or its subcontractors in the performance of this Agreement.

E. In the event the Contractor requires any subcontractor to maintain insurance with regard to any operations under this Agreement and requires such subcontractor to list the Contractor as an additional insured under such insurance, the Contractor shall ensure that such entity also list the City, including its officials and employees, and any other entity listed as an additional insured on Schedule A as an additional insured. With respect to commercial general liability insurance, such coverage must be at least as broad as the most recently issued ISO form CG 20 26.

ARTICLE 8 - PROTECTION OF PERSONS AND PROPERTY AND INDEMNIFICATION

Section 8.01 Reasonable Precautions

The Contractor shall take all reasonable precautions to protect all persons and the property of the City and of others from injury, damage, or loss resulting from the Contractor's and/or its subcontractors' operations under this Agreement.

Section 8.02 Protection of City Property

The Contractor assumes the risk of, and shall be responsible for, any loss or damage to City property, including property and equipment leased by the City, used in the performance of this Agreement, where such loss or damage is caused by negligence, any tortious act, or failure to

comply with the provisions of this Agreement or of Law by the Contractor, its officers, employees, agents or subcontractors.

Section 8.03 Indemnification

To the fullest extent permitted by Law, the Contractor shall defend, indemnify, and hold harmless the City, including its officials and employees, against any and all claims (even if the allegations of the claim are without merit), judgments for damages on account of any injuries or death to any person or damage to any property, and costs and expenses to which the City or its officials or employees, may be subject to or which they may suffer or incur allegedly arising out of any of the operations of the Contractor and/or its subcontractors under this Agreement to the extent resulting from any negligent act of commission or omission, any intentional tortious act, and/or the failure to comply with Law or any of the requirements of this Agreement. Insofar as the facts or Law relating to any of the foregoing would preclude the City or its officials or employees from being completely indemnified by the Contractor, the City and its officials and employees shall be partially indemnified by the Contractor to the fullest extent permitted by Law.

Section 8.04 Infringement Indemnification

To the fullest extent permitted by Law, the Contractor shall defend, indemnify, and hold harmless the City, including its officials and employees, against any and all claims (even if the allegations of the claim are without merit), judgments for damages, and costs and expenses to which the City or its officials or employees, may be subject to or which they may suffer or incur allegedly arising out of any infringement, violation, or unauthorized use of any copyright, trade secret, trademark or patent or any other property or personal right of any third party by the Contractor and/or its employees, agents, or subcontractors in the performance of this Agreement. To the fullest extent permitted by Law, the Contractor shall defend, indemnify, and hold harmless the City and its officials and employees regardless of whether or not the alleged infringement, violation, or unauthorized use arises out of compliance with the Agreement's scope of services/scope of work. Insofar as the facts or Law relating to any of the foregoing would preclude the City and its officials and employees from being completely indemnified by the Contractor, the City and its officials and employees shall be partially indemnified by the Contractor to the fullest extent permitted by Law.

Section 8.05 Indemnification Obligations Not Limited By Insurance Obligation

The Contractor's obligation to indemnify, defend and hold harmless the City and its officials and employees shall neither be (i) limited in any way by the Contractor's obligations to obtain and maintain insurance under this Agreement, nor (ii) adversely affected by any failure on the part of the City or its officials or employees to avail themselves of the benefits of such insurance.

Section 8.06 Actions By or Against Third Parties

A. If any claim is made or any action brought in any way relating to Agreement other than an action between the City and the Contractor, the Contractor shall diligently render to the City without additional compensation all assistance that the City may reasonably require of the Contractor.

B. The Contractor shall report to the Department in writing within five business days of the initiation by or against the Contractor of any legal action or proceeding relating to this Agreement.

Section 8.07 Withholding of Payments

A. If any claim is made or any action is brought against the City for which the Contractor may be required to indemnify the City pursuant to this Agreement, the City shall have the right to withhold further payments under this Agreement for the purpose of set-off in sufficient sums to cover the said claim or action.

B. If any City property is lost or damaged as set forth in Section 8.02, except for normal wear and tear, the City shall have the right to withhold payments under this Agreement for the purpose of set-off in sufficient sums to cover such loss or damage.

C. The City shall not, however, impose a set-off in the event that an insurance company that provided insurance pursuant to Section 7.03 above has accepted the City's tender of the claim or action without a reservation of rights.

D. The Department may, at its option, withhold for purposes of set-off any monies due to the Contractor under this Agreement up to the amount of any disallowances or questioned costs resulting from any audits of the Contractor or to the amount of any overpayment to the Contractor with regard to this Agreement.

E. The rights and remedies of the City provided for in this Section 8.07 are not exclusive and are in addition to any other rights and remedies provided by Law or this Agreement.

Section 8.08 No Third Party Rights

The provisions of this Agreement shall not be deemed to create any right of action in favor of third parties against the Contractor or the City or their respective officials and employees.

ARTICLE 9 - CONTRACT CHANGES

Section 9.01 Contract Changes

Changes to this Agreement may be made only as duly authorized by the ACCO or his or her designee and in accordance with the PPB Rules. Any amendment or change to this Agreement shall not be valid unless made in writing and signed by authorized representatives of both parties. The Contractor deviates from the requirements of this Agreement without a duly approved and executed change order document or written contract modification or amendment at its own risk.

Section 9.02 Changes Through Fault of Contractor

If any change is required in the data, documents, deliverables, or other services to be provided under this Agreement because of negligence or error of the Contractor, no additional compensation shall be paid to the Contractor for making such change, and the Contractor is obligated to make such change without additional compensation.

ARTICLE 10 - TERMINATION, DEFAULT, REDUCTIONS IN FUNDING, AND LIQUIDATED DAMAGES

Section 10.01 Termination by the City Without Cause

A. The City shall have the right to terminate this Agreement, in whole or in part, without cause, in accordance with the provisions of Section 10.05.

B. In its sole discretion, the City shall have the right to terminate this Agreement, in whole or in part, upon the request of the Contractor to withdraw from the Contract, in accordance with the provisions of Section 10.05.

C. If the City terminates this Agreement pursuant to this Section 10.01, the following provisions apply. The City shall not incur or pay any further obligation pursuant to this Agreement beyond the termination date set by the City pursuant to Section 10.05. The City shall pay for services provided in accordance with this Agreement prior to the termination date. In addition, any obligation necessarily incurred by the Contractor on account of this Agreement prior to receipt of notice of termination and falling due after the termination date shall be paid by the City in accordance with the terms of this Agreement. In no event shall such obligation be construed as including any lease or other occupancy agreement, oral or written, entered into between the Contractor and its landlord.

Section 10.02 Reductions in Federal, State, and/or City Funding

A. This Agreement is funded in whole or in part by funds secured from the federal, State and/or City governments. Should there be a reduction or discontinuance of such funds by action of the federal, State and/or City governments, the City shall have, in its sole discretion, the right to terminate this Agreement in whole or in part, or to reduce the funding and/or level of services of this Agreement caused by such action by the federal, State and/or City governments, including, in the case of the reduction option, but not limited to, the reduction or elimination of programs, services or service components; the reduction or elimination of contract-reimbursable

staff or staff-hours, and corresponding reductions in the budget of this Agreement and in the total amount payable under this Agreement. Any reduction in funds pursuant to this Section 10.02(A) shall be accompanied by an appropriate reduction in the services performed under this Agreement.

B. In the case of the reduction option referred to in Section 10.02(A), above, any such reduction shall be effective as of the date set forth in a written notice thereof to the Contractor, which shall be not less than 30 Days from the date of such notice. Prior to sending such notice of reduction, the Department shall advise the Contractor that such option is being exercised and afford the Contractor an opportunity to make within seven Days any suggestion(s) it may have as to which program(s), service(s), service component(s), staff or staff-hours might be reduced or eliminated, provided, however, that the Department shall not be bound to utilize any of the Contractor's suggestions and that the Department shall have sole discretion as to how to effectuate the reductions.

C. If the City reduces funding pursuant to this Section 10.02, the following provisions apply. The City shall pay for services provided in accordance with this Agreement prior to the reduction date. In addition, any obligation necessarily incurred by the Contractor on account of this Agreement prior to receipt of notice of reduction and falling due after the reduction date shall be paid by the City in accordance with the terms of this Agreement. In no event shall such obligation be construed as including any lease or other occupancy agreement, oral or written, entered into between the Contractor and its landlord.

D. To the extent that the reduction in public funds is a result of the State determining that the Contractor may receive medical assistance funds pursuant to title eleven of article five of the Social Services Law to fund the services contained within the scope of a program under this Agreement, then the notice and effective date provisions of this Section 10.02 shall not apply, and the Department may reduce such public funds authorized under this Agreement by informing the Contractor of the amount of the reduction and revising attachments to this Agreement as appropriate.

Section 10.03 Contractor Default

A. The City shall have the right to declare the Contractor in default:

1. Upon a breach by the Contractor of a material term or condition of this Agreement, including unsatisfactory performance of the services;

2. Upon insolvency or the commencement of any proceeding by or against the Contractor, either voluntarily or involuntarily, under the Bankruptcy Code or relating to the insolvency, receivership, liquidation, or composition of the Contractor for the benefit of creditors;

3. If the Contractor refuses or fails to proceed with the services under the Agreement when and as directed by the Commissioner;

4. If the Contractor or any of its officers, directors, partners, five percent or greater shareholders, principals, or other employee or person substantially involved in its activities are indicted or convicted after execution of the Agreement under any state or federal law of any of the following:

a. a criminal offense incident to obtaining or attempting to obtain or performing a public or private contract;

b. fraud, embezzlement, theft, bribery, forgery, falsification, or destruction of records, or receiving stolen property;

c. a criminal violation of any state or federal antitrust law;

d. violation of the Racketeer Influence and Corrupt Organization Act, 18 U.S.C. §§ 1961 *et seq*., or the Mail Fraud Act, 18 U.S.C. §§ 1341 *et seq*., for acts in connection with the submission of bids or proposals for a public or private contract;

e. conspiracy to commit any act or omission that would constitute grounds for conviction or liability under any statute described in subparagraph (d) above; or

f. an offense indicating a lack of business integrity that seriously and directly affects responsibility as a City vendor.

5. If the Contractor or any of its officers, directors, partners, five percent or greater shareholders, principals, or other employee or person substantially involved in its activities are subject to a judgment of civil liability under any state or federal antitrust law for acts or omissions in connection with the submission of bids or proposals for a public or private contract; or

6. If the Contractor or any of its officers, directors, partners, five percent or greater shareholders, principals, or other employee or person substantially involved in its activities makes or causes to be made any false, deceptive, or fraudulent material statement, or fail to make a required material statement in any bid, proposal, or application for City or other government work.

B. The right to declare the Contractor in default shall be exercised by sending the Contractor a written notice of the conditions of default, signed by the Commissioner, setting forth the ground or grounds upon which such default is declared ("Notice to Cure"). The Contractor shall have ten Days from receipt of the Notice to Cure or any longer period that is set forth in the Notice to Cure to cure the default. The Commissioner may temporarily suspend services under the Agreement pending the outcome of the default proceedings pursuant to this Section 10.03.

C. If the conditions set forth in the Notice to Cure are not cured within the period set forth in the Notice to Cure, the Commissioner may declare the Contractor in default pursuant to this Section 10.03. Before the Commissioner may exercise his or her right to declare the Contractor

in default, the Commissioner shall give the Contractor an opportunity to be heard upon not less than five business days' notice. The Commissioner may, in his or her discretion, provide for such opportunity to be in writing or in person. Such opportunity to be heard shall not occur prior to the end of the cure period but notice of such opportunity to be heard may be given prior to the end of the cure period and may be given contemporaneously with the Notice to Cure.

D. After the opportunity to be heard, the Commissioner may terminate the Agreement, in whole or in part, upon finding the Contractor in default pursuant to this Section 10.03, in accordance with the provisions of Section 10.05.

E. The Commissioner, after declaring the Contractor in default, may have the services under the Agreement completed by such means and in such manner, by contract with or without public letting, or otherwise, as he or she may deem advisable in accordance with applicable PPB Rules. After such completion, the Commissioner shall certify the expense incurred in such completion, which shall include the cost of re-letting. Should the expense of such completion, as certified by the Commissioner, exceed the total sum which would have been payable under the Agreement if it had been completed by the Contractor, any excess shall be promptly paid by the Contractor upon demand by the City. The excess expense of such completion, including any and all related and incidental costs, as so certified by the Commissioner, and any liquidated damages assessed against the Contractor, may be charged against and deducted out of monies earned by the Contractor.

Section 10.04 Force Majeure

A. For purposes of this Agreement, a force majeure event is an act or event beyond the control and without any fault or negligence of the Contractor ("Force Majeure Event"). Such events may include, but are not limited to, fire, flood, earthquake, storm or other natural disaster, civil commotion, war, terrorism, riot, and labor disputes not brought about by any act or omission of the Contractor.

B. In the event the Contractor cannot comply with the terms of the Agreement (including any failure by the Contractor to make progress in the performance of the services) because of a Force Majeure Event, then the Contractor may ask the Commissioner to excuse the nonperformance and/or terminate the Agreement. If the Commissioner, in his or her reasonable discretion, determines that the Contractor cannot comply with the terms of the Agreement because of a Force Majeure Event, then the Commissioner shall excuse the nonperformance and may terminate the Agreement. Such a termination shall be deemed to be without cause.

C. If the City terminates the Agreement pursuant to this Section 10.04, the following provisions apply. The City shall not incur or pay any further obligation pursuant to this Agreement beyond the termination date. The City shall pay for services provided in accordance with this Agreement prior to the termination date. Any obligation necessarily incurred by the Contractor on account of this Agreement prior to receipt of notice of termination and falling due after the termination date shall be paid by the City in accordance with the terms of this Agreement. In no

event shall such obligation be construed as including any lease or other occupancy agreement, oral or written, entered into between the Contractor and its landlord.

Section 10.05 Procedures for Termination

A. The Department and/or the City shall give the Contractor written notice of any termination of this Agreement. Such notice shall specify the applicable provision(s) under which the Agreement is terminated and the effective date of the termination. Except as otherwise provided in this Agreement, the notice shall comply with the provisions of this Section 10.05 and Section 14.04. For termination without cause, the effective date of the termination shall not be less than ten Days from the date the notice is personally delivered, or 15 Days from the date the notice is either sent by certified mail, return receipt requested, delivered by overnight or same day courier service in a properly addressed envelope with confirmation, or sent by email and, unless the receipt of the email is acknowledged by the recipient by email, deposited in a post office box regularly maintained by the United States Postal Service in a properly addressed postage pre-paid envelope. In the case of termination for default, the effective date of the termination shall be as set forth above for a termination without cause or such earlier date as the Commissioner may determine. If the City terminates the Agreement in part, the Contractor shall continue the performance of the Agreement to the extent not terminated.

B. Upon termination or expiration of this Agreement, the Contractor shall comply with the City close-out procedures, including but not limited to:

1. Accounting for and refunding to the Department, within 45 Days, any unexpended funds which have been advanced to the Contractor pursuant to this Agreement;

2. Furnishing within 45 Days an inventory to the Department of all equipment, appurtenances and property purchased through or provided under this Agreement and carrying out any Department or City directive concerning the disposition of such equipment, appurtenances and property;

3. Turning over to the Department or its designees all books, records, documents and material specifically relating to this Agreement that the Department has requested be turned over;

4. Submitting to the Department, within 90 Days, a final statement and report relating to the Agreement. The report shall be made by a certified public accountant or a licensed public accountant, unless the Department waives, in writing, the requirement that a certified public accountant or licensed public accountant make such report; and

5. Providing reasonable assistance to the Department in the transition, if any, to a new contractor.

Section 10.06 Miscellaneous Provisions

A. The Commissioner, in addition to any other powers set forth in this Agreement or by operation of Law, may suspend, in whole or in part, any part of the services to be provided under this Agreement whenever in his or her judgment such suspension is required in the best interest of the City. If the Commissioner suspends this Agreement pursuant to this Section 10.06, the City shall not incur or pay any further obligation pursuant to this Agreement beyond the suspension date until such suspension is lifted. The City shall pay for services provided in accordance with this Agreement prior to the suspension date. In addition, any obligation necessarily incurred by the Contractor on account of this Agreement prior to receipt of notice of suspension and falling due during the suspension period shall be paid by the City in accordance with the terms of this Agreement.

B. Notwithstanding any other provisions of this Agreement, the Contractor shall not be relieved of liability to the City for damages sustained by the City by virtue of the Contractor's breach of the Agreement, and the City may withhold payments to the Contractor for the purpose of set-off in the amount of damages due to the City from the Contractor.

C. The rights and remedies of the City provided in this Article 10 shall not be exclusive and are in addition to all other rights and remedies provided by Law or under this Agreement.

Section 10.07 Liquidated Damages

If Schedule A or any other part of this Agreement includes liquidated damages for failure to comply with a provision of this Agreement, the sum indicated is fixed and agreed as the liquidated damages that the City will suffer by reason of such noncompliance and not as a penalty.

ARTICLE 11 - PROMPT PAYMENT AND ELECTRONIC FUNDS TRANSFER

Section 11.01 Prompt Payment

A. The prompt payment provisions of PPB Rule § 4-06 are applicable to payments made under this Agreement. With some exceptions, the provisions generally require the payment to the Contractor of interest on payments made after the required payment date, as set forth in the PPB Rules.

B. The Contractor shall submit a proper invoice to receive payment, except where the Agreement provides that the Contractor will be paid at predetermined intervals without having to submit an invoice for each scheduled payment.

C. Determination of interest due will be made in accordance with the PPB Rules and the applicable rate of interest shall be the rate in effect at the time of payment.

Section 11.02 Electronic Funds Transfer

A. In accordance with Admin. Code § 6-107.1, the Contractor agrees to accept payments under this Agreement from the City by electronic funds transfer. An electronic funds transfer is any transfer of funds, other than a transaction originated by check, draft, or similar paper instrument, which is initiated through an electronic terminal, telephonic instrument or computer or magnetic tape so as to order, instruct, or authorize a financial institution to debit or credit an account. Prior to the first payment made under this Agreement, the Contractor shall designate one financial institution or other authorized payment agent and shall complete the "EFT Vendor Payment Enrollment Form" available from the Agency or at http://www.nyc.gov/dof in order to provide the commissioner of the Department of Finance with information necessary for the Contractor to receive electronic funds transfer payments through the designated financial institution or authorized payment agent. The crediting of the amount of a payment to the appropriate account on the books of a financial institution or other authorized payment agent designated by the Contractor shall constitute full satisfaction by the City for the amount of the payment under this Agreement. The account information supplied by the Contractor to facilitate the electronic funds transfer shall remain confidential to the fullest extent provided by Law.

B. The Agency Head may waive the application of the requirements of this Section 11.02 to payments on contracts entered into pursuant to Charter § 315. In addition, the commissioner of the Department of Finance and the Comptroller may jointly issue standards pursuant to which the Department may waive the requirements of this Section 11.02 for payments in the following circumstances: (i) for individuals or classes of individuals for whom compliance imposes a hardship; (ii) for classifications or types of checks; or (iii) in other circumstances as may be necessary in the best interest of the City.

C. This Section 11.02 is applicable to contracts valued at $25,000.00 and above.

ARTICLE 12 - CLAIMS

Section 12.01 Choice of Law

This Agreement shall be deemed to be executed in the City and State of New York, regardless of the domicile of the Contractor, and shall be governed by and construed in accordance with the Laws of the State of New York (notwithstanding New York choice of law or conflict of law principles) and the Laws of the United States, where applicable.

Section 12.02 Jurisdiction and Venue

Subject to Section 12.03, the parties agree that any and all claims asserted by or against the City arising under or related to this Agreement shall solely be heard and determined either in the courts of the United States located in the City or in the courts of the State located in the City and County of New York. The parties shall consent to the dismissal and/or transfer of any claims asserted in any other venue or forum to the proper venue or forum. If the Contractor initiates any action in breach of this Section 12.02, the Contractor shall be responsible for and shall promptly

reimburse the City for any attorneys' fees incurred by the City in removing the action to a proper court consistent with this Section 12.02.

Section 12.03 Resolution of Disputes

A. Except as provided in Subparagraphs (A)(1) and (A)(2) below, all disputes between the City and the Contractor that arise under, or by virtue of, this Agreement shall be finally resolved in accordance with the provisions of this Section 12.03 and PPB Rule § 4-09. This procedure shall be the exclusive means of resolving any such disputes.

1. This Section 12.03 shall not apply to disputes concerning matters dealt with in other sections of the PPB Rules or to disputes involving patents, copyrights, trademarks, or trade secrets (as interpreted by the courts of New York State) relating to proprietary rights in computer software, or to termination other than for cause.

2. For construction and construction-related services this Section 12.03 shall apply only to disputes about the scope of work delineated by the Agreement, the interpretation of Agreement documents, the amount to be paid for extra work or disputed work performed in connection with the Agreement, the conformity of the Contractor's work to the Agreement, and the acceptability and quality of the Contractor's work; such disputes arise when the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head makes a determination with which the Contractor disagrees. For construction, this Section 12.03 shall not apply to termination of the Agreement for cause or other than for cause.

B. All determinations required by this Section 12.03 shall be clearly stated, with a reasoned explanation for the determination based on the information and evidence presented to the party making the determination. Failure to make such determination within the time required by this Section 12.03 shall be deemed a non-determination without prejudice that will allow application to the next level.

C. During such time as any dispute is being presented, heard, and considered pursuant to this Section 12.03, the Agreement terms shall remain in full force and effect and, unless otherwise directed by the ACCO or Engineer, the Contractor shall continue to perform work in accordance with the Agreement and as directed by the ACCO or City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head. Failure of the Contractor to continue the work as directed shall constitute a waiver by the Contractor of any and all claims being presented pursuant to this Section 12.03 and a material breach of contract.

D. Presentation of Dispute to Agency Head.

1. Notice of Dispute and Agency Response. The Contractor shall present its dispute in writing ("Notice of Dispute") to the Agency Head within the time specified herein, or, if no time is specified, within 30 Days of receiving written notice of the determination or action that is the subject of the dispute. This notice requirement shall not

be read to replace any other notice requirements contained in the Agreement. The Notice of Dispute shall include all the facts, evidence, documents, or other basis upon which the Contractor relies in support of its position, as well as a detailed computation demonstrating how any amount of money claimed by the Contractor in the dispute was arrived at. Within 30 Days after receipt of the complete Notice of Dispute, the ACCO or, in the case of construction or construction-related services, the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head, shall submit to the Agency Head all materials he or she deems pertinent to the dispute. Following initial submissions to the Agency Head, either party may demand of the other the production of any document or other material the demanding party believes may be relevant to the dispute. The requested party shall produce all relevant materials that are not otherwise protected by a legal privilege recognized by the courts of New York State. Any question of relevancy shall be determined by the Agency Head whose decision shall be final. Willful failure of the Contractor to produce any requested material whose relevancy the Contractor has not disputed, or whose relevancy has been affirmatively determined, shall constitute a waiver by the Contractor of its claim.

2. Agency Head Inquiry. The Agency Head shall examine the material and may, in his or her discretion, convene an informal conference with the Contractor and the ACCO and, in the case of construction or construction-related services, the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head, to resolve the issue by mutual consent prior to reaching a determination. The Agency Head may seek such technical or other expertise as he or she shall deem appropriate, including the use of neutral mediators, and require any such additional material from either or both parties as he or she deems fit. The Agency Head's ability to render, and the effect of, a decision hereunder shall not be impaired by any negotiations in connection with the dispute presented, whether or not the Agency Head participated therein. The Agency Head may or, at the request of any party to the dispute, shall compel the participation of any other contractor with a contract related to the work of this Agreement and that contractor shall be bound by the decision of the Agency Head. Any contractor thus brought into the dispute resolution proceeding shall have the same rights and obligations under this Section 12.03 as the Contractor initiating the dispute.

3. Agency Head Determination. Within 30 Days after the receipt of all materials and information, or such longer time as may be agreed to by the parties, the Agency Head shall make his or her determination and shall deliver or send a copy of such determination to the Contractor and ACCO and, in the case of construction or construction-related services, the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head, together with a statement concerning how the decision may be appealed.

4. Finality of Agency Head Decision. The Agency Head's decision shall be final and binding on all parties, unless presented to the Contract Dispute Resolution Board ("CDRB") pursuant to this Section 12.03. The City may not take a petition to the CDRB. However, should the Contractor take such a petition, the City may seek, and the CDRB

may render, a determination less favorable to the Contractor and more favorable to the City than the decision of the Agency Head.

E. Presentation of Dispute to the Comptroller. Before any dispute may be brought by the Contractor to the CDRB, the Contractor must first present its claim to the Comptroller for his or her review, investigation, and possible adjustment.

1. Time, Form, and Content of Notice. Within 30 Days of receipt of a decision by the Agency Head, the Contractor shall submit to the Comptroller and to the Agency Head a Notice of Claim regarding its dispute with the Agency. The Notice of Claim shall consist of (i) a brief statement of the substance of the dispute, the amount of money, if any, claimed and the reason(s) the Contractor contends the dispute was wrongly decided by the Agency Head; (ii) a copy of the decision of the Agency Head; and (iii) a copy of all materials submitted by the Contractor to the Agency, including the Notice of Dispute. The Contractor may not present to the Comptroller any material not presented to the Agency Head, except at the request of the Comptroller.

2. Agency Response. Within 30 Days of receipt of the Notice of Claim, the Agency shall make available to the Comptroller a copy of all material submitted by the Agency to the Agency Head in connection with the dispute. The Agency may not present to the Comptroller any material not presented to the Agency Head, except at the request of the Comptroller.

3. Comptroller Investigation. The Comptroller may investigate the claim in dispute and, in the course of such investigation, may exercise all powers provided in Admin. Code §§ 7-201 and 7-203. In addition, the Comptroller may demand of either party, and such party shall provide, whatever additional material the Comptroller deems pertinent to the claim, including original business records of the Contractor. Willful failure of the Contractor to produce within 15 Days any material requested by the Comptroller shall constitute a waiver by the Contractor of its claim. The Comptroller may also schedule an informal conference to be attended by the Contractor, Agency representatives, and any other personnel desired by the Comptroller.

4. Opportunity of Comptroller to Compromise or Adjust Claim. The Comptroller shall have 45 Days from his or her receipt of all materials referred to in Paragraph (E)(3) above to investigate the disputed claim. The period for investigation and compromise may be further extended by agreement between the Contractor and the Comptroller, to a maximum of 90 Days from the Comptroller's receipt of all the materials. The Contractor may not present its petition to the CDRB until the period for investigation and compromise delineated in this Paragraph has expired. In compromising or adjusting any claim hereunder, the Comptroller may not revise or disregard the terms of the Agreement.

F. Contract Dispute Resolution Board. There shall be a Contract Dispute Resolution Board composed of:

1. the chief administrative law judge of the Office of Administrative Trials and Hearings ("OATH") or his or her designated OATH administrative law judge, who shall act as chairperson, and may adopt operational procedures and issue such orders consistent with this Section 12.03 as may be necessary in the execution of the CDRB's functions, including, but not limited to, granting extensions of time to present or respond to submissions;

2. the City Chief Procurement Officer ("CCPO") or his or her designee; any designee shall have the requisite background to consider and resolve the merits of the dispute and shall not have participated personally and substantially in the particular matter that is the subject of the dispute or report to anyone who so participated; and

3. a person with appropriate expertise who is not an employee of the City. This person shall be selected by the presiding administrative law judge from a prequalified panel of individuals, established, and administered by OATH, with appropriate background to act as decision-makers in a dispute. Such individuals may not have a contract or dispute with the City or be an officer or employee of any company or organization that does, or regularly represent persons, companies, or organizations having disputes with the City.

G. Petition to CDRB. In the event the claim has not been settled or adjusted by the Comptroller within the period provided in this Section 12.03, the Contractor, within thirty (30) Days thereafter, may petition the CDRB to review the Agency Head determination.

1. Form and Content of Petition by the Contractor. The Contractor shall present its dispute to the CDRB in the form of a petition, which shall include (i) a brief statement of the substance of the dispute, the amount of money, if any, claimed, and the reason(s) the Contractor contends that the dispute was wrongly decided by the Agency Head; (ii) a copy of the decision of the Agency Head; (iii) copies of all materials submitted by the Contractor to the Agency; (iv) a copy of the decision of the Comptroller, if any, and (v) copies of all correspondence with, and material submitted by the Contractor to, the Comptroller's Office. The Contractor shall concurrently submit four complete sets of the petition: one to the Corporation Counsel (Attn: Commercial and Real Estate Litigation Division), and three to the CDRB at OATH's offices, with proof of service on the Corporation Counsel. In addition, the Contractor shall submit a copy of the statement of the substance of the dispute, cited in (i) above, to both the Agency Head and the Comptroller.

2. Agency Response. Within 30 Days of receipt of the petition by the Corporation Counsel, the Agency shall respond to the statement of the Contractor and make available to the CDRB all material it submitted to the Agency Head and Comptroller. Three complete copies of the Agency response shall be submitted to the CDRB at OATH's offices and one to the Contractor. Extensions of time for submittal of the Agency response shall be given as necessary upon a showing of good cause or, upon the consent of the parties, for an initial period of up to 30 Days.

3. Further Proceedings. The CDRB shall permit the Contractor to present its case by submission of memoranda, briefs, and oral argument. The CDRB shall also permit the Agency to present its case in response to the Contractor by submission of memoranda, briefs, and oral argument. If requested by the Corporation Counsel, the Comptroller shall provide reasonable assistance in the preparation of the Agency's case. Neither the Contractor nor the Agency may support its case with any documentation or other material that was not considered by the Comptroller, unless requested by the CDRB. The CDRB, in its discretion, may seek such technical or other expert advice as it shall deem appropriate and may seek, on it own or upon application of a party, any such additional material from any party as it deems fit. The CDRB, in its discretion, may combine more than one dispute between the parties for concurrent resolution.

4. CDRB Determination. Within 45 Days of the conclusion of all submissions and oral arguments, the CDRB shall render a decision resolving the dispute. In an unusually complex case, the CDRB may render its decision in a longer period of time, not to exceed 90 Days, and shall so advise the parties at the commencement of this period. The CDRB's decision must be consistent with the terms of this Agreement. Decisions of the CDRB shall only resolve matters before the CDRB and shall not have precedential effect with respect to matters not before the CDRB.

5. Notification of CDRB Decision. The CDRB shall send a copy of its decision to the Contractor, the ACCO, the Corporation Counsel, the Comptroller, the CCPO, and, in the case of construction or construction-related services, the City Engineer, City Resident Engineer, City Engineering Audit Officer, or other designee of the Agency Head. A decision in favor of the Contractor shall be subject to the prompt payment provisions of the PPB Rules. The required payment date shall be 30 Days after the date the parties are formally notified of the CDRB's decision.

6. Finality of CDRB Decision. The CDRB's decision shall be final and binding on all parties. Any party may seek review of the CDRB's decision solely in the form of a challenge, filed within four months of the date of the CDRB's decision, in a court of competent jurisdiction of the State of New York, County of New York pursuant to Article 78 of the Civil Practice Law and Rules. Such review by the court shall be limited to the question of whether or not the CDRB's decision was made in violation of lawful procedure, was affected by an error of Law, or was arbitrary and capricious or an abuse of discretion. No evidence or information shall be introduced or relied upon in such proceeding that was not presented to the CDRB in accordance with PPB Rules § 4-09.

H. Any termination, cancellation, or alleged breach of the Agreement prior to or during the pendency of any proceedings pursuant to this Section 12.03 shall not affect or impair the ability of the Agency Head or CDRB to make a binding and final decision pursuant to this Section 12.03.

Section 12.04 Claims and Actions

A. Any claim, that is not subject to dispute resolution under the PPB Rules or this Agreement, against the City for damages for breach of contract shall not be made or asserted in any action, unless the Contractor shall have strictly complied with all requirements relating to the giving of notice and of information with respect to such claims, as provided in this Agreement.

B. No action shall be instituted or maintained on any such claims unless such action shall be commenced within six months after the final payment under this Agreement, or within six months of the termination or expiration of this Agreement, or within six months after the accrual of the cause of action, whichever first occurs.

Section 12.05 No Claim Against Officials, Agents, or Employees

No claim shall be made by the Contractor against any official, agent, or employee of the City in their personal capacity for, or on account of, anything done or omitted in connection with this Agreement.

Section 12.06 General Release

The acceptance by the Contractor or its assignees of the final payment under this Agreement, whether by check, wire transfer, or other means, and whether pursuant to invoice, voucher, judgment of any court of competent jurisdiction or any other administrative means, shall constitute and operate as a release of the City from any and all claims of and liability to the Contractor, of which the Contractor was aware or should reasonably have been aware, arising out of the performance of this Agreement based on actions of the City prior to such acceptance of final payment, excepting any disputes that are the subject of pending dispute resolution procedures.

Section 12.07 No Waiver

Waiver by either the Department or the Contractor of a breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of the Agreement unless and until the same shall be agreed to in writing by the parties as set forth in Section 9.01.

ARTICLE 13 - APPLICABLE LAWS

Section 13.01 PPB Rules

This Agreement is subject to the PPB Rules. If there is a conflict between the PPB Rules and a provision of this Agreement, the PPB Rules shall take precedence.

Section 13.02 All Legal Provisions Deemed Included

Each and every provision required by Law to be inserted in this Agreement is hereby deemed to be a part of this Agreement, whether actually inserted or not.

Section 13.03 Severability / Unlawful Provisions Deemed Stricken

If this Agreement contains any unlawful provision not an essential part of the Agreement and which shall not appear to have been a controlling or material inducement to the making of this Agreement, the unlawful provision shall be deemed of no effect and shall, upon notice by either party, be deemed stricken from the Agreement without affecting the binding force of the remainder.

Section 13.04 Compliance With Laws

The Contractor shall perform all services under this Agreement in accordance with all applicable Laws as are in effect at the time such services are performed.

Section 13.05 Unlawful Discrimination in the Provision of Services

A. *Discrimination in Public Accommodations.* With respect to services provided under this Agreement, the Contractor shall not unlawfully discriminate against any person because of actual or perceived age, religion, creed, sex, gender, gender identity or gender expression, sexual orientation, partnership status, marital status, disability, presence of a service animal, race, color, national origin, alienage, citizenship status, or military status, or any other class of individuals protected from discrimination in public accommodations by City, State or Federal laws, rules or regulations. The Contractor shall comply with all statutory and regulatory obligations to provide reasonable accommodations to individuals with disabilities.

B. *Discrimination in Housing Accommodations.* With respect to services provided under this Agreement, the Contractor shall not unlawfully discriminate against any person because of actual or perceived age, religion, creed, sex, gender, gender identity or gender expression, sexual orientation, status as a victim of domestic violence, stalking, and sex offenses, partnership status, marital status, presence of children, disability, presence of a service or emotional support animal, race, color, national origin, alienage or citizenship status, lawful occupation, or lawful source of income (including income derived from social security, or any form of federal, state, or local public government assistance or housing assistance including Section 8 vouchers), or any other class of individuals protected from discrimination in housing accommodations by City, State or Federal laws, rules or regulations. The Contractor shall comply with all statutory and regulatory obligations to provide reasonable accommodations to individuals with disabilities.

C. *Admin. Code § 6-123*. In accordance with Admin. Code § 6-123, the Contractor will not engage in any unlawful discriminatory practice as defined in and pursuant to the terms of Title 8 of the Admin. Code. The Contractor shall include a provision in any agreement with a first-level subcontractor performing services under this Agreement for an amount in excess of $50,000.00 that such subcontractor shall not engage in any such unlawful discriminatory practice.

D. *Immigration status*. In connection with the services provided under this Agreement, the Contractor shall not inquire about the immigration status of a recipient or potential recipient of

such services unless (i) it is necessary for the determination of program, service or benefit eligibility or the provision of City services or (ii) the Contractor is required by law to inquire about such person's immigration status.

Section 13.06 Americans with Disabilities Act (ADA)

A. This Agreement is subject to the provisions of Subtitle A of Title II of the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12131 *et seq.* ("ADA") and regulations promulgated pursuant thereto, see 28 CFR Part 35. The Contractor shall not discriminate against an individual with a disability, as defined in the ADA, in providing services, programs, or activities pursuant to this Agreement. If directed to do so by the Department to ensure the Contractor's compliance with the ADA during the term of this Agreement, the Contractor shall prepare a plan ("Compliance Plan") which lists its program site(s) and describes in detail, how it intends to make the services, programs and activities set forth in the scope of services herein readily accessible and usable by individuals with disabilities at such site(s). If the program site is not readily accessible and usable by individuals with disabilities, contractor shall also include in the Compliance Plan, a description of reasonable alternative means and methods that result in making the services, programs or activities provided under this Agreement, readily accessible to and usable by individuals with disabilities, including but not limited to people with visual, auditory or mobility disabilities. The Contractor shall submit the Compliance Plan to the ACCO for review within ten Days after being directed to do so and shall abide by the Compliance Plan and implement any action detailed in the Compliance Plan to make the services, programs, or activities accessible and usable by the disabled.

B. The Contractor's failure to either submit a Compliance Plan as required herein or implement an approved Compliance Plan may be deemed a material breach of this Agreement and result in the City terminating this Agreement.

Section 13.07 Voter Registration

A. *Participating Agencies.* Pursuant to Charter § 1057-a, if this Agreement is made by and through a participating City agency and the Contractor has regular contact with the public in the daily administration of its business, the Contractor must comply with the requirements of this Section 13.06. The participating City agencies are: the Administration for Children's Services; the City Clerk; the Civilian Complaint Review Board; the Commission on Human Rights; Community Boards; SBS; the Department of Citywide Administrative Services; the Department of Consumer Affairs; the Department of Correction; the Department of Environmental Protection; the Department of Finance; the Department of Health and Mental Hygiene; the Department of Homeless Services; the Department of Housing Preservation and Development; the Department of Parks and Recreation; the Department of Probation; the Taxi and Limousine Commission; the Department of Transportation; and the Department of Youth and Community Development.

B. *Distribution of Voter Registration Forms.* In accordance with Charter § 1057-a, the Contractor, if it has regular contact with the public in the daily administration of its business under this Agreement, hereby agrees as follows:

1. The Contractor shall provide and distribute voter registration forms to all persons together with written applications for services, renewal, or recertification for services and change of address relating to such services. Such voter registration forms shall be provided to the Contractor by the City. The Contractor should be prepared to provide forms written in Spanish or Chinese, and shall obtain a sufficient supply of such forms from the City.

2. The Contractor shall also include a voter registration form with any Contractor communication sent through the United States mail for the purpose of supplying clients with materials for application, renewal, or recertification for services and change of address relating to such services. If forms written in Spanish or Chinese are not provided in such mailing, the Contractor shall provide such forms upon the Department's request.

3. The Contractor shall, subject to approval by the Department, incorporate an opportunity to request a voter registration application into any application for services, renewal, or recertification for services and change of address relating to such services provided on computer terminals, the World Wide Web or the Internet. Any person indicating that they wish to be sent a voter registration form via computer terminals, the World Wide Web or the Internet shall be sent such a form by the Contractor or be directed, in a manner subject to approval by the Department, to a link on that system where such a form may be downloaded.

4. The Contractor shall, at the earliest practicable or next regularly scheduled printing of its own forms, subject to approval by the Department, physically incorporate the voter registration forms with its own application forms in a manner that permits the voter registration portion to be detached therefrom. Until such time when the Contractor amends its form, the Contractor should affix or include a postage-paid City Board of Elections voter registration form to or with its application, renewal, recertification, and change of address forms.

5. The Contractor shall prominently display in its public office, subject to approval by the Department, promotional materials designed and approved by the City or State Board of Elections.

6. For the purposes of Paragraph A of this Section 13.06, the word "Contractor" shall be deemed to include subcontractors having regular contact with the public in the daily administration of their business.

7. The provisions of Paragraph A of this Section 13.06 shall not apply to services that must be provided to prevent actual or potential danger to life, health, or safety of any individual or of the public.

C. *Assistance in Completing Voter Registration Forms*. In accordance with Charter § 1057-a, the Contractor hereby agrees as follows:

1. In the event the Department provides assistance in completing distributed voter registration forms, the Contractor shall also provide such assistance, in the manner and to the extent specified by the Department.

2. In the event the Department receives and transmits completed registration forms from applicants who wish to have the forms transmitted to the City Board of Elections, the Contractor shall similarly provide such service, in the manner and to the extent specified by the Department.

3. If, in connection with the provision of services under this Agreement, the Contractor intends to provide assistance in completing distributed voter registration forms or to receive and transmit completed registration forms from applicants who wish to have the forms transmitted to the City Board of Elections, the Contractor shall do so only by prior arrangement with the Department.

4. The provision of Paragraph B services by the Contractor may be subject to Department protocols, including protocols regarding confidentiality.

D. *Required Statements*. In accordance with Charter § 1057-a, the Contractor hereby agrees as follows:

1. The Contractor shall advise all persons seeking voter registration forms and information, in writing together with other written materials provided by the Contractor or by appropriate publicity, that the Contractor's or government services are not conditioned on being registered to vote.

2. No statement shall be made and no action shall be taken by the Contractor or an employee of the Contractor to discourage an applicant from registering to vote or to encourage or discourage an applicant from enrolling in any particular political party.

3. The Contractor shall communicate to applicants that the completion of voter registration forms is voluntary.

4. The Contractor and the Contractor's employees shall not:

a. seek to influence an applicant's political preference or party designation;

b. display any political preference or party allegiance;

c. make any statement to an applicant or take any action the purpose or effect of which is to discourage the applicant from registering to vote; or

d. make any statement to an applicant or take any action the purpose or effect of which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

E. The Contractor, as defined above and in this Agreement, agrees that the covenants and representations in this Section 13.06 are material conditions of this Agreement.

F. The provisions of this Section 13.06 do not apply where the services under this Agreement are supported by a federal or State grant of funds and the source of funds prohibits the use of federal or State funds for the purposes of this Section.

Section 13.08 Political Activity

The Contractor's provision of services under this Agreement shall not include any partisan political activity or any activity to further the election or defeat of any candidate for public, political, or party office, nor shall any of the funds provided under this Agreement be used for such purposes.

Section 13.09 Religious Activity

There shall be no religious worship, instruction, or proselytizing as part of or in connection with the Contractor's provision of services under this Agreement, nor shall any of the funds provided under this Agreement be used for such purposes.

Section 13.10 Participation in an International Boycott

A. The Contractor agrees that neither the Contractor nor any substantially-owned affiliated company is participating or shall participate in an international boycott in violation of the provisions of the federal Export Administration Act of 1979, as amended, 50 U.S.C. Appendix. §§ 2401 *et seq*., or the regulations of the United States Department of Commerce promulgated thereunder.

B. Upon the final determination by the Commerce Department or any other agency of the United States as to, or conviction of, the Contractor or a substantially-owned affiliated company thereof, of participation in an international boycott in violation of the provisions of the Export Administration Act of 1979, as amended, or the regulations promulgated thereunder, the Comptroller may, at his or her option, render forfeit and void this Agreement.

C. The Contractor shall comply in all respects, with the provisions of Admin. Code § 6-114 and the rules issued by the Comptroller thereunder.

Section 13.11 MacBride Principles

A. In accordance with and to the extent required by Admin. Code § 6-115.1, the Contractor stipulates that the Contractor and any individual or legal entity in which the Contractor

holds a ten percent (10%) or greater ownership interest and any individual or legal entity that holds a ten percent (10%) or greater ownership interest in the Contractor either (a) have no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations they have in Northern Ireland in accordance with the MacBride Principles, and shall permit independent monitoring of their compliance with such principles.

B. The Contractor agrees that the covenants and representations in Paragraph A above are material conditions to this Agreement.

C. This Section does not apply if the Contractor is a not-for-profit corporation.

Section 13.12 Access to Public Health Insurance Coverage Information

A. Participating Agencies. Pursuant to Charter § 1069, if this Agreement is with a participating City agency and the Contractor is one to whom this Section 13.11 applies as provided in Paragraph B of this Section 13.11, the Contractor hereby agrees to fulfill the obligations in Paragraph C of this Section 13.11. The participating City agencies are: the Administration for Children's Services; the City Clerk; the Commission on Human Rights; the Department for the Aging; the Department of Corrections; the Department of Homeless Services; the Department of Housing Preservation and Development; the Department of Juvenile Justice; the Department of Health and Mental Hygiene; the Department of Probation; the Department of Social Services/Human Resources Administration; the Taxi and Limousine Commission; the Department of Youth and Community Development; the Office to Combat Domestic Violence; and the Office of Immigrant Affairs.

B. Applicability to Certain Contractors. This Section 13.11 shall be applicable to a Contractor operating pursuant to an Agreement which (i) is in excess of $250,000.00 and (ii) requires such Contractor to supply individuals with a written application for, or written renewal or recertification of services, or request for change of address form in the daily administration of its contractual obligation to such participating City agency. "Contractors" to whom this Section 13.11 applies shall be deemed to include subcontractors if the subcontract requires the subcontractor to supply individuals with a written application for, or written renewal or recertification of services, or request for change of address form in the daily administration of the subcontractor's contractual obligation.

C. Distribution of Public Health Insurance Pamphlet. In accordance with Charter § 1069, when the participating City agency supplies the Contractor with the public health insurance program options pamphlet published by the Department of Health and Mental Hygiene pursuant to Section 17-183 of the Admin. Code (hereinafter "pamphlet"), the Contractor hereby agrees as follows:

1. The Contractor will distribute the pamphlet to all persons requesting a written application for services, renewal or recertification of services or request for a change of address relating to the provision of services.

2. The Contractor will include a pamphlet with any Contractor communication sent through the United States mail for the purpose of supplying an individual with a written application for services, renewal or recertification of services or with a request for a change of address form relating to the provision of services.

3. The Contractor will provide an opportunity for an individual requesting a written application for services, renewal or recertification for services or change of address form relating to the provision of services via the Internet to request a pamphlet, and will provide such pamphlet by United States mail or an Internet address where such pamphlet may be viewed or downloaded, to any person who indicates via the Internet that they wish to be sent a pamphlet.

4. The Contractor will ensure that its employees do not make any statement to an applicant for services or client or take any action the purpose or effect of which is to lead the applicant or client to believe that a decision to request public health insurance or a pamphlet has any bearing on their eligibility to receive or the availability of services or benefits.

5. The Contractor will comply with: (i) any procedures established by the participating City agency to implement Charter § 1069; (ii) any determination of the commissioner or head of the participating City agency (which is concurred in by the commissioner of the Department of Health and Mental Hygiene) to exclude a program, in whole or in part, from the requirements of Charter § 1069; and (iii) any determination of the commissioner or head of the participating City agency (which is concurred in by the commissioner of the Department of Health and Mental Hygiene) as to which Workforce Investment Act of 1998 offices providing workforce development services shall be required to fulfill the obligations under Charter § 1069.

D. Non-applicability to Certain Services. The provisions of this Section 13.11 shall not apply to services that must be provided to prevent actual or potential danger to the life, health or safety of any individual or to the public.

Section 13.13 Distribution of Personal Identification Materials

A. Participating Agencies. Pursuant to City Executive Order No. 150 of 2011 ("E.O. 150"), if this Agreement is with a participating City agency and the Contractor has regular contact with the public in the daily administration of its business, the Contractor must comply with the requirements of this Section 13.12. The participating City agencies are: Administration for Children's Services, Department of Consumer Affairs, Department of Correction, Department of Health and Mental Hygiene, Department of Homeless Services, Department of Housing Preservation and Development, Human Resources Administration, Department of Parks and Recreation, Department of Probation, and Department of Youth and Community Development.

B. Policy. As expressed in E.O. 150, it is the policy of the City to provide information to individuals about how they can obtain the various forms of City, State, and Federal government-

issued identification and, where appropriate, to assist them with the process for applying for such identification.

C. Distribution of Materials. If the Contractor has regular contact with the public in the daily administration of its business, the Contractor hereby agrees to provide and distribute materials and information related to whether and how to obtain various forms of City, State, and Federal government-issued identification as the Agency directs in accordance with the Agency's plans developed pursuant to E.O. 150.

ARTICLE 14 - MISCELLANEOUS PROVISIONS

Section 14.01 Conditions Precedent

A. This Agreement shall be neither binding nor effective unless and until it is registered pursuant to Charter § 328.

B. The requirements of this Section 14.01 shall be in addition to, and not in lieu of, any approval or authorization otherwise required for this Agreement to be effective and for the expenditure of City funds.

Section 14.02 Merger

This written Agreement contains all the terms and conditions agreed upon by the parties, and no other agreement, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind either of the parties, or to modify any of the terms contained in this Agreement, other than a written change, amendment or modification duly executed by both parties pursuant to Article 9 of this Appendix A.

Section 14.03 Headings

Headings are inserted only as a matter of convenience and therefore are not a part of and do not affect the substance of this Agreement.

Section 14.04 Notice

A. The Contractor and the Department hereby designate the business addresses and email addresses specified in Schedule A (and if not specified in Schedule A, as specified at the beginning of this Agreement) as the places where all notices, directions, or communications from one such party to the other party shall be delivered, or to which they shall be mailed. Either party may change its notice address at any time by an instrument in writing executed and acknowledged by the party making such change and delivered to the other party in the manner as specified below.

B. Any notice, direction, or communication from either party to the other shall be in writing and shall be deemed to have been given when (i) delivered personally; (ii) sent by certified

mail, return receipt requested; (iii) delivered by overnight or same day courier service in a properly addressed envelope with confirmation; or (iv) sent by email and, unless receipt of the e-mail is acknowledged by the recipient by email, deposited in a post office box regularly maintained by the United States Postal Service in a properly addressed, postage pre-paid envelope.

C. Nothing in this Section 14.04 shall be deemed to serve as a waiver of any requirements for the service of notice or process in the institution of an action or proceeding as provided by Law, including the New York Civil Practice Law and Rules.

AFFIRMATION

The undersigned proposer or bidder affirms and declares that said proposer or bidder is not in arrears to the City of New York upon debt, contract or taxes and is not a defaulter, as surety or otherwise, upon obligation to the City of New York, and has not been declared not responsible, or disqualified, by any agency of the City of New York, nor is there any proceeding pending relating to the responsibility or qualification of the proposer or bidder to receive public contract except _____.

Full name of Proposer or Bidder *[below]*

_____

Address_____

City_____ State_____ Zip Code_____

CHECK ONE BOX AND INCLUDE APPROPRIATE NUMBER:

☐ A - ☐ Individual or Sole Proprietorships
SOCIAL SECURITY NUMBER _____

☐ B - ☐ Partnership, Joint Venture or other unincorporated organization
EMPLOYER IDENTIFICATION NUMBER _____

☐ C - ☐ Corporation
EMPLOYER IDENTIFICATION NUMBER _____

By_____
Signature

_____
Title

If a corporation place seal here

Must be signed by an officer or duly authorized representative.

* Under the Federal Privacy Act, the furnishing of Social Security numbers by bidders or proposers on City contracts is voluntary. Failure to provide a Social Security number will not result in a bidder's/proposer's disqualification. Social Security numbers will be used to identify bidders, proposers, or vendors to ensure their compliance with laws, to assist the City in enforcement of laws, as well as to provide the City a means of identifying businesses seeking City contracts.

CITY OF NEW YORK
CERTIFICATION BY INSURANCE BROKER OR AGENT

The undersigned insurance broker or agent represents to the City of New York that the attached Certificate of Insurance is accurate in all material respects.

_____
[Name of broker or agent (typewritten)]

_____
[Address of broker or agent (typewritten)]

_____
[Email address of broker or agent (typewritten)]

_____
[Phone number/Fax number of broker or agent (typewritten)]

_____
[Signature of authorized official, broker, or agent]

_____
[Name and title of authorized official, broker, or agent (typewritten)]

State of …….)
) ss.:
County of …….)

Sworn to before me this _____ day of _____ 20___

_____
NOTARY PUBLIC FOR THE STATE OF _____

CERTIFICATES OF INSURANCE

Instructions to New York City Agencies, Departments, and Offices

All certificates of insurance (except certificates of insurance solely evidencing Workers' Compensation Insurance, Employer's Liability Insurance, and/or Disability Benefits Insurance) must be accompanied by one of the following:

(1) the Certification by Insurance Broker or Agent on the following page setting forth the required information and signatures;

-- OR --

(2) copies of all policies as certified by an authorized representative of the issuing insurance carrier that are referenced in such certificate of insurance. If any policy is not available at the time of submission, certified binders may be submitted until such time as the policy is available, at which time a certified copy of the policy shall be submitted.

SCHEDULE A

EmblemHealth Plan, Inc
(with endorsements written for the duties and obligations provided through the JV Agreement)

Article 7 -- Insurance	
Types of Insurance (per Article 7 in its entirety, including listed paragraph)	**Minimum Limits and Special Conditions**
■ Workers' Compensation §7.02 ■ Disability Benefits Insurance §7.02 ■ Employers' Liability §7.02	Statutory amounts under applicable laws, rules, and regulations Waiver of Subrogation by blanket or endorsement coverage
■ Commercial General Liability §7.03(A)	$10,000,000 (ten-million dollars) Per Occurrence, with $10,000,000 (ten-million dollars) Aggregate limits of liability Waiver of Subrogation by blanket or specific endorsement coverage Additional Insureds: 1. City of New York, including its officials and employees
■ Commercial Auto Liability §7.03(B)	$1,000,000.00 per accident combined single limit If vehicles are used for transporting hazardous materials, the Contractor shall provide pollution liability broadened coverage for covered vehicles (endorsement CA 99 48) as well as proof of MCS 90
■ Professional Liability/Errors & Omissions §7.03(C)	$10,000,000 (ten-million dollars) Each Occurrence limit of liability, and $20,000,000 (twenty-million dollars) Aggregate limit of liability (Coverage for aggregate limit in excess of $10,000,000 may be satisfied through a policy of primary insurance or a combination of primary/excess (umbrella) insurance)
■ Crime Insurance §7.03(D)	$10,000,000 (ten-million dollars) Per Occurrence, with $10,000,000 (ten-million dollars) Aggregate limits of liability, including coverage for Employee Theft/Dishonesty and Computer Fraud

	City of New York is a loss payee as its interests may appear
■ Cyber Liability Insurance §7.03(E)	$20,000,000 (twenty-million dollars) per occurrence with $20,000,000 (twenty-million dollars) aggregate limits of liability
Section 10.07 Liquidated Damages	
Violation of Section 3.02(H), reporting subcontractors in the City's Payee Information Portal	$100/day
Section 14.04 – Notice	
Department's Mailing Address and Email Address for Notices	NYC Office of Labor Relations Employee Benefits Program 22 Cortlandt Street, 12th Floor New York, NY 10007 Attn: Dean Weltman, Agency Chief Contracting Officer Email: Dweltman@olr.nyc.gov
Contractor's Mailing Address and Email Address for Notices	EmblemHealth, Inc. 55 Water Street, 13th Floor New York, New York 10041 Attn: George Babitsch, SVP Email: George Babitsch, SVP GBabitsch@emblemhealth.com With a copy to: Jeffrey Chansler, Chief Legal Officer jchansler@emblemhealth.com

SCHEDULE A

UMR, Inc.
(with endorsements written for the duties and obligations provided through the JV Agreement)

Article 7 -- Insurance	
Types of Insurance (per Article 7 in its entirety, including listed paragraph)	**Minimum Limits and Special Conditions**
■ Workers' Compensation §7.02 ■ Disability Benefits Insurance §7.02 ■ Employers' Liability §7.02	Statutory amounts under applicable laws, rules, and regulations Waiver of Subrogation by blanket or endorsement coverage
■ Commercial General Liability §7.03(A)	$10,000,000 (ten-million dollars) Per Occurrence, with $10,000,000 (ten-million dollars) Aggregate limits of liability Waiver of Subrogation by blanket or specific endorsement coverage Additional Insureds: 1. City of New York, including its officials and employees
■ Commercial Auto Liability §7.03(B)	$1,000,000.00 per accident combined single limit If vehicles are used for transporting hazardous materials, the Contractor shall provide pollution liability broadened coverage for covered vehicles (endorsement CA 99 48) as well as proof of MCS 90
■ Professional Liability/Errors & Omissions §7.03(C)	$10,000,000 (ten-million dollars) Each Claim limit of liability, and $20,000,000 (twenty-million dollars) Aggregate limit of liability (Coverage for aggregate limit in excess of $10,000,000 may be satisfied through a policy of primary insurance or a combination of primary/excess (umbrella) insurance)
■ Crime Insurance §7.03(D)	$10,000,000 (ten-million dollars) Per Occurrence, with $10,000,000 (ten-million dollars) Aggregate limits of liability, including coverage for Employee Theft/Dishonesty and Computer Fraud

	City of New York is a loss payee as its interests may appear
■ Cyber Liability Insurance §7.03(E)	$20,000,000 (twenty-million dollars) per Claim with $20,000,000 (twenty-million dollars) aggregate limits of liability
Section 10.07 Liquidated Damages	
• Violation of Section 3.02(H), reporting subcontractors in the City's Payee Information Portal	$100/day
Section 14.04 – Notice	
Department's Mailing Address and Email Address for Notices	NYC Office of Labor Relations Employee Benefits Program 22 Cortlandt Street, 12th Floor New York, NY 10007 Attn: Dean Weltman, Agency Chief Contracting Officer Email: Dweltman@olr.nyc.gov
Contractor's Mailing Address and Email Address for Notices	UMR, Inc./United Healthcare Cityplace I 185 Asylum Avenue Hartford, CT 06103 Attn: Phil Barbaro, CT039-RW30 Email: philip_m_barbaro@uhc.com With a copy to: John Aissis, Deputy General Counsel Email: john_s_aissis@uhc.com

WHISTLEBLOWER PROTECTION EXPANSION ACT POSTER

REPORT

CORRUPTION, FRAUD, UNETHICAL CONDUCT

RELATING TO A NYC-FUNDED CONTRACT
OR PROJECT
CALL THE NYC DEPARTMENT OF INVESTIGATION

212-825-5959

DOI CAN ALSO BE REACHED BY MAIL OR IN PERSON AT: **New York City Department of Investigation (DOI)** **80 Maiden Lane, 17th floor** **New York, New York 10038** **Attention: COMPLAINT BUREAU** **OR FILE A COMPLAINT ON-LINE AT:** **www.nyc.gov/doi** **All communications are confidential**	**Or scan the QR Code above to make a complaint**

THE LAW PROTECTS EMPLOYEES OF
CITY CONTRACTORS WHO REPORT CORRUPTION

- Any employee of a City contractor, or subcontractor of the City, or a City contractor with a contract valued at more than $100,000 is protected under the law from retaliation by his or her employer if the employee reports wrongdoing related to the contract to the DOI.
- **To be protected by this law,** an employee must report to DOI − or to certain other specified government officials − information about fraud, false claims, corruption, criminality, conflict of interest, gross mismanagement, or abuse of authority relating to a City contract valued at more than $100,000.
- Any employee who makes such a report and who believes he or she has been dismissed, demoted, suspended, or otherwise subject to an adverse personnel action because of that report is entitled to bring a lawsuit against the contractor and recover damages

CITY OF NEW YORK

ADDENDUM
TO
APPENDIX A JANUARY 2018 FINAL

This Addendum modifies Appendix A January 2018 Final, General Provisions Governing Contracts for Consultants, Professional, Technical, Human, and Client Services ("Appendix A"), as set forth below.

Subsection B of Section 5.08 (Confidentiality) of Appendix A is deleted in its entirety and replaced with the following:

Section 5.08 Confidentiality

* * *

B. Where in connection with the services under this Agreement the Contractor, or its employees, subcontractors, or agents, will have access to, acquire, disclose, or use any data that includes private information (as defined in Admin. Code § 10-501(b)), the Contractor shall provide written notice to the Department within three days of the earlier of discovery by the Contractor or notification to Contractor of any breach of security (as defined in Admin. Code § 10-501(c)). Such notice shall inform the Department of the nature and scope of the breach of security.

1. Upon such discovery or notification of such breach of security, the Contractor shall take reasonable steps to determine the cause(s) of such breach and to remediate the cause(s) of such breach, shall provide written notice to the Department of such steps, and shall cooperate with any investigation conducted by the City of such breach. Such cooperation includes, but is not limited to, promptly responding to the City's reasonable inquiries and providing prompt access to in human and machine readable format all evidentiary artifacts associated with such breach of security, such as relevant records, logs, files, data reporting, and other materials.

2. In the event of such breach of security, the Contractor shall cooperate and coordinate with the City regarding any notifications determined by the City to be made to individuals affected by such breach.

3. Without limiting any other right of the City, the City shall have the right to withhold further payments under this Agreement for the purpose of set-off in sufficient sums to cover the costs of such notifications to individuals affected by the breach of security and/or other actions mandated by any Law, or administrative or judicial order, to address such breach of security, and to cover the costs of any fines or disallowances imposed by the State or federal government as a result of such breach. The City shall

also have the right to withhold further payments hereunder for the purpose of set-off in sufficient sums to cover the costs of identity theft monitoring services for individuals affected by such breach of security by a national credit reporting agency, and/or any other commercially reasonable preventive measure. The Department shall provide the Contractor with written notice and an opportunity to comment on such preventive measures prior to implementation. Alternatively, at the City's discretion, or if monies remaining to be earned or paid under this Agreement are insufficient to cover the costs detailed above, the Contractor shall pay directly for the costs, detailed above, if any.

NYC EARNED SAFE AND SICK TIME ACT CONTRACT RIDER

(To supersede Section 4.06 of the January 2018 Appendix A and Section 35.5 of the March 2017 Standard Construction Contract and to be attached to other City contracts and solicitations)

A. *Introduction and General Provisions.*

1. The Earned Safe and Sick Time Act ("ESSTA"), codified at Title 20, Chapter 8 of the New York City Administrative Code, also known as the "Paid Safe and Sick Leave Law," requires covered employees (as defined in Admin. Code § 20-912) in New York City ("City") to be provided with paid safe and sick time. Contractors of the City or of other governmental entities may be required to provide safe and sick time pursuant to the ESSTA. The ESSTA is enforced by the City's Department of Consumer and Worker Protection ("DCWP"), which has promulgated 6 RCNY §§ 7-101 and 201 *et seq*. ("DCWP Rules").

2. The Contractor agrees to comply in all respects with the ESSTA and the DCWP Rules, and as amended, if applicable, in the performance of this agreement. The Contractor further acknowledges that such compliance is a material term of this agreement and that failure to comply with the ESSTA in performance of this agreement may result in its termination.

3. The Contractor must notify (with a copy to DCWP at ComplianceMonitoring@dcwp.nyc.gov) the Agency Chief Contracting Officer of the City Agency or other entity with whom it is contracting in writing within 10 days of receipt of a complaint (whether oral or written) or notice of investigation regarding the ESSTA involving the performance of this agreement. Additionally, the Contractor must cooperate with DCWP's guidance and must comply with DCWP's subpoenas, requests for information, and other document demands as set forth in the ESSTA and the DCWP Rules. More information is available at https://www1.nyc.gov/site/dca/about/paid-sick-leave-what-employers-need-to-know.page.

4. Upon conclusion of a DCWP investigation, Contractor will receive a findings letter detailing any employee relief and civil penalties owed. Pursuant to the findings, Contractor will have the opportunity to settle any violations and cure the breach of this agreement caused by failure to comply with the ESSTA either i) without a trial by entering into a consent order or ii) appearing before an impartial judge at the City's administrative tribunal. In addition to and notwithstanding any other rights and remedies available to the City, non-payment of relief and penalties owed pursuant to a consent order or final adjudication within 30 days of such consent order or final adjudication may result in the termination of this agreement without further opportunity to settle or cure the violations.

5. The ESSTA is briefly summarized below for the convenience of the Contractor. The Contractor is advised to review the ESSTA and the DCWP Rules in their entirety. The Contractor may go to www.nyc.gov/PaidSickLeave for resources for employers, such as Frequently Asked Questions, timekeeping tools and model forms, and an event calendar of upcoming presentations and webinars at which the Contractor can get more information about how to comply with the ESSTA and the DCWP Rules. The Contractor acknowledges that it is responsible for compliance with the ESSTA and the DCWP Rules notwithstanding any inconsistent language contained herein.

B. *Pursuant to the ESSTA and DCWP Rules: Applicability, Accrual, and Use.*

1. An employee who works within the City must be provided paid safe and sick time.[1] Employers with one hundred or more employees are required to provide 56 hours of safe and sick time for an employee each calendar year. Employers with fewer than one hundred employees are required to provide 40 hours of sick leave each calendar year. Employers must provide a minimum of one hour of safe and sick time for every 30 hours worked by an employee and compensation for such safe and sick time must be provided at the greater of the employee's regular hourly rate or the minimum wage at the time the paid safe or sick time is taken. Employers are not discouraged or prohibited from providing more generous safe and sick time policies than what the ESSTA requires.

2. Employees have the right to determine how much safe and sick time they will use, provided that an employer may set a reasonable minimum increment for the use of safe and sick time not to exceed four hours per day. For the use of safe time or sick time beyond the set minimum increment, an employer may set fixed periods of up to thirty minutes beyond the minimum increment. In addition, an employee may carry over up to 40 or 56 hours of unused safe and sick time to the following calendar year, provided that no employer is required to carry over unused paid safe and sick time if the employee is paid for such unused safe and sick time and the employer provides the employee with at least the legally required amount of paid safe and sick time for such employee for the immediately subsequent calendar year on the first day of such calendar year.

3. An employee entitled to safe and sick time pursuant to the ESSTA may use safe and sick time for any of the following:

a. such employee's mental illness, physical illness, injury, or health condition or the care of such illness, injury, or condition or such employee's need for medical diagnosis or preventive medical care;

b. such employee's care of a family member (an employee's child, spouse, domestic partner, parent, sibling, grandchild, or grandparent, the child or parent of an employee's spouse or domestic partner, any other individual related by blood to the employee, and any other individual whose close association with the employee is the equivalent of a family relationship) who has a mental illness, physical illness, injury or health condition or who has a need for medical diagnosis or preventive medical care;

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[1] Pursuant to the ESSTA, if fewer than five employees work for the same employer, and the employer had a net income of less than one million dollars during the previous tax year, such employer has the option of providing such employees uncompensated safe and sick time.

c. closure of such employee's place of business by order of a public official due to a public health emergency;

d. such employee's need to care for a child whose school or childcare provider has been closed due to a public health emergency; or

e. when the employee or a family member has been the victim of a family offense matter, sexual offense, stalking, or human trafficking:

1. to obtain services from a domestic violence shelter, rape crisis center, or other shelter or services program for relief from a family offense matter, sexual offense, stalking, or human trafficking;
2. to participate in safety planning, temporarily or permanently relocate, or take other actions to increase the safety of the employee or employee's family members from future family offense matters, sexual offenses, stalking, or human trafficking;
3. to meet with a civil attorney or other social service provider to obtain information and advice on, and prepare for or participate in any criminal or civil proceeding, including but not limited to, matters related to a family offense matter, sexual offense, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit;
4. to file a complaint or domestic incident report with law enforcement;
5. to meet with a district attorney's office;
6. to enroll children in a new school; or
7. to take other actions necessary to maintain, improve, or restore the physical, psychological, or economic, health or safety of the employee or the employee's family member or to protect those who associate or work with the employee.

4. An employer must not require an employee, as a condition of taking safe and sick time, to search for a replacement. However, where the employee's need for safe and sick time is foreseeable, an employer may require an employee to provide reasonable notice of the need to use safe and sick time. For an absence of more than three consecutive work days, an employer may require reasonable documentation that the use of safe and sick time was needed for a reason listed in Admin. Code § 20-914; and/or written confirmation that an employee used safe and sick time pursuant to the ESSTA. However, an employer may not require documentation specifying the nature of a medical condition, require disclosure of the details of a medical condition, or require disclosure of the details of a family offense matter, sexual offense, stalking, or human trafficking, as a condition of providing safe and sick time. Health information and information concerning family offenses, sexual offenses, stalking or human trafficking obtained solely due to an

employee's use of safe and sick time pursuant to the ESSTA must be treated by the employer as confidential. An employer must reimburse an employee for all reasonable costs or expenses incurred in obtaining such documentation for the employer.

5. An employer must provide to all employees a written policy explaining its method of calculating sick time, policies regarding the use of safe and sick time (including any permissible discretionary conditions on use), and policies regarding carry-over of unused time at the end of the year, among other topics. It must provide the policy to employees using a delivery method that reasonably ensures that employees receive the policy. If such employer has not provided its written policy, it may not deny safe and sick time to an employee because of non-compliance with such a policy.

6. An employer must provide a pay statement or other form of written documentation that informs the employee of the amount of safe/sick time accrued and used during the relevant pay period and the total balance of the employee's accrued safe/sick time available for use.

7. Safe and sick time to which an employee is entitled must be paid no later than the payday for the next regular payroll period beginning after the safe and sick time was used.

C. *Exemptions and Exceptions*. Notwithstanding the above, the ESSTA does not apply to any of the following:

1. an independent contractor who does not meet the definition of employee under N.Y. Labor Law § 190(2);

2. an employee covered by a valid collective bargaining agreement, if the provisions of the ESSTA are expressly waived in such agreement and such agreement provides a benefit comparable to that provided by the ESSTA for such employee;

3. an audiologist, occupational therapist, physical therapist, or speech language pathologist who is licensed by the New York State Department of Education and who calls in for work assignments at will, determines their own schedule, has the ability to reject or accept any assignment referred to them, and is paid an average hourly wage that is at least four times the federal minimum wage;

4. an employee in a work study program under Section 2753 of Chapter 42 of the United States Code;

5. an employee whose work is compensated by a qualified scholarship program as that term is defined in the Internal Revenue Code, Section 117 of Chapter 20 of the United States Code; or

6. a participant in a Work Experience Program (WEP) under N.Y. Social Services Law § 336-c.

D. *Retaliation Prohibited.* An employer shall not take any adverse action against an employee that penalizes the employee for, or is reasonably likely to deter the employee from or interfere with the employee exercising or attempting in good faith to exercise any right provided by the ESSTA. In addition, an employer shall not interfere with any investigation, proceeding, or hearing pursuant to the ESSTA.

E. *Notice of Rights.*

1. An employer must provide its employees with written notice of their rights pursuant to the ESSTA. Such notice must be in English and the primary language spoken by an employee, provided that DCWP has made available a translation into such language. Downloadable notices are available on DCWP's website at https://www1.nyc.gov/site/dca/about/Paid-Safe-Sick-Leave-Notice-of-Employee-Rights.page. The notice must be provided to the employees by a method that reasonably ensures personal receipt by the employee.

2. Any person or entity that willfully violates these notice requirements is subject to a civil penalty in an amount not to exceed $50.00 for each employee who was not given appropriate notice.

F. *Records*. An employer must retain records documenting its compliance with the ESSTA for a period of at least three years, and must allow DCWP to access such records in furtherance of an investigation related to an alleged violation of the ESSTA.

G. *Enforcement and Penalties.*

1. Upon receiving a complaint alleging a violation of the ESSTA, DCWP must investigate such complaint. DCWP may also open an investigation to determine compliance with the ESSTA on its own initiative. Upon notification of a complaint or an investigation by DCWP, the employer must provide DCWP with a written response and any such other information as DCWP may request. If DCWP believes that a violation of the ESSTA has occurred, it has the right to issue a notice of violation to the employer .

2. DCWP has the power to grant an employee or former employee all appropriate relief as set forth in Admin. Code § 20-924(d). Such relief may include, but is not limited to, treble damages for the wages that should have been paid; statutory damages for unlawful retaliation; and damages, including statutory damages, full compensation for wages and benefits lost, and reinstatement, for unlawful discharge. In addition, DCWP may impose on an employer found to have violated the ESSTA civil penalties not to exceed $500.00 for a first violation, $750.00 for a second violation within two years of the first violation, and $1,000.00 for each succeeding violation within two years of the previous violation. When an employer has a policy or practice of not providing or refusing to allow the use of safe and sick time to its employees, DCWP may seek penalties and relief on a per employee basis.

3. Pursuant to Admin. Code § 20-924.2, (a) where reasonable cause exists to believe that an employer is engaged in a pattern or practice of violations of the ESSTA, the Corporation Counsel may commence a civil action on behalf of the City in a court of competent jurisdiction by filing a complaint setting forth facts relating to such pattern or practice and requesting relief, which may include injunctive relief, civil penalties and any other appropriate relief. Nothing in § 20-924.2 prohibits DCWP from exercising its authority under section 20-924 or the Charter, provided that a civil action pursuant to § 20-924.2 shall not have previously been commenced.

H. *More Generous Polices and Other Legal Requirements.* Nothing in the ESSTA is intended to discourage, prohibit, diminish, or impair the adoption or retention of a more generous safe and sick time policy, or the obligation of an employer to comply with any contract, collective bargaining agreement, employment benefit plan or other agreement providing more generous safe and sick time. The ESSTA provides minimum requirements pertaining to safe and sick time and does not preempt, limit, or otherwise affect the applicability of any other law, regulation, rule, requirement, policy or standard that provides for greater accrual or use by employees of safe and sick leave or time, whether paid or unpaid, or that extends other protections to employees. The ESSTA may not be construed as creating or imposing any requirement in conflict with any federal or state law, rule or regulation.

APPENDIX B

Identifying Information Rider

1. Purpose.

Contractor agrees to comply with this Identifying Information Rider ("Rider") and the Identifying Information Law, as applicable, in the performance of this Agreement.

2. Definitions.

A. "Access" to Identifying Information means gaining the ability to read, use, copy, modify, process, or delete any information whether or not by automated means.

B. "Agency" means a City agency or office through which the City has entered into this Agreement.

C. "Authorized Users" means employees, officials, subcontractors, or agents of Contractor whose collection, use, disclosure of, or access to Identifying Information is necessary to carry out the Permitted Purpose.

D. "Chief Privacy Officer" means the City's Chief Privacy Officer.

E. "Collection" means an action to receive, retrieve, extract, or access identifying information. Collection does not include receiving information that Contractor did not ask for.

F. "Contractor" means an entity entering into this Agreement with the City.

G. "Disclosure" means releasing, transferring, disseminating, giving access to, or otherwise providing identifying information in any manner outside Contractor. Disclosure includes accidentally releasing information and access to identifying information obtained through a potential unauthorized access to Contractor's systems or records.

H. "Exigent circumstances" means cases where following this Rider would cause undue delays.

I. "Identifying Information" means any information provided by the City to Contractor or obtained by Contractor in connection with this Agreement that may be used on its own or with other information to identify or locate an individual.

J. "Identifying Information Law" means §§ 23-1201 – 1205 of the Administrative Code of the City of New York.

K. "Permitted Purpose" means a use of Identifying Information that is necessary to carry out Contractor's obligations under this Agreement.

L. "Use" of Identifying Information means any operation performed on identifying information, whether or not via automated means, such as collection, storage, transmission, consultation, retrieval, disclosure, or destruction.

3. General Requirements.

A. Contractor will use appropriate physical, technological, and procedural safeguards to protect Identifying Information.

B. Contractor will restrict collection, use, disclosure of, or access to Identifying Information to Authorized Users for a Permitted Purpose.

C. Contractor will comply with the Citywide Cybersecurity Requirements for Vendors and Contractors set forth by the New York City Office of Technology and Innovation and its Office of Cyber Command as they appear at https://nyc.gov/infosec. Contractor will ensure that Authorized Users understand and comply with the provisions of this Agreement applicable to Identifying Information.

D. Contractor and Authorized Users will not use Identifying Information for personal benefit or the benefit of another, nor publish, sell, license, distribute, or otherwise reveal Identifying Information outside the terms of this Agreement.

4. Collection.

A. Absent Exigent Circumstances (Section 7), Contractor may collect Identifying Information if the collection:

i. has been approved by the Agency Privacy Officer;

ii. is required by law or treaty;

iii. is required by the New York City Police Department in connection with a criminal investigation; or

iv. is required by a City agency in connection with an open investigation concerning the welfare of a minor or an individual who is not legally competent.

5. Disclosure.

A. Absent Exigent Circumstances (Section 7), Contractor may disclose Identifying Information if the disclosure:

i. has been approved by the Agency Privacy Officer;

ii. is required by law or treaty;

iii. is required by the New York City Police Department in connection with a criminal investigation; or

iv. is required by a City agency in connection with an open investigation concerning the welfare of a minor or an individual who is not legally competent; or

v. has been authorized in writing by the individual to whom such information pertains or, if the individual is a minor or is otherwise not legally competent, by the individual's parent, legal guardian, or other person with legal authority to consent on behalf of the individual.

6. Disclosures of Identifying Information to Third Parties.

Unless prohibited by law, Contractor will promptly notify the Agency Privacy Officer of any third-party requests for Identifying Information, cooperate with the Agency Privacy Officer to handle such requests, and comply with the Chief Privacy Officer's policies and protocols concerning requirements for a written agreement governing the disclosure of Identifying Information to a third party.

7. Exigent Circumstances.

A. Notwithstanding Section 4 (Collection) and 5 (Disclosure), if Contractor collects or discloses Identifying Information due to Exigent Circumstances, then as soon as practicable after the collection or disclosure but not to exceed 24 hours, Contractor will send to the Agency Privacy Officer in writing:

i. The name, e-mail address, phone number, and title of a Contractor point of contact with sufficient knowledge and authority who will respond promptly to and collaborate with the Agency Privacy Officer;

ii. A description of the Exigent Circumstances, including a detailed timeline, all involved parties, the types of Identifying Information disclosed or collected, and Contractor's estimate of the likelihood of the Exigent Circumstances reoccurring.

B. If the Agency Privacy Officer determines the collection or disclosure was not made under Exigent Circumstances, the collection or disclosure will be deemed in violation of this Rider and subject to the provisions of Section 8(A)-8(D).

8. Unauthorized Collection, Use, Disclosure of, or Access to Identifying Information.

A. If Contractor collects, discloses, uses, or accesses Identifying Information in violation of this Rider, Contractor will:

i. notify the Agency Privacy Officer in writing as soon as practicable but no later than 24 hours after discovery, including a description of the collection, disclosure, use, or

access, the types of Identifying Information that may have been involved or compromised, the names and affiliations of the parties (if known) who gained access to Identifying Information without authorization, and a description of the steps taken, if any, to mitigate the effects of the collection, disclosure, use, or access incident;

ii. cooperate with the Agency Privacy Officer and relevant City officials, including the City's Chief Privacy Officer, Office of Cyber Command, and the City's Law Department, to investigate the occurrence and scope of the collection, disclosure, use, or access, and make any required or voluntary notices; and,

iii. take all necessary steps, as determined by the Agency Privacy Officer, to prevent or mitigate the effects of the collection, disclosure, use, or access.

B. If there is an alleged collection, use, disclosure, or access violation, the Agency may investigate the alleged violation. Contractor will cooperate with the investigation, which may include prompt:

i. provision to the City of information related to security controls and processes, such as third-party certifications, policies and procedures, self-assessments, independent evaluations and audits, view-only samples of security controls, logs, files, incident reports or evaluations;

ii. verbal interviews of individuals with knowledge of Contractor's security controls and processes or the unauthorized collection, use, disclosure, or access;

iii. an evaluation or audit by the City of Contractor's security controls and processes, and the unauthorized collection, use, disclosure, or access;

iv. an evaluation or audit by Contractor of its security controls and processes and the unauthorized collection, use, disclosure, or access, and provision of any attendant results to the City; or,

v. an independent evaluation or audit to be provided to the City of Contractor's security controls and processes, and the unauthorized collection, use, disclosure, or access.

C. If the Agency Privacy Officer or Chief Privacy Officer determines that notification to affected individuals is required pursuant to the policies and protocols promulgated by the Chief Privacy Officer under subdivision 6 of Section 23-1203, then the Agency Privacy Officer will inform Contractor whether the Agency or the Contractor will issue the notification. If the Agency Privacy Officer directs Contractor to issue the notification, the notification will be issued in writing as soon as practicable and will conform to the Agency Privacy Officer's instructions as to form, content, scope, and recipients.

D. Monies and Set-Off.

i. Contractor will pay for services deemed necessary by the Agency Privacy Officer to address Contractor's collection, disclosure, use, or access of Identifying Information in violation of this Rider, subject to limitations of liability contained elsewhere in this Agreement. These services may include: (a) credit monitoring services; (b) notifications; (c) payment of any fines or disallowances imposed by the State or federal government related to a collection, use, disclosure, or access in violation of this Rider; (d) other actions mandated by any law, administrative or judicial order, Agency Privacy Officer, or the Chief Privacy Officer.

ii. At the Agency Privacy Officer's discretion, the Agency may pay for services deemed necessary to address Contractor's collection, disclosure, use, or access of Identifying Information in violation of this Rider. If the Agency pays for any of these services, it may submit invoices to Contractor and Contractor will promptly reimburse the Agency.

iii. If Contractor refuses to pay for services deemed necessary by the Agency Privacy Officer, the City may, for the purpose of set-off in sufficient sums without waiver of any other rights and remedies:

a. withhold further payments under this Agreement to cover the costs of notifications and other actions mandated by any law, administrative or judicial order, Agency Privacy Officer, or the Chief Privacy Officer, including any related fines or disallowances imposed by the State or federal government;

b. withhold further payments to cover the costs of credit monitoring services, and any other commercially reasonable preventive measures;

c. instruct Contractor to pay directly for the services detailed in this subsection 8(c)(iii)(a) and 8(C)(iii)(b) using monies remaining to be earned under this Agreement.

E. Contractor is not required to make any notification that would compromise public safety, violate any law, or interfere with a law enforcement investigation or other investigative activity by the Agency.

9. Retention.

Contractor will retain Identifying Information as required by law or as otherwise necessary in furtherance of this Agreement, or as otherwise approved by the Agency Privacy Officer.

10. Reporting.

Contractor will provide the Agency with reports as requested by the Agency Privacy Officer or Chief Privacy Officer regarding Contractor's collection, retention, disclosure of, and access to Identifying Information. Each report will include information concerning Identifying Information collected, retained, disclosed, and accessed including: (a) the types of Identifying Information collected, retained, disclosed, or accessed; (b) the types of collections and disclosures classified as "routine" and any collections or disclosures approved by the Agency Privacy Officer or Chief Privacy Officer; and (c) any other related information that may be reasonably required by the Agency Privacy Officer or Chief Privacy Officer.

11. Coordination with Agency Privacy Officer.

The Agency may assign powers and duties of the Agency Privacy Officer to Contractor for purposes of this Agreement. Insuch event, Contractor will exercise those powers and duties in accordance with applicable law in relation to this Agreement and will comply with directions of the Agency Privacy Officer and Chief Privacy Officer concerning coordination and reporting.

12. Destruction of Identifying Information.

If the Agency instructs Contractor to destroy Identifying Information, Contractor will destroy it within 30 days after receiving the instruction in a way that it cannot be reconstructed, subject to any litigation holds. Contractor will provide written confirmation to the Agency Privacy Officer that it has destroyed the Identifying Information within 30 days after receiving the instruction. If it is impossible for Contractor to destroy the Identifying Information, Contractor will promptly explain in writing why it is impossible, and will, upon receiving the destruction request, immediately stop accessing or using the Identifying Information, and will maintain such Identifying Information in accordance with this Rider.

13. Subcontracts.

A. Contractor will include this Rider in all subcontracts to provide human services or other services designated inthe policies and protocols of the Chief Privacy Officer.

B. Contractor will be responsible to the Agency for compliance with this Rider by its subcontractors that provide human services or other services designated by the Chief Privacy Officer.

14. Conflicts with Provisions Governing Records and Reports.

To the extent allowed by law, the provisions of this Rider will control if there is a conflict between any of its provisions and, as applicable, either (a) Article 5 of Appendix A (General Provisions Governing Contracts forConsultants, Professional, Technical, Human, and Client Services); (b) if the value of this Agreement is $100,000 or less and is funded by City Council Discretionary Funds, Article7(E) and Rider 1,

Article 1 of this Agreement; or (c) if neither (a) nor (b) apply, the other provisions concerning records retention and reports designated elsewhere in this Agreement. The provisions of this Rider do not replace or supersede any other obligations or requirements of this Agreement.

Appendix C-1: Business Associate Agreement

This Business Associate Agreement (this "Agreement") is entered into by and between EmblemHealth Plan, Inc. ("Emblem") ("Business Associate") and the City of New York acting through the Mayor's Office of Labor Relations pursuant to New York City Administrative Code § 12.126(d) ("Plan Sponsor") on behalf of the Plan, as such term is defined in the Services Agreement, as defined below (such Plan referred to herein as "Covered Entity"), and effective as of [•][1] (the "Effective Date"). Plan Sponsor and Business Associate may both be referred to herein individually as a "Party" or collectively as the "Parties." This Agreement is entered into pursuant to that certain Administrative Services Agreement effective as of even date herewith and entered into by and between UMR, Inc., EmblemHealth Plan, Inc., and Plan Sponsor (the "Services Agreement").

The Parties hereby agree as follows:

I. DEFINITIONS

Any capitalized terms used and not otherwise defined in this Agreement shall have the same meanings established by 45 C.F.R. Parts 160 and 164. The terms "use," "disclose" and "discovery," or derivations thereof, although not capitalized, shall also have the meanings set forth in HIPAA.

"Affiliates" means, with respect to any entity, an entity that, directly or indirectly, controls, is controlled by, or is under common control with such entity. For purposes of this definition, "control" means, with respect to any entity, the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such entity, whether through the ownership of voting securities (or other ownership interest), by contract or otherwise.

"Authorized Users" means employees or other workforce members, subcontractors (including, without limitation, Subcontractors as defined by 45 C.F.R. §160.103), Affiliates, and agents of Business Associate.

"HIPAA" means, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations at 45 C.F.R. Parts 160-64, along with its implementing regulations promulgated by the Department of Health and Human Services, including 45 C.F.R. Part 160 and Subparts A and E of Part 164 (the **"Privacy Rule"**) and 45 C.F.R. Parts 160 and Subparts A and C of Part 164 (the **"Security Rule"**), each as may be amended from time to time.

"Individual" shall have the same meaning as the term "individual" in 45 C.F.R. §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. §164.502(g).

"**Protected Health Information**" or "**PHI**" means "Protected Health Information" as defined in 45 C.F.R. § 160.103.

"Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his or her designee.

II. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

(a) **Permitted Uses.** Except as expressly requested by Covered Entity, Business Associate agrees not to use and/or disclose PHI (including disclosures to Affiliates), except as necessary to provide the Services,

[1] Note to Draft: To be effective as of the Effective Date of the Administrative Services Agreement.

as permitted or required by this Agreement and/or the Services Agreement, and in compliance with each applicable requirement of 45 C.F.R. §164.504(e), or as otherwise Required by Law.

(b) **Appropriate Safeguards.** Business Associate agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement, and with respect to Electronic Protected Health Information to comply with the specifications of the Security Rule, in addition to any specific safeguards required by the Services Agreement. Business Associate shall also comply with the Citywide Cybersecurity Requirements for Vendors and Contractors set forth by the New York City Office of Technology and Innovation and its Office of Cyber Command as they appear at https://nyc.gov/infosec. Business Associate will ensure that Authorized Users understand and comply with the provisions of this Agreement applicable to PHI.

(c) **Breach Notification.**

(1) Business Associate shall report to Plan Sponsor as soon as possible, but no later than three (3) business days after discovery of (A) any use or disclosure of PHI not permitted by this Agreement, the Services Agreement, and/or applicable law, and (B) any Security Incident of which Business Associate becomes aware.

(2) With respect to any actual or suspected Breach, Security Incident, or any collection, disclosure, use, or access of PHI not permitted by this Agreement, Business Associate will notify Plan Sponsor in writing as soon as practicable but no later than three (3) business days after discovery, including a description of the collection, disclosure, use, or access, the types of information that may have been involved or compromised, the names and affiliations of the parties who gained access to PHI without authorization, and a description of the steps taken, if any, to mitigate the effects of the incident. Business Associate shall fully cooperate with any investigation conducted by Covered Entity (or its designees) with respect to any incident. Notwithstanding the foregoing, the Parties acknowledge and agree that this Section II(c) constitutes notice by Business Associate to Covered Entity of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Covered Entity shall be required. "Unsuccessful Security Incidents" means routine, unsuccessful attempts to access, modify or destroy electronic data, or to interfere with an electronic data system, such as "pings" or other broadcast attacks on a firewall, port scans, routine unsuccessful log-on attempts, or denials of service.

(3) In the event Covered Entity determines a Breach has occurred, Covered Entity will inform Business Associate whether Covered Entity (or its designees) or Business Associate will issue the notifications required by 45 C.F.R. §§ 164.404 and 164.406. To the extent Business Associate's or any Authorized User's acts or omissions result in a Breach, Business Associate shall be responsible for reasonable costs involved in fulfilling the risk assessment, risk mitigation and notification requirements set forth in this Section II(c), including, but not limited to, under 45 C.F.R. Part 164, Subpart D, which may include: (A) providing such notifications, including if applicable, but not limited to, written notice, substitute notice, additional notice in urgent situations, and notification to media; and (B) all measures deemed reasonably necessary by Covered Entity or required by law to mitigate the harmful effects of any acquisition, access, use, or disclosure of PHI, including but not limited to, credit monitoring services for individuals affected by such Breach.

(d) **Authorized Users.** In accordance with 45 C.F.R. §§164.502(e)(1)(ii) and 164.308(b)(2), as applicable, Business Associate agrees to ensure that all Authorized Users that create, receive, maintain, transmit, or access Protected Health Information agree in writing to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such Protected Health Information. Business Associate is not in compliance with this Agreement if Business Associate knew of a pattern of activity or

practice of any Authorized User that constituted a material breach or violation of the Authorized User obligations related to the protections contemplated hereunder, unless Business Associate took all reasonable steps to ensure cure of the breach or cessation of the violation, as applicable, and if such steps were unsuccessful, notified Covered Entity of such breach or violation and terminated such Authorized User relationship and/or agreement (unless otherwise requested or permitted by Covered Entity).

(e) **Access by Individual.** Business Associate agrees to provide access to Protected Health Information in a Designated Record Set, to Covered Entity or an Individual or Individual's permitted designee in accordance with the requirements of 45 C.F.R. §164.524.

(f) **Amendment to PHI.** Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of Covered Entity or an Individual, and in the reasonable time and manner designated by the Covered Entity or the requesting Individual, and to take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. §164.526.

(g) **Accounting of PHI.** Business Associate agrees to document such disclosures of Protected Health Information, and information related to such disclosures, as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. §164.528. Business Associate agrees to make available to Covered Entity or an Individual, in the reasonable time and manner designated by the Covered Entity, information collected pursuant to this Section II(g) in order to provide an accounting of disclosures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. §164.528.

(h) **Additional Restrictions on PHI.** If Covered Entity notifies Business Associate that it has agreed to be bound by additional restrictions on the uses or disclosures of certain Protected Health Information not addressed in this Agreement, Business Associate agrees to be bound by such additional restrictions and shall not disclose such PHI in violation of such additional restrictions.

(i) **Carrying Out Covered Entity Obligation(s).** To the extent that Business Associate is to carry out one or more of Covered Entity's obligation(s) under the Privacy Rule, Business Associate shall comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligation(s).

(j) **Access to Books and Records.** Business Associate agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information created, received, maintained, transmitted, or accessed by Business Associate on behalf of Covered Entity, available to the Secretary, in the reasonable time and manner designated by the Covered Entity, or in the time and manner designated by the Secretary, as applicable, for purposes of determining compliance with HIPAA and this Agreement.

III. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

(a) **Use and Disclosure for Performance.** Except as otherwise provided in this Agreement, Business Associate may only use or disclose Protected Health Information as necessary to perform services, functions, activities, and/or duties for, or on behalf of, Covered Entity as specified in the Services Agreement, or as necessary to perform its duties under this Agreement, or as Required by Law.

(b) **Disclosure to Third Parties.** Subject to Section II(a) and Section II(d) of this Agreement, Business Associate may disclose Protected Health Information (1) as directed by Covered Entity, or (2) to Authorized

Users to the extent necessary for such Authorized Users to perform services, functions, activities, and/or duties for, or on behalf of, Covered Entity as specified in the Services Agreement.

(c) **Minimum Necessary Use and Disclosure.** Except with respect to Covered Entity-directed disclosures, when using or disclosing Protected Health Information, including disclosures to Authorized Users, or when requesting PHI from Covered Entity or another covered entity or business associate, Business Associate agrees to limit the PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

(d) Business Associate may not use or disclose Protected Health Information in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Plans, except that Business Associate may do the following:

(1) **Use for Management, Administration and Legal Responsibilities.** Business Associate may use Protected Health Information to the extent necessary for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

(2) **Disclosure for Management, Administration and Legal Responsibilities.** Business Associate may disclose Protected Health Information to the extent necessary for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that (1) the disclosure is Required By Law, or (2) Business Associate obtains written assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and that the person will notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached. Business Associate agrees that if it has a legal obligation to disclose PHI as Required by Law to a law enforcement, regulatory, administrative, or oversight agency, or in response to a subpoena, court order, civil investigative demand, or other compulsory document or lawful process, Business Associate shall respond to such obligation on behalf of Covered Entity.

(3) **Data Aggregation Services.** Business Associate may use or disclose Protected Health Information to provide data aggregation services relating to the health care operations of the Covered Entity as permitted by 45 C.F.R. §164.504(e)(2)(i)(B). Under no circumstances may Business Associate disclose PHI to any other person or entity pursuant to this Section III(d) without the express authorization of Covered Entity.

(g) **De-identified PHI.** Business Associate may de-identify Protected Health Information in accordance with 45 C.F.R. §164.514(a)–(c) and utilize such de-identified PHI solely as necessary for Business Associate to perform Services, functions, activities, and/or duties for, or on behalf of, Covered Entity or Plan Sponsor as specified in the Services Agreement. All other creation, use, and/or disclosure of de-identified PHI is prohibited.

(h) **Use of PHI or De-identified PHI for Research Purposes.** Business Associate agrees that it will obtain the prior written approval of Covered Entity prior to using or disclosing Protected Health Information or de-identified PHI in connection with research purposes.

IV. COMPLIANCE WITH CERTAIN NEW YORK STATE LAWS

(a) **Confidentiality Under New York Law.** In addition to fulfilling its obligations with respect to HIPAA, Business Associate agrees to comply with all applicable New York State laws and any regulations promulgated thereunder governing the confidentiality of information created, received, maintained, transmitted, or accessed by Business Associate or its Authorized Users on behalf of Covered Entity,

including but not limited to the following provisions, as applicable: New York Public Health Law §18 (Access to Patient Information) and Article 27-F (HIV and AIDS Related Information); New York Mental Hygiene Law §§22.05 and 33.13; New York Civil Rights Law §79-*l*; New York General Business Law §399-ddd (Confidentiality of Social Security Account Numbers), §399-h and §899-aa; and chapter 5 of title 10 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

(b) **Breach Notification Under New York Law.** Pursuant to New York General Business Law ("GBL") §899-aa(2) and (3), Business Associate shall, within the timeframes identified in Section II(c) above, notify Covered Entity of any "breach of the security of the system," as defined in GBL §899-aa(1)(c), that involves Protected Health Information containing individuals' "private information," as defined in GBL §899-aa(1)(b), that was, or was reasonably believed to be, acquired from Business Associate or any Authorized User by a person without valid authorization. Business Associate shall bear all costs related to its or its Authorized Users' "breach of the security of the system" under GBL §899-aa. In the event such breach has occurred, Business Associate shall reimburse Plan Sponsor for all reasonable costs incurred by Covered Entity or Plan Sponsor related to providing the notice required by GBL §899-aa(5), which may include, if applicable: written notice; electronic notice; telephone notification; substitute notice; email notice; posting of notice on web site; and notification to major statewide media.

V. OBLIGATIONS OF COVERED ENTITY

(a) **Limitation(s) in Privacy Notice.** Covered Entity shall notify Business Associate of any limitation(s) in the notice of privacy practices utilized by Covered Entity under 45 C.F.R. §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

(b) **Changes in Individual's Permission.** Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information of which Covered Entity becomes aware, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

(c) **Restriction on Use or Disclosure.** Covered Entity shall notify Business Associate of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

(d) **Impermissible Request by Covered Entity.** Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under HIPAA if done by Covered Entity.

VI. TERM AND TERMINATION

(a) **Term**. This Agreement shall be effective as of the Effective Date and continue in full force and effect until the later of (1) the expiration or termination of the Services Agreement, or (2) the date on which Business Associate and its Authorized Users no longer maintain or have access to Covered Entity's PHI.

(b) **Termination for Breach.** In the event that Covered Entity reasonably believes that Business Associate may have violated a material term of this Agreement or is otherwise not managing PHI in accordance with HIPAA or other applicable law, Covered Entity shall have the right to investigate such violation, and Business Associate shall fully cooperate with any such investigation. If Covered Entity determines that Business Associate has violated a material term of this Agreement, and Business Associate has failed to cure such breach within ten (10) calendar days of receiving notice of such violation from

Covered Entity, Covered Entity may immediately terminate the Services Agreement without penalty or recourse to Covered Entity. Such termination shall be deemed a "for cause" termination by Covered Entity for purposes of the termination provision of the Services Agreement. If Covered Entity determines that neither cure of such violation nor termination is feasible, Covered Entity may report such violation to the Secretary and/or to any other governmental agency as may be required by applicable law. Termination pursuant to this Section VI(b) shall be effectuated by a written notice to Business Associate that specifies the violation upon which the termination is based and the effective date of the termination.

(c) **Effect of Termination.**

(1) Except as provided in paragraph (2) of this Section VI(c), upon termination or expiration of the Services Agreement, Business Associate shall return (or, if so directed by Covered Entity, destroy), and ensure that all Authorized Users return (or, if so directed by Covered Entity, destroy), all Protected Health Information received from Covered Entity, or created, maintained, received, or accessed by or on behalf of Business Associate or Covered Entity, that Business Associate or any of its Authorized Users still maintain in any form. Except to the extent otherwise specifically contemplated by the Services Agreement, Business Associate shall not retain, and shall ensure that its Authorized Users not retain, copies of the Protected Health Information.

(2) In the event that Business Associate determines that returning or destroying all or part of the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. If Covered Entity agrees that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement, and shall ensure that its Authorized Users in writing extend the same protections, to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate or any Authorized User, as applicable, maintain such Protected Health Information.

(d) **Non-exclusive Provisions.** The termination provisions of this Section VI are in addition to, and not in lieu of, the termination provisions provided elsewhere in the Services Agreement to which this is an Agreement and any other rights and remedies of the Covered Entity that are provided by law or by such Agreement.

VII. MISCELLANEOUS

(a) **Agency.** For purposes of this Agreement, it is the understanding and intention of the parties that Business Associate is acting as an independent contractor, and not an agent, of Covered Entity.

(b) **Amendment.** This Agreement may not be amended or otherwise modified except by an instrument in writing signed by all Parties hereto, provided, however, that in order to ensure that this Agreement at all times remains consistent with applicable law and rules regarding use and disclosure of Protected Health Information, Business Associate agrees that this Agreement may be amended from time to time upon written notice from Covered Entity to Business Associate as to the revisions required to make this Agreement consistent with applicable law and rules.

(c) **Survival.** The Parties' respective rights and obligations under this Agreement shall survive the expiration or termination of the Services Agreement.

(d) **Interpretation.** Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and Business Associate to comply with HIPAA and the applicable laws cited in Section IV of this Agreement.

(e) **No Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

(f) **More Restrictive Provisions Control.** In the event that the Services Agreement or any agreement or instrument referenced or incorporated therein contains provisions relating to the use or disclosure of Protected Health Information that are more restrictive than the provisions of this Agreement, including, without limitation, **Appendix B**, the provisions that are more restrictive shall control.

[*End of Agreement; Signature Page Follows*]

By and through its authorized representative listed below, each Party hereby agrees to the terms of this Agreement.

PLAN SPONSOR:	**BUSINESS ASSOCIATE:**
City of New York acting through the Mayor's Office of Labor Relations – Employee Benefits Program	**EmblemHealth Plan, Inc.**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Appendix C-2: Business Associate Agreement

This Business Associate Agreement (this "Agreement") is entered into by and between UMR, Inc., on behalf of itself and its Affiliates ("UMR") ("Business Associate") and the City of New York acting through the Mayor's Office of Labor Relations pursuant to New York City Administrative Code § 12.126(d) ("Plan Sponsor") on behalf of the Plan, as such term is defined in the Services Agreement, as defined below (such Plan referred to herein as "Covered Entity"), and effective as of [•][1] (the "Effective Date"). Plan Sponsor and Business Associate may both be referred to herein individually as a "Party" or collectively as the "Parties." This Agreement is entered into pursuant to that certain Administrative Services Agreement effective as of even date herewith and entered into by and between UMR, Inc., EmblemHealth Plan, Inc., and Plan Sponsor (the "Services Agreement").

The Parties hereby agree as follows:

I. DEFINITIONS

Any capitalized terms used and not otherwise defined in this Agreement shall have the same meanings established by 45 C.F.R. Parts 160 and 164. The terms "use," "disclose" and "discovery," or derivations thereof, although not capitalized, shall also have the meanings set forth in HIPAA.

"Affiliates" means, with respect to any entity, an entity that, directly or indirectly, controls, is controlled by, or is under common control with such entity. For purposes of this definition, "control" means, with respect to any entity, the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of such entity, whether through the ownership of voting securities (or other ownership interest), by contract or otherwise.

"Authorized Users" means employees or other workforce members, subcontractors (including, without limitation, Subcontractors as defined by 45 C.F.R. §160.103), Affiliates, and agents of Business Associate.

"HIPAA" means, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations at 45 C.F.R. Parts 160-64, along with its implementing regulations promulgated by the Department of Health and Human Services, including 45 C.F.R. Part 160 and Subparts A and E of Part 164 (the **"Privacy Rule"**) and 45 C.F.R. Parts 160 and Subparts A and C of Part 164 (the **"Security Rule"**), each as may be amended from time to time.

"Individual" shall have the same meaning as the term "individual" in 45 C.F.R. §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. §164.502(g).

"**Protected Health Information**" or "**PHI**" means "Protected Health Information" as defined in 45 C.F.R. § 160.103.

"Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his or her designee.

II. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

(a) **Permitted Uses.** Except as expressly requested by Covered Entity, Business Associate agrees not to use and/or disclose PHI (including disclosures to Affiliates), except as necessary to provide the Services,

[1] Note to Draft: To be effective as of the Effective Date of the Administrative Services Agreement.

as permitted or required by this Agreement and/or the Services Agreement, and in compliance with each applicable requirement of 45 C.F.R. §164.504(e), or as otherwise Required by Law.

(b) **Appropriate Safeguards.** Business Associate agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement, and with respect to Electronic Protected Health Information to comply with the specifications of the Security Rule, in addition to any specific safeguards required by the Services Agreement. Business Associate shall also comply with the Citywide Cybersecurity Requirements for Vendors and Contractors set forth by the New York City Office of Technology and Innovation and its Office of Cyber Command as they appear at https://nyc.gov/infosec. Business Associate will ensure that Authorized Users understand and comply with the provisions of this Agreement applicable to PHI.

(c) **Breach Notification.**

(1) Business Associate shall report to Plan Sponsor as soon as possible, but no later than three (3) business days after discovery of (A) any use or disclosure of PHI not permitted by this Agreement, the Services Agreement, and/or applicable law, and (B) any Security Incident of which Business Associate becomes aware.

(2) With respect to any actual or suspected Breach, Security Incident, or any collection, disclosure, use, or access of PHI not permitted by this Agreement, Business Associate will notify Plan Sponsor in writing as soon as practicable but no later than three (3) business days after discovery, including a description of the collection, disclosure, use, or access, the types of information that may have been involved or compromised, the names and affiliations of the parties who gained access to PHI without authorization, and a description of the steps taken, if any, to mitigate the effects of the incident. Business Associate shall fully cooperate with any investigation conducted by Covered Entity (or its designees) with respect to any incident. Notwithstanding the foregoing, the Parties acknowledge and agree that this Section II(c) constitutes notice by Business Associate to Covered Entity of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Covered Entity shall be required. "Unsuccessful Security Incidents" means routine, unsuccessful attempts to access, modify or destroy electronic data, or to interfere with an electronic data system, such as "pings" or other broadcast attacks on a firewall, port scans, routine unsuccessful log-on attempts, or denials of service.

(3) In the event Covered Entity determines a Breach has occurred, Covered Entity will inform Business Associate whether Covered Entity (or its designees) or Business Associate will issue the notifications required by 45 C.F.R. §§ 164.404 and 164.406. To the extent Business Associate's or any Authorized User's acts or omissions result in a Breach, Business Associate shall be responsible for reasonable costs involved in fulfilling the risk assessment, risk mitigation and notification requirements set forth in this Section II(c), including, but not limited to, under 45 C.F.R. Part 164, Subpart D, which may include: (A) providing such notifications, including if applicable, but not limited to, written notice, substitute notice, additional notice in urgent situations, and notification to media; and (B) all measures deemed reasonably necessary by Covered Entity or required by law to mitigate the harmful effects of any acquisition, access, use, or disclosure of PHI, including but not limited to, credit monitoring services for individuals affected by such Breach.

(d) **Authorized Users.** In accordance with 45 C.F.R. §§164.502(e)(1)(ii) and 164.308(b)(2), as applicable, Business Associate agrees to ensure that all Authorized Users that create, receive, maintain, transmit, or access Protected Health Information agree in writing to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such Protected Health Information. Business Associate is not in compliance with this Agreement if Business Associate knew of a pattern of activity or

practice of any Authorized User that constituted a material breach or violation of the Authorized User obligations related to the protections contemplated hereunder, unless Business Associate took all reasonable steps to ensure cure of the breach or cessation of the violation, as applicable, and if such steps were unsuccessful, notified Covered Entity of such breach or violation and terminated such Authorized User relationship and/or agreement (unless otherwise requested or permitted by Covered Entity).

(e) **Access by Individual.** Business Associate agrees to provide access to Protected Health Information in a Designated Record Set, to Covered Entity or an Individual or Individual's permitted designee in accordance with the requirements of 45 C.F.R. §164.524.

(f) **Amendment to PHI.** Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of Covered Entity or an Individual, and in the reasonable time and manner designated by the Covered Entity or the requesting Individual, and to take other measures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. §164.526.

(g) **Accounting of PHI.** Business Associate agrees to document such disclosures of Protected Health Information, and information related to such disclosures, as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. §164.528. Business Associate agrees to make available to Covered Entity or an Individual, in the reasonable time and manner designated by the Covered Entity, information collected pursuant to this Section II(g) in order to provide an accounting of disclosures as necessary to satisfy Covered Entity's obligations under 45 C.F.R. §164.528.

(h) **Additional Restrictions on PHI.** If Covered Entity notifies Business Associate that it has agreed to be bound by additional restrictions on the uses or disclosures of certain Protected Health Information not addressed in this Agreement, Business Associate agrees to be bound by such additional restrictions and shall not disclose such PHI in violation of such additional restrictions.

(i) **Carrying Out Covered Entity Obligation(s).** To the extent that Business Associate is to carry out one or more of Covered Entity's obligation(s) under the Privacy Rule, Business Associate shall comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligation(s).

(j) **Access to Books and Records.** Business Associate agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information created, received, maintained, transmitted, or accessed by Business Associate on behalf of Covered Entity, available to the Secretary, in the reasonable time and manner designated by the Covered Entity, or in the time and manner designated by the Secretary, as applicable, for purposes of determining compliance with HIPAA and this Agreement.

III. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

(a) **Use and Disclosure for Performance.** Except as otherwise provided in this Agreement, Business Associate may only use or disclose Protected Health Information as necessary to perform services, functions, activities, and/or duties for, or on behalf of, Covered Entity as specified in the Services Agreement, or as necessary to perform its duties under this Agreement, or as Required by Law.

(b) **Disclosure to Third Parties.** Subject to Section II(a) and Section II(d) of this Agreement, Business Associate may disclose Protected Health Information (1) as directed by Covered Entity, or (2) to Authorized

Users to the extent necessary for such Authorized Users to perform services, functions, activities, and/or duties for, or on behalf of, Covered Entity as specified in the Services Agreement.

(c) **Minimum Necessary Use and Disclosure.** Except with respect to Covered Entity-directed disclosures, when using or disclosing Protected Health Information, including disclosures to Authorized Users, or when requesting PHI from Covered Entity or another covered entity or business associate, Business Associate agrees to limit the PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

(d) Business Associate may not use or disclose Protected Health Information in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by Plans, except that Business Associate may do the following:

(1) **Use for Management, Administration and Legal Responsibilities.** Business Associate may use Protected Health Information to the extent necessary for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

(2) **Disclosure for Management, Administration and Legal Responsibilities.** Business Associate may disclose Protected Health Information to the extent necessary for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that (1) the disclosure is Required By Law, or (2) Business Associate obtains written assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and that the person will notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached. Business Associate agrees that if it has a legal obligation to disclose PHI as Required by Law to a law enforcement, regulatory, administrative, or oversight agency, or in response to a subpoena, court order, civil investigative demand, or other compulsory document or lawful process, Business Associate shall respond to such obligation on behalf of Covered Entity.

(3) **Data Aggregation Services.** Business Associate may use or disclose Protected Health Information to provide data aggregation services relating to the health care operations of the Covered Entity as permitted by 45 C.F.R. §164.504(e)(2)(i)(B). Under no circumstances may Business Associate disclose PHI to any other person or entity pursuant to this Section III(d) without the express authorization of Covered Entity.

(g) **De-identified PHI.** Business Associate may de-identify Protected Health Information in accordance with 45 C.F.R. §164.514(a)–(c) and utilize such de-identified PHI solely as necessary for Business Associate to perform Services, functions, activities, and/or duties for, or on behalf of, Covered Entity or Plan Sponsor as specified in the Services Agreement. All other creation, use, and/or disclosure of de-identified PHI is prohibited.

(h) **Use of PHI or De-identified PHI for Research Purposes.** Business Associate agrees that it will obtain the prior written approval of Covered Entity prior to using or disclosing Protected Health Information or de-identified PHI in connection with research purposes.

IV. COMPLIANCE WITH CERTAIN NEW YORK STATE LAWS

(a) **Confidentiality Under New York Law.** In addition to fulfilling its obligations with respect to HIPAA, Business Associate agrees to comply with all applicable New York State laws and any regulations promulgated thereunder governing the confidentiality of information created, received, maintained, transmitted, or accessed by Business Associate or its Authorized Users on behalf of Covered Entity,

including but not limited to the following provisions, as applicable: New York Public Health Law §18 (Access to Patient Information) and Article 27-F (HIV and AIDS Related Information); New York Mental Hygiene Law §§22.05 and 33.13; New York Civil Rights Law §79-*l*; New York General Business Law §399-ddd (Confidentiality of Social Security Account Numbers), §399-h and §899-aa; and chapter 5 of title 10 of the Official Compilation of Codes, Rules, and Regulations of the State of New York.

(b) **Breach Notification Under New York Law.** Pursuant to New York General Business Law ("GBL") §899-aa(2) and (3), Business Associate shall, within the timeframes identified in Section II(c) above, notify Covered Entity of any "breach of the security of the system," as defined in GBL §899-aa(1)(c), that involves Protected Health Information containing individuals' "private information," as defined in GBL §899-aa(1)(b), that was, or was reasonably believed to be, acquired from Business Associate or any Authorized User by a person without valid authorization. Business Associate shall bear all costs related to its or its Authorized Users' "breach of the security of the system" under GBL §899-aa. In the event such breach has occurred, Business Associate shall reimburse Plan Sponsor for all reasonable costs incurred by Covered Entity or Plan Sponsor related to providing the notice required by GBL §899-aa(5), which may include, if applicable: written notice; electronic notice; telephone notification; substitute notice; email notice; posting of notice on web site; and notification to major statewide media.

V. OBLIGATIONS OF COVERED ENTITY

(a) **Limitation(s) in Privacy Notice.** Covered Entity shall notify Business Associate of any limitation(s) in the notice of privacy practices utilized by Covered Entity under 45 C.F.R. §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

(b) **Changes in Individual's Permission.** Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information of which Covered Entity becomes aware, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

(c) **Restriction on Use or Disclosure.** Covered Entity shall notify Business Associate of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

(d) **Impermissible Request by Covered Entity.** Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under HIPAA if done by Covered Entity.

VI. TERM AND TERMINATION

(a) **Term**. This Agreement shall be effective as of the Effective Date and continue in full force and effect until the later of (1) the expiration or termination of the Services Agreement, or (2) the date on which Business Associate and its Authorized Users no longer maintain or have access to Covered Entity's PHI.

(b) **Termination for Breach.** In the event that Covered Entity reasonably believes that Business Associate may have violated a material term of this Agreement or is otherwise not managing PHI in accordance with HIPAA or other applicable law, Covered Entity shall have the right to investigate such violation, and Business Associate shall fully cooperate with any such investigation. If Covered Entity determines that Business Associate has violated a material term of this Agreement, and Business Associate has failed to cure such breach within ten (10) calendar days of receiving notice of such violation from

Covered Entity, Covered Entity may immediately terminate the Services Agreement without penalty or recourse to Covered Entity. Such termination shall be deemed a "for cause" termination by Covered Entity for purposes of the termination provision of the Services Agreement. If Covered Entity determines that neither cure of such violation nor termination is feasible, Covered Entity may report such violation to the Secretary and/or to any other governmental agency as may be required by applicable law. Termination pursuant to this Section VI(b) shall be effectuated by a written notice to Business Associate that specifies the violation upon which the termination is based and the effective date of the termination.

(c) **Effect of Termination.**

(1) Except as provided in paragraph (2) of this Section VI(c), upon termination or expiration of the Services Agreement, Business Associate shall return (or, if so directed by Covered Entity, destroy), and ensure that all Authorized Users return (or, if so directed by Covered Entity, destroy), all Protected Health Information received from Covered Entity, or created, maintained, received, or accessed by or on behalf of Business Associate or Covered Entity, that Business Associate or any of its Authorized Users still maintain in any form. Except to the extent otherwise specifically contemplated by the Services Agreement, Business Associate shall not retain, and shall ensure that its Authorized Users not retain, copies of the Protected Health Information.

(2) In the event that Business Associate determines that returning or destroying all or part of the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. If Covered Entity agrees that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement, and shall ensure that its Authorized Users in writing extend the same protections, to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate or any Authorized User, as applicable, maintain such Protected Health Information.

(d) **Non-exclusive Provisions.** The termination provisions of this Section VI are in addition to, and not in lieu of, the termination provisions provided elsewhere in the Services Agreement to which this is an Agreement and any other rights and remedies of the Covered Entity that are provided by law or by such Agreement.

VII. MISCELLANEOUS

(a) **Agency.** For purposes of this Agreement, it is the understanding and intention of the parties that Business Associate is acting as an independent contractor, and not an agent, of Covered Entity.

(b) **Amendment.** This Agreement may not be amended or otherwise modified except by an instrument in writing signed by all Parties hereto, provided, however, that in order to ensure that this Agreement at all times remains consistent with applicable law and rules regarding use and disclosure of Protected Health Information, Business Associate agrees that this Agreement may be amended from time to time upon written notice from Covered Entity to Business Associate as to the revisions required to make this Agreement consistent with applicable law and rules.

(c) **Survival.** The Parties' respective rights and obligations under this Agreement shall survive the expiration or termination of the Services Agreement.

(d) **Interpretation.** Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and Business Associate to comply with HIPAA and the applicable laws cited in Section IV of this Agreement.

(e) **No Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

(f) **More Restrictive Provisions Control.** In the event that the Services Agreement or any agreement or instrument referenced or incorporated therein contains provisions relating to the use or disclosure of Protected Health Information that are more restrictive than the provisions of this Agreement, including, without limitation, **Appendix B**, the provisions that are more restrictive shall control.

[*End of Agreement; Signature Page Follows*]

By and through its authorized representative listed below, each Party hereby agrees to the terms of this Agreement.

PLAN SPONSOR:	**BUSINESS ASSOCIATE:**
City of New York acting through the Mayor's Office of Labor Relations – Employee Benefits Program	**UMR, Inc.**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

EXHIBIT B

Pharmacy Services

Co-Administrators, through Emblem's contract with Prime Therapeutics, LLC, shall provide Services for Plan benefits for prescription drugs and related supplies and services in accordance with the terms and conditions of this Exhibit B (the "Pharmacy Services"). In addition:

A. The Parties agree that the terms and conditions of this Exhibit B are intended solely to supplement, and shall not limit, the application of the other terms and conditions of the Agreement unless the context expressly indicates otherwise.

B. Without limiting the responsibilities of Co-Administrators for the provision of the Pharmacy Services, the Parties expressly acknowledge that Emblem, on behalf of the Co-Administrators, shall be involved in the day-to-day management of the Pharmacy Services and administration of the Pharmacy Services through Subcontractor (referred to in this Exhibit B as "PBM"). As of the Effective Date, PBM shall be Prime Therapeutics Management LLC.

C. For clarity, PBM shall be a Subcontractor of Co-Administrators, who shall be fully responsible for ensuring PBM's performance of PBM's obligations in accordance with the relevant requirements of the Agreement, including, without limitation, this Exhibit B and the Division of Operations set forth on Schedule B-3.

DEFINITIONS

The definitions below shall apply to this Exhibit B (which, for clarity, includes Schedule B-1 through B-7 (collectively "Exhibit B")) and not more broadly to other sections of the Agreement, unless the context expressly indicates otherwise.

1.1 "340B Eligible Claims" means Claims that are: (i) submitted by 340B contracted pharmacies that adjudicate at a 340B price (i.e., at the price the 340B contracted pharmacy paid the Manufacturer/wholesaler/distributer for the Covered Product); (ii) identified by the submission of "20" in the "Submission Clarification Code" field; (iii) submitted by 340B contracted pharmacies which are categorized as Type 39 in the National Council for Prescription Drug Programs (NCPDP) DataQ database; or (iv) identified by the submission of "08" in the "Basis of Cost Determination (423-DN)" field. In addition, a 340B Eligible Claim includes any Claim for which a Manufacturer disputes payment of Rebates via contract terms or invoice, for which Emblem has not reasonably provided evidence (e.g. attestation or data) or for which PBM, after making a good faith effort, is unable to resolve the Manufacturer dispute in Emblem's favor, based on the rationale that the Claim was for a Covered Product dispensed under Section 340B of the Public Health Service Act to an eligible patient (such will be included in the definition of 340B Claim).

1.2 "ACA Coverage" means the program of Covered Products and services under the Plan (as such term is defined in Section 1 of the Agreement) with respect to for prescription medications which are not otherwise covered under Plan Sponsor's PICA program and are

preventative Covered Products designated by the United States Affordable Care Act, formally known as the Patient Protection and Affordable Care Act, enacted in March 2010.

1.3 "Applicable Law(s)" means (i) Law (as such term is defined in Section 1 of the Agreement) which applies to either Party, or the Pharmacy Services; (ii) any and all then current local, state or federal statutes, regulations, ordinances, guidelines or other requirements or judicial decisions having the force and effect of law and which apply to either Party or PBM, or the Pharmacy Services; and (iii) includes any interpretation of law by a regulatory authority having jurisdiction over any of the Parties, PBM or the Pharmacy Services, including but not limited to guidance communicated by a regulatory authority.

1.4 "Auditing Parties" means Plan Sponsor, its authorized representatives or third-party auditors, and any of the forgoing's respective designees.

1.5 "Average Wholesale Price" or "AWP" means the "average wholesale price" for a Covered Product based on the most current pricing information published by Medi-Span for the date and time the Covered Product is dispensed by the pharmacy. The AWP of a Covered Product will be the AWP unit price as published by Medi-Span for the 11digit NDC. Co-Administrator shall ensure that PBM shall not allow adjudication of NDCs of licensed re-packagers where the data source identifies the licensed re-packagers AWP is greater than the original pharmaceutical AWP. Co-Administrators shall ensure that PBM updates AWP data no less than weekly.

1.6 "Benefit Edit Tool" or "BET" means the on-line tool in JUDI for use by Emblem to set up and edit the Benefit Plan designs.

1.7 "Benefit Plan" means the Plan (as such term is defined in Section 1 of the Agreement) with respect to the ACA Coverage, the Optional Rider Coverage, and the Diabetic Mandate Coverage, as described in the Plan Documents (as such term is defined in Section 1 of the Agreement) including, without limitation, the processing parameters and other information such as cost sharing entitling a Member to receive Covered Products.

1.8 "Brand Drug" means a prescription drug or product set forth in Medi-Span's National Drug Data File (MS) with the following criteria:

a. Multisource Code "M" and Brand Name Code of "B" and "T"
b. Multisource Code "N" and Brand Name Code of "B" and "T"
c. Multisource Code "O" and Brand Name Code of "B" and "T"

Brand Drug also includes any Covered Product that is not a Generic Drug. When a drug or product is classified as a Brand Drug, it shall be considered a Brand Drug for therapeutic classification and all pricing and guarantee purposes. Member cost share determination is excluded from this definition and will be based on the Benefit Plan design and Formulary tier for each drug or product. If other Multisource Codes and Brand Name Codes are added to Medi-Span's National Drug Data File, the Parties shall mutually agree in writing to change applicable to Brand Drug and Generic Drug definitions, if necessary.

1.9 "Brand Name Code" shall have the meaning set forth in Medi-Span's National Drug Data File (MS).

1.10 "Claim" means a 'Claim' (as such term is defined in Section 1 of the Agreement) submitted by a Network Participant, or a Member for Covered Products under the Benefit Plan.

1.11 "Claims Adjudication" or "Adjudication" means the process which PBM uses to apply the criteria and parameters of Benefit Plan to determine eligibility for coverage of Covered Products, pharmacy benefit management services, perform concurrent (on-line at point of service) Drug Utilization Reviews, determine Covered Products' reimbursement amounts and perform related Pharmacy Services associated with Claims payments under the Agreement.

1.12 "Coinsurance" means that portion of the amount claimed for Covered Products, calculated as a percentage of the charge for such services, which is to be paid by a Member pursuant to the Member's Benefit Plan.

1.13 "Compound Drug" refers to a prescription drug product where two or more ingredients are mixed together when at least one of the ingredients is an FDA approved federal legend drug or state restricted drug in a therapeutic amount, prepared by a pharmacist according to a prescriber's order, and which is not otherwise available in an equivalent commercial form. For purposes of clarity, the definition of "Compound Drug" shall exclude preparations that involve the addition of only water, alcohol, flavoring, coloring or sodium chloride to the active ingredient.

1.14 "Copayment/Deductible" means a fixed dollar portion of the amount claimed for Covered Products that is payable by a Member pursuant to the Member's Benefit Plan.

1.15 "Covered Products" means any prescription drug, supply or related service or good (e.g. OTCs) that is included for coverage in the Benefit Plan.

1.16 "Custom Formulary" means any variation of a Formulary, excluding any Formulary subset or other variations required to manage the Benefit Plan, with restrictions by class, specialty or a restricted group of specific medications such as diabetic supplies), which is modeled and researched by PBM and presented to Plan Sponsor in order to achieve specified results, that is then reviewed and approved by Plan Sponsor for PBM to implement and maintain on their behalf.

1.17 "Diabetic Mandate Coverage" means the Covered Products and services under Plan Sponsor's plan benefits for prescription medications which are not otherwise covered under Plan Sponsor's PICA program and are Covered Products as designated by the New York laws and regulations related to the treatment of Diabetes.

1.18 "Dispensing Fee" means the service fee or amount payable to a Network Participant to cover the cost of dispensing a Covered Product. The Dispensing Fee is added to the discounted AWP or MAC and not applicable to claims paid off a U&C basis.

1.19 "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 Member's Benefit Plan.

1.20 "E-prescribing" means the process of creating, storing and transmitting prescription information electronically, either by computer or hand-held device.

1.21 "Extended Supply Network" or "ESN" means the retail Network Participants who are agreed to and are able to dispense a supply greater than eighty-three (83) days of a Covered Product.

1.22 "Formulary" means a list of various pharmaceutical products agreed upon, in writing and in advance, by the Plan Sponsor, which is available under the Benefit Plan, and made available to Network Participants, Members, physicians or other health care providers for purposes of providing information about the coverage and tier status of Covered Products.

1.23 "Generic Drug" means a drug or product set forth in the Medi-Span's National Drug Data File (MS) with the following criteria:

a. Multisource Codes "M," "N," and "O" and a Brand Name Code of "G."
b. Multisource Code of "Y" and any Brand Name Code.

When a drug is classified as a Generic Drug, it shall be considered a Generic Drug for therapeutic classification and all pricing and guarantee purposes. Member Cost Sharing Amounts are excluded from this definition and will be based on the plan design and formulary tier for each drug. If other Multisource Codes and Brand Name Codes are added to the Medi-Span's National Drug Data File (MS), the Parties shall mutually agree in writing to change applicable to Brand Drug and Generic Drug definitions, if necessary.

1.24 "Home Delivery" means the services through which Members may receive prescription drugs through the mail, courier, or other mechanism to their place of residence, business, or designated location from a Home Delivery Pharmacy regardless of requested supply.

1.25 "Home Delivery Pharmacy" means a pharmacy that primarily dispenses prescriptions (but not primarily Specialty Products) through home delivery service that is both: (i) contracted with PBM or owned or operated by PBM, and (ii) selected for inclusion as a Home Delivery Pharmacy by Plan Sponsor.

1.26 "Ingredient Cost" means the component of the price that represents the cost of the Covered Product, excluding the Dispensing Fee and taxes.

1.27 "Limited Distribution Drug" or "LDD" means a Specialty Product that meets both of the following criteria: (1) PBM has no access through a direct manufacturer limited distribution relationship through an owned/operated/direct relationship dispensing specialty pharmacy and (2) AWP per unit is greater than $5,000.

1.28 "Manufacturer" means a company that manufactures and/or distributes pharmaceutical drugs or products.

1.29 "Manufacturer Administration Fee" or "MAF" means fees paid to PBM, its Subcontractor or group purchasing organization ("GPO") by Manufacturers for bona fide Rebate services performed by PBM, its designee or GPO on the Manufacturers' behalf, which shall be retained by PBM to the extent described in this Exhibit, including Schedule B-2.

1.30 "Manufacturer Agreement" shall have the meaning set forth in Section 3.1.1(a) of this Exhibit B.

1.31 "Maximum Allowable Cost" or "MAC" means the highest drug cost at which PBM will reimburse the Network Participant or Member for a specific drug, as set forth in the MAC List in effect at the time the Claim was adjudicated.

1.32 "Maximum Allowable Cost List(s)" or "MAC List(s)" means the proprietary database listing(s), owned and maintained by PBM, of multi-source pharmaceutical drug products and supplies and the corresponding MAC. A separate MAC List may be maintained for Home Delivery. Copies of current MAC Lists by NDC shall be provided to Plan Sponsor by Co-Administrator upon request in excel.

1.33 "Member" means an Eligible Individual (as such term is defined in Section 1 of the Agreement) who is eligible and/or elects coverage under either the ACA Coverage and Diabetic Mandate Coverage, or under the Optional Rider Program, to receive Covered Products under the Benefit Plan.

1.34 "Member Cost Sharing Amounts" means the fixed dollar Copayment/Deductible and Coinsurance amounts payable out-of-pocket by any Member pursuant to the Benefit Plan.

1.35 "Minimum Rebate Guarantee" or "Rebate Guarantee(s)") means the guaranteed Rebate amounts shown in Schedule B-2.

1.36 "Multisource Code" or "Brand Name Code" shall have the meaning set forth in Medi-Span's National Drug Data File (MS).

1.37 "Network" or "Pharmacy Network" means the entire group of pharmacies that have been accepted as Network Participants and have entered into agreements with PBM or its designee to provide Covered Products to Members.

1.38 "Network Contract" means a contract between a Network Participant and PBM or its designee to provide Covered Products to Members under the Benefit Plan, as may be amended from time to time.

1.39 "Network Participant" or "Participating Pharmacy" means an individual pharmacy, chain or other dispensing pharmacy provider that has entered into a Network Contract with PBM

or its designee directly or through a pharmacy services administration organization (PSAO) to provide Covered Products to Members under the Benefit Plan.

1.40 "Open Refill Transfer File" or "ORTF" means a data file created by Emblem's previous pharmacy benefit manager for Plan Sponsor containing its Members' mail prescriptions, thus enabling a subsequent pharmacy benefit manager, such as PBM, to facilitate the continued filling of those open mail prescriptions.

1.41 "Optional Rider Coverage" means the Covered Products and services under Plan Sponsor's optional coverage for prescription medications under the Plan, which are not otherwise covered under Plan Sponsor's PICA program or covered under the ACA Coverage or Diabetic Mandate Coverage.

1.42 "Originator Product" means a type of biological product that is licensed (approved) by the FDA as the original or first biologic for a product, large complex molecules produced from living systems, approved in market.

1.43 "Over-the-Counter" or ""OTC" means products that are identified by Medi-Span RXOTC Indicator as OTC.

1.44 "Paper Claim" means a manual/paper claim submitted by a Member for a Covered Product dispensed by a pharmacy that was paid by the Member. For the avoidance of doubt, Co-Administrators and PBM shall ensure that Network Pharmacies shall not submit any Paper Claims.

1.45 "Pharmacy Operations Manual" means the document distributed to Network Participants by PBM which describes the administrative policies and procedures of the Claims Adjudication system, the requirements for participation in the Pharmacy Network, and for providing pharmacy services to Members. The Pharmacy Operations Manual details the method for submitting Claims from the Network Participant to the Claims Adjudication system and procedures for the resolution of Claims rejected by the Claims Adjudication system.

1.46 "Prior Authorization" or "PA" means a utilization management process used to determine if a prescribed product or service is a Covered Product under the Benefit Plan. It requires the prescriber or Member to obtain advance approval from Emblem before the drug is dispensed or the service is provided in order to qualify for coverage and reimbursement.

1.47 "Rebate(s)" means all rebates (including base, incentive, portfolio and market share rebates), price protections, retrospective discounts and all other monies paid by a Manufacturer or rebate intermediary to PBM, its designee or GPO (or paid to a Co-Administrator other than by PBM, its designee or GPO) that are attributable to Covered Products dispensed to a Member under the Benefit Plan. The term "Rebates" also includes reimbursements or payments to PBM, its designee or GPO (or paid to a Co-Administrator other than by PBM, its designee or GPO) from Manufacturers relating to inflation or price increase protection arrangements that are attributable to Covered Products. Rebates do not

include VBC revenue or MAF retained by PBM, but do include any VBC revenue or MAF to which Emblem is entitled.

1.48 "Retail Extended" refers to Claims from a Retail Pharmacy with a days' supply of greater than eighty-three (83).

1.49 "Retail" refers to Claims from a Retail Pharmacy with a days' supply of less than eighty-four (84).

1.50 "Retail Pharmacy" means any duly licensed pharmacy that is a Network Participant and excludes the following pharmacy types: Indian/Tribal/Urban, pharmacies operated by federally qualified health centers, long term care, home infusion, Home Delivery Pharmacy and Specialty Pharmacy Network.

1.51 "Specialty Pharmacy Network" means a Pharmacy Network of Specialty Pharmacies that primarily dispenses Specialty Products and provides services under the Benefit Plan, as selected by Emblem on advance written notice to and agreement of Plan Sponsor, and mutually agreed to by PBM (e.g. either a single Specialty Pharmacy such as Accredo with appropriate additional Specialty Pharmacy to satisfy requirements such as LDD, or shall include a network of Specialty Pharmacies).

1.52 "Specialty Pharmacy" means a specialty pharmacy that is a Network Participant and selected by Emblem on advance written notice to and agreement of Plan Sponsor, to dispense Specialty Products to Members. "Specialty Pharmacy" does not include pharmacies that dispense only Limited Distribution Drugs.

1.53 "Specialty Product" means a Covered Product listed on the Specialty Product List that: (i) is injected, infused, orally or topically administered, or inhaled for the ongoing treatment of complex, chronic conditions; (ii) requires extensive patient education, risk assessment, mitigation strategies, and/or clinical monitoring; (iii) may require temperature-controlled shipping or other special handling and careful adherence to treatment. When a drug is identified as a Specialty Product, it shall be considered a Specialty Product for all purposes, including for purposes of determining Member Cost Sharing Amounts, therapeutic classification, pricing and all related guarantees.

1.54 "Specialty Product List" (also known as the "Drug Management List" or "DML") means the list of Specialty Products included on Schedule B-7, as updated from time to time upon the mutual agreement of the Parties, which is developed and maintained by PBM, but the contents of which are ultimately approved by Emblem, and agreed upon in writing by Plan Sponsor for the Benefit Plan. The Specialty Product List shall be used to provide Specialty Pharmacy Network access, discounts, guarantees and Dispensing Fees. Co-Administrators shall ensure that PBM makes, and PBM shall make a copy of the Specialty Product List available to Emblem, which will make available to Plan Sponsor, at all times. For the avoidance of doubt, in the event that Emblem elects not to include any item on the Specialty Product List that PBM has made available for inclusion on the Specialty Product List, it must do so only with the approval of Plan Sponsor.

1.55 "Subcontractors" means any subcontractor, third party support contractors, suppliers, service providers, outsource vendors, Affiliate, or other third party to whom Co-Administrators, PBM, or any of their respective Affiliates grant access to Plan Sponsor's Confidential Information or otherwise uses in connection with the Pharmacy Services

1.56 "Subrogation Claim" means a claim submitted by any state or a person or entity acting on behalf of a state under Medicaid or similar United States or state government health care programs, for which Plan Sponsor is deemed to be the primary payer by operation of Applicable Law.

1.57 "Transition" means: (i) Plan Sponsor's conversion from its existing/prior pharmacy benefit vendor to PBM (current) and its replacement of such vendor with PBM, or (ii) Emblem's (on behalf of the Co-Administrators) conversion from an existing PBM to a successor PBM to provide Pharmacy Services under the Agreement, or (iii) Plan Sponsor's conversion to such successor PBM.

1.58 "Usual and Customary" or "U&C" means the lowest price a pharmacy would charge a customer without any insurance coverage if such customer were paying cash for the identical drug and quantity 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, but does not include: (i) any other discount drug card program that Plan Sponsor may participate in that is accepted by the Participating Pharmacy but not funded by the Pharmacy, or (ii) Manufacturer coupon programs, copay assistance programs and other similar programs, unless required by Applicable Law.

1.59 "Utilization Management" or "UM" means a broad collection of standard clinical products and services that may be selected by Emblem, as agreed to in advance and in writing by Plan Sponsor, that are designed to encourage proper drug utilization in order to enhance Member outcomes while managing drug benefit costs for Plan Sponsor. Such services include, but are not limited to the following, Formulary exception, Prior Authorization, step therapy, quantity limits and retrospective DUR.

1.60 "Utilized Pharmacies" means those Network Participants located nationwide, with an emphasis on those located in the state of New York, that were utilized by Plan Sponsor's Members during the previous calendar year.

1.61 "Vaccine" means a Claim for a Covered Product within the Medi-Span Drug Groups of Vaccines or Toxoids.

1.62 "Value Based Contracts" or "VBCs" means agreements made between PBM and a Manufacturer or an aggregator and a Manufacturer, for which payment is conditioned upon a measured therapeutic result or outcome (and not based solely on a Claim) related to a Covered Product dispensed to a Member under this Exhibit B. For the avoidance of doubt, VBC revenue, other than VBC revenue to which Emblem is entitled to, shall not be taken into account in determining or reconciling Rebate Guarantees for any purpose.

2. CERTAIN NETWORK SERVICES

2.1 Pharmacy Network Services

2.1.1 Network Utilization and Pricing. Co-Administrators shall ensure that PBM provides and maintains, and PBM will, either directly or through a Subcontractor, provide and maintain Pharmacy Network(s) to provide prescription drugs and supplies as set forth in Plan Sponsor's Benefit Plan. Network Participants include large pharmacy chains as well as independent pharmacies.

2.1.2 Network Establishment and Maintenance.

(a) Co-Administrators will ensure that PBM maintains, and PBM will maintain, the Pharmacy Network and will make available to Members an updated list of Participating Pharmacies in the Pharmacy Network, including an online pharmacy search tool. If Plan Sponsor requests the addition of a pharmacy or pharmacies to the Pharmacy Network, Emblem will work with PBM to make commercially reasonable efforts to add the pharmacy as a Network Participant. Co-Administrators and PBM shall ensure that the Pharmacy Network(s) complies with all Applicable Laws, including Applicable Laws addressing network adequacy and Member choice of pharmacy. PBM may lease certain pharmacies or pharmacy networks, or directly contract with pharmacies and pharmacy networks, which pharmacies shall be considered part of the Network, but only in compliance with the terms and conditions of this Exhibit B.

(b) Co-Administrators shall ensure that PBM complies, and PBM will comply, with Applicable Laws related to the maintenance of the Pharmacy Network and prompt payment to Participating Providers. Unless otherwise prohibited by Applicable Law, PBM reserves the right to charge and retain for its own account transaction fees to be paid by the Participating Pharmacies for bona fide services provided to Participating Pharmacies such as coordination of contracting and billing, access to PBM clients, electronic claims administration, and support from PBM pharmacy help desk. The Parties agree that such fees shall not be passed through to Emblem or Plan Sponsor. Co-Administrators shall ensure that PBM maintains, and PBM or its Subcontractor will maintain, Network Contracts with an adequate number of Participating Pharmacies in the various geographical areas where Members reside and will comply with all Applicable Laws and applicable regulatory access requirements. Co-Administrators shall ensure that PBM furnishes, and PBM will furnish, each Network Participant with Benefit Plan information in such a format and media as necessary for Network Pharmacies to provide Covered Products to Members. ID cards provided to Members, will identify the appropriate Benefit Plan configuration information and will include a customer service phone number for pharmacy-related services.

(c) PBM reserves the right, in accordance with Applicable Law and this Exhibit B, to periodically change Participating Pharmacies in order to maintain satisfactory compliance with PBM's policies on pricing, quality, and operations; provided, however, that Co-Administrators shall ensure that any such changes to the Pharmacy Network comply with Applicable Law. To the extent that any such change represents a material change to the Pharmacy Network, the Co-Administrators shall notify Plan Sponsor in writing of such material change as soon as practicable. To the extent that Plan Sponsor does not agree with such material change, Co-Administrators shall work together with PBM to make a good faith effort to maintain the current Pharmacy Network composition, provided, however, that no Specialty Pharmacy or Home Delivery Pharmacy may be removed from the Pharmacy Network without Plan Sponsor's prior written consent, subject to, in the case of any Home Delivery Pharmacy, the pricing terms provisions set forth in Schedule B-1 of this Exhibit B.

2.1.3 Network Contracts. Co-Administrators shall ensure that PBM complies, and PBM will comply, and will require any designee to comply, with all Applicable Laws related to Network Contracts, including applicable state regulatory or other governmental agencies' filings if necessary (including, but not limited to, filings regarding all Network Participant terminations). Participating Pharmacies will be appropriately credentialed and/or accredited, licensed, and maintain insurance in an amount no less than industry standard. Co-Administrators shall ensure that PBM uses, and PBM will include, and will require its designee to include, the following provisions in the Network Contracts unless such provisions conflict with or fail to comply with Applicable Law, including, but not limited to, Applicable Laws of New York State or federal agencies:

(a) A provision prohibiting Network Pharmacies from billing, charging, collecting a deposit from, seeking remuneration from, or having any recourse against Members except for applicable Member Cost Sharing Amounts or fees for uncovered services;

(b) A provision requiring Participating Pharmacies to provide PBM with at least ninety (90) days, or other time frame as required by Applicable Law, written notice in the event the Participating Pharmacy wishes to terminate the Network Contract without cause;

(c) In accordance with all Applicable Laws, a provision requiring Participating Pharmacies to develop a means for receiving and forwarding all Member complaints, inquiries and opinions concerning the operations and policies of the Participating Pharmacy to PBM (upon receipt of any such complaints, inquiries or opinions, PBM will report such information to Emblem for resolution); and

(d) A provision requiring Participating Pharmacies to abide by and comply with all quality improvement, care management, dispute resolution and utilization review requirements and procedures established by PBM.

Co-Administrators shall ensure that PBM has, and PBM shall have a process which includes an interdisciplinary committee to review Participating Pharmacy participation issues at a minimum quarterly and shall provide a report of the outcomes of those meetings to Emblem's special investigations unit and/or pharmacy director, who shall share all findings applicable to the Benefits Plan with Plan Sponsor.

Co-Administrators shall ensure that PBM manages, and PBM shall also manage a process to ensure adequate independent pharmacy participation in the Pharmacy Network incorporating rural rates that vary by the distance to the next closest pharmacy to ensure these rural areas are covered and this reimbursement reflects their buying capabilities. Co-Administrators shall ensure that PBM engages, and PBM shall also engage with independent pharmacies on a routine basis on quality initiatives affording such pharmacies the opportunity to earn bonus payments or higher dispensing fees by working to meet Emblem's specific needs such as closing gaps in care, HEDIS measure outcomes, adherence, social determinants of health (SDoH) initiatives, or outcomes measures such as high blood pressure or comprehensive diabetes measures.

2.1.4 PBM Maximum Allowable Cost List. Participating Pharmacies will be required to accept the MAC List(s) for Members. Co-Administrators shall ensure that PBM maintains, and PBM shall maintain the MAC List in compliance with all Applicable Laws.

2.1.5 Non-Payment to Excluded Providers. Co-Administrators shall ensure that PBM does not, and PBM shall not, make payments to Network Participants that are not licensed as required by Applicable Law or that have been debarred, suspended or otherwise excluded from a federal or state program under Applicable Law.

2.2 **Home Delivery Contact Center**. Co-Administrators and PBM shall ensure that Home Delivery Pharmacy makes available a toll-free customer service line for use by Members utilizing Home Delivery, which shall be available to Members twenty-four (24) hours per day, seven (7) days per week.

2.3 **Pharmacy Locator**. Co-Administrators shall ensure that PBM provides, and PBM will provide the ability, including through a toll-free telephone line and electronic means (i.e. an online pharmacy locator), for Members to contact and identify Network Participants in a particular area. Emblem will include this telephone number on Member ID cards or communicate it to Members through other means. The toll-free telephone line will be available during the Member Contact Center hours specified above.

2.4 **Pharmacy Help Desk Service**. Co-Administrators shall ensure that PBM provides, and PBM will provide help desk service for pharmacist Claim inquiries twenty-four (24) hours a day, seven (7) days a week. This help desk service will also handle calls from Network Participants in the event they have questions concerning reconciliation reports provided to them for purposes of pharmacy payments. Co-Administrators shall ensure that PBM handles, and PBM will be responsible for handling all Network Participant issues through resolution.

2.5 **Pharmacy Network Audit Services.** Co-Administrators shall ensure that PBM performs, and PBM will perform pharmacy Claims analysis and Claims audits to ensure Network Participants' compliance with contractual obligations and Applicable Laws. PBM will perform its pharmacy Claims audits pursuant to the authority granted to PBM in the applicable Network Contracts in order to detect and recover fraud, waste and abuse. Co-Administrators shall ensure that PBM is responsible, and PBM shall, at a minimum, be responsible for Claims Analysis, Daily/Concurrent Audit, Desktop Audits, On-site Audits, Reporting and Recoveries, as detailed below.

2.5.1 Claims Audits. Co-Administrators shall ensure that PBM performs, and PBM will perform Claims analysis and Claims audits to ensure Network Participants' compliance with Network Contract obligations and Applicable Laws. Co-Administrators shall ensure that PBM performs, and PBM will perform its Claims audits pursuant to the authority granted to PBM in the applicable Network Contracts in order to detect and recover fraud, waste and abuse. Co-Administrators shall ensure that PBM is responsible, and PBM shall at a minimum be responsible for Claims analysis, daily/concurrent audit, desktop audits, on-site audits, reporting, and recoveries as detailed below and as otherwise set forth in this Exhibit B.

2.5.2 Claims Analysis. Co-Administrators shall ensure that PBM performs, and PBM will perform, daily and historical analytics on one hundred percent (100%) of Claims daily to detect fraud, waste and abuse. This reporting analytics must include areas such as: daily monitoring of high dollar Claims which shall allow for engagement with Network Participants immediately after Claim submission (e.g. within two (2) business days) to prevent inappropriate Claims prior to dispensing when possible, reporting that is routinely updated based on fraud schemes reported through government entities, inappropriate schemes - ointment/creams, controlled substances, use of wholesalers with concerns, etc.). A list of analytic tools shall be provided to Emblem routinely for review and comment by the Emblem's special investigations unit and/or pharmacy director. Claims subject to potential Claim audits will be identified through Claim analytics performed on one hundred percent (100%) of Claims, specific Claims upon request of Emblem or Plan Sponsor, or as otherwise identified by PBM.

2.5.3 Daily/Concurrent Audits. Co-Administrators shall ensure that PBM performs, and PBM will perform daily audits (i.e., an audit performed within seventy-two (72) hours of Claim submission) of Claims submitted electronically by Network

Participants that present a high risk of potential billing, payment, and/or compliance errors. Co-Administrators shall ensure that PBM selects, and PBM will select Claims for daily audit on a prepayment basis. For Network Participant errors identified through daily Claim audits, Co-Administrators shall ensure that PBM contacts, and PBM will contact Network Participant and instruct the pharmacist to reverse and resubmit the applicable Claim using accurate Claim information, when appropriate.

2.5.4 Desktop Audits. Co-Administrators shall ensure that PBM performs, and PBM will perform historical desktop audits of Claims submitted electronically by Network Participants that present a high risk of potential billing, payment, and/or compliance errors. Co-Administrators shall ensure that PBM reviews, and PBM will review Claims submitted within the previous twelve (12) months for a historical desktop audit. For Network Participant errors identified through historical Claim audits, Co-Administrators shall ensure that PBM reverses, and PBM will reverse and/or resubmit the corrected Claims on behalf of Network Participants and/or use commercially reasonable efforts to recover erroneous payments from Network Participants. During each calendar year, Co-Administrators shall ensure that PBM conducts, and PBM shall conduct historical claim or desk audits of at least eight percent (8%) of Utilized Pharmacies with more than two hundred (200) annual Claims. During the first year that PBM provides Claim audits for Emblem and Plan Sponsor, Co-Administrators shall ensure that PBM performs, and PBM will perform a prorated number of Claim audits. If additional audits are needed Emblem will notify Plan Sponsor, including the volume and associated fees, and any such additional fees will be mutually agreed upon in advance by Emblem and Plan Sponsor, such agreement not to be unreasonably withheld. Prompt notice of the discovery of any concerns relative to fraud and abuse shall be sent to the special investigations unit, provided by PBM and Emblem to Plan Sponsor.

2.5.5 On-Site Audits. Co-Administrators shall ensure that PBM performs, and PBM will perform on-site audits of Network Participants identified through the pharmacy audit profile, upon request of Emblem or Plan Sponsor, or as otherwise identified by PBM. Co-Administrators shall ensure that PBM reviews, and PBM will review up to twenty-four (24) months of Claims and verify audited Claims at the Network Participant's location. Co-Administrators shall ensure that PBM verifies, and PBM will also verify Network Participant is in compliance with the Network Contract and the Pharmacy Operations Manual. For Network Participant errors identified through on-site audits, Co-Administrators shall ensure that PBM reverses, and PBM will reverse and/or resubmit the corrected Claims on behalf of Network Participants and/or use commercially reasonable efforts to recover erroneous payments from Network Participants. During each calendar year, Co-Administrators shall ensure that PBM performs, and PBM will perform the number of on-site audits that equals four percent (4%) of Utilized Pharmacies with more than two hundred (200) annual Claims. During the first year that PBM provides onsite audits for Emblem and Plan Sponsor, Co-Administrators shall ensure that

PBM performs, and PBM will perform a prorated number of onsite audits that will begin after six months of Claims have been processed by PBM. If additional audits are needed Emblem will notify Plan Sponsor, including the volume and associated fees, and any such additional fees will be mutually agreed upon in advance by Emblem and Plan Sponsor.

2.5.6 Reporting. Co-Administrators shall ensure that PBM reports, and PBM will report to Emblem the results of Claim and on-site audits within thirty (30) days of the end of each quarter. Co-Administrators shall ensure that PBM reports, and PBM will also report to Emblem any instances of suspected abusive and/or fraudulent billing activities within ten (10) business days following such discovery or as otherwise required by Applicable Law. Emblem shall promptly provide such reports to Plan Sponsor, and upon Plan Sponsor request.

2.6 **E-Prescribing Services.** Co-Administrators shall ensure that PBM supports, and PBM will support e-Prescribing for eligibility, Formulary, and medication history to allow prescribers to electronically send Members' prescriptions directly to a Participating Pharmacy from the point-of-care.

2.7 **Home Delivery Pharmacy Services**.

2.7.1 Home Delivery Pharmacy. Members may access Home Delivery, for Covered Products (not limited to maintenance medications) through a Home Delivery Pharmacy. Plan Sponsor may select or change the designated Home Delivery Pharmacy(ies) at any time during the Term upon notice to Emblem from Plan Sponsor, subject to the pricing terms provisions set forth in Schedule B-1 of this Exhibit B.

2.7.2 Home Delivery Pricing Terms. Emblem's payments to PBM for Covered Products dispensed by a Home Delivery Pharmacy will not exceed, in the aggregate, the guaranteed amounts indicated on Schedule B-1.

2.7.3 MAC at Home Delivery Pricing. MAC pricing for Home Delivery is specified on Schedule B-1.

2.8 **Fraud, Waste and Abuse Services**. Co-Administrators shall ensure that PBM provides, and PBM will provide mechanisms to detect and prevent pharmacy fraud by leveraging various services described herein, including advanced fraud analytics, the concurrent DUR program, retrospective DUR program, PBM's Network Participant audit program and special investigation unit. When Network Participant fraud or abuse is suspected, Co-Administrators shall ensure that PBM investigates, and PBM will investigate, which shall include evaluations of inventory, member-validations, and prescriber-validations, and take appropriate action, which may include, but is not limited to, termination of the Network Participant from the Pharmacy Network in accordance with this Exhibit B, and/or reporting the matter to appropriate legal and/or regulatory authorities when authorized to do so by Emblem, and PBM will notify Emblem of the matter and its resolution in accordance with

the terms of this Exhibit B. When Member fraud is suspected, Co-Administrators shall ensure that PBM notifies, and PBM will immediately notify Emblem and shall cooperate with Emblem as directed by Emblem to investigate, gather evidence and address/finalize remediation efforts. Emblem shall report all allegations of fraud or abuse to Plan Sponsor.

Emblem, on behalf of Plan Sponsor, has elected participation in the Advanced Fraud, Waste and Abuse Program (fee specified on Schedule B-1) for the Benefit Plan, and Co-Administrators shall ensure that PBM provides, and PBM will provide mechanisms to detect and prevent Member and prescriber pharmacy fraud by leveraging various services described herein, including advanced fraud analytics, investigation, and consultation. When Member or prescriber fraud is suspected, Co-Administrators shall ensure that PBM investigates, and PBM will investigate, gather evidence, notify Emblem, provide Emblem with a recommendation and collaborate with Emblem on remediation efforts. Emblem shall promptly report all allegations of fraud or abuse to Plan Sponsor.

If Emblem, or Plan Sponsor, declines or opts out of the Advanced Fraud, Waste and Abuse Program at a future date, which Emblem, or Plan Sponsor, reserves the right to do at any time during the Term of this Exhibit B, if/when Member or prescriber fraud is suspected, PBM will advise Emblem and collaborate with Emblem as mutually agreed upon.

Co-Administrators shall ensure that PBM tracks, and PBM will track all instances of suspected fraud reported to or identified by PBM, capturing all applicable dates, nature and details of suspected fraud, and steps of resolution by PBM. Co-Administrators shall ensure that PBM cooperates, and PBM will cooperate as directed by Emblem with respect to any investigation of potential or actual fraud arising in connection with the Pharmacy Services, including requests for Claims or other data. Once an allegation of suspected fraud, waste and abuse is received, Co-Administrators shall ensure that PBM conducts, and PBM agrees to conduct an initial review within fourteen (14) days of receiving the allegation. Once an allegation of fraud, waste, and abuse warrants an investigation, Co-Administrators shall ensure that PBM complies, and PBM agrees to comply with an average turnaround time to complete the investigation of ninety (90) days.

2.9 **Compliance Program.** Co-Administrators shall ensure that PBM maintains, and PBM agrees to maintain its compliance program and code of conduct throughout the term of this Exhibit B. Co-Administrators shall ensure that PBM agrees, and PBM further agrees, including in order to assist Emblem in meeting the requirements under the federal Violent Crimes Control Act, under 18 U.S.C. §§ 1033 and 1034, to gather any necessary authorizations and records to conduct criminal history background checks on all new hires assigned to perform services under this Exhibit B. Co-Administrators shall ensure that PBM contracts, and PBM will contract with an outside vendor to perform such background checks. The purpose of conducting such background checks will be to identify whether a person's record contains any prior history of the following:

(a) Plea of guilty or no contest to any state or federal felony; or

(b) Conviction under any state or federal felony law.

Co-Administrators shall complete, and shall ensure that PBM complete, all background checks prior to the date any new hire is assigned to begin performing any services for or on behalf of Emblem and shall conduct ongoing screening of its personnel and Subcontractors as set forth below. Any person with any such felony record will be ineligible to perform services in connection with this Exhibit B or the Pharmacy Services. Co-Administrators shall, and shell ensure that PBM shall, conduct all such screenings as set forth below, which shall include, but not limited to, all such screenings and background check requirements as may be required by the State of New York regulatory authorities and the Centers for Medicare and Medicaid Services. Co-Administrators shall ensure that PBM produces, and Emblem and PBM will produce documentation of their compliance with these requirements upon Plan Sponsor request. The foregoing shall be performed in compliance with Applicable Law.

2.9.1 Sanction Screening. The federal and state governments exclude certain individuals and entities (each an "Excluded Party" and together "Excluded Parties") from participation in Medicare, Medicaid and similarly funded programs because of certain crimes, including, but not limited to, healthcare fraud, patient abuse, felony drug charges, and default on a healthcare student loan. All providers of health care related services including PBM′s associated medical professionals are prohibited from paying for any items or services from an Excluded Party. Co-Administrators shall ensure that PBM screens, and PBM is required to and shall regularly screen employees, temporary workers, volunteers, consultants, governing body members, and First Tier, Downstream and Related Entities ("FDR") against relevant exclusions lists prior to hiring or contracting and monthly thereafter and require its downstream entities to do the same. In addition, Co-Administrators shall ensure that PBM complies, and PBM is required to comply with Emblem′s Sanction Screening Program (the "Screening Program").

Co-Administrators shall ensure that PBM maintains, and PBM must and shall retain a Sanction Screening vendor to review the HHS OIG List of Excluded Individuals and Entities ("LEIE List"), the GSA System for Award Management ("SAM"), Excluded Parties Lists System ("EPLS"), Social Security Administration Death Master File ("SSADMF"), Office of Foreign Assets Control ("OFAC"), and New York State Office of the Medicaid Inspector General ("OMIG") prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or FDR, to ensure that none of these persons or entities is excluded or has become excluded from participation in federal or state programs.

Co-Administrators shall ensure that PBM retains, and PBM must also retain a Sanction Screening vendor to conduct monthly screening/validation of itself as an entity and any individuals that will be performing any of the services described in an SOW governed by this Exhibit ("Assigned Individuals") or who routinely interact directly with Emblem.

All screening results must be retained by PBM for the established Records Retention period outlined in the Agreement, including Section 4.3 of this Exhibit B, and shall be provided to Emblem within five (5) business days of a written request for such records. Emblem may request results for a specific individual or group of individuals, or from a specific time, or any combination thereof, including, but not limited to, all results in PBM's possession. Results should be sent to: screening@EmblemHealth.com or as otherwise directed at the time of said request.

Any Assigned Individual who is identified as excluded from participation in federal or state programs must immediately cease performing work in connection with this Exhibit B or the Pharmacy Services and be prohibited from accessing any Plan Sponsor Confidential Information in any form by Emblem and PBM. Emblem shall promptly report all allegations of any Excluded Party hereunder to Plan Sponsor.

2.10 **Use of Subcontractors**. Co-Administrator or PBM may contract with one or more Subcontractors (also referred to herein as "designees") in order to assist in providing the Pharmacy Services or satisfy other Co-Administrator or PBM obligations set forth under this Exhibit B, subject to all provisions applicable to Subcontractors set forth in the Agreement. Upon Plan Sponsor's request, an annual oversight attestation shall be provided attesting that any Subcontractors have agreed to provide any subcontracted services or delegated functions consistent with Applicable Laws and any other applicable terms and conditions of the Agreement including, but not limited to, this Exhibit B.

2.11 **Final Authority.** Co-Administrators agree that Plan Sponsor has final authority and responsibility to manage the operation and administration of the Benefit Plan. Co-Administrators and PBM, in the performance of the Pharmacy Services, shall abide by all decisions made by Plan Sponsor with respect to the Benefit Plan. PBM and Co-Administrators shall obtain Plan Sponsor**'s** guidance regarding any questions it may have regarding the operation or interpretation of the Benefit Plan.

2.12 **Payments to Participating Pharmacies.** Plan Sponsor's liability, if any, for payments to a Participating Pharmacy by PBM or Co-Administrators with respect to Covered Products dispensed to Members shall be fully satisfied by the payments made by Plan Sponsor to the Co-Administrators under the Agreement, including, without limitation, this Exhibit B. As between Plan Sponsor and Co-Administrators, Co-Administrators shall assure that PBM, its Subcontractors, and each Participating Pharmacy looks only to the Co-Administrators, and not to Plan Sponsor, for all payments for Covered Products that may be due to such Persons.

3. CERTAIN PHARMACY MANAGEMENT SERVICES

3.1 Rebate Services

3.1.1 Negotiating Manager and Rebate Conditions. Co-Administrators shall ensure that PBM negotiates, and PBM, its designee or GPO will negotiate on behalf of Emblem (including for Plan Sponsor) with Manufacturers to obtain Rebates for Covered

Products. Rebates from any Manufacturer will accrue, if at all, only after five (5) conditions precedent are satisfied:

(a) PBM, its designee or GPO has entered into a contract or reimbursement agreement with the Manufacturer for Rebates ("Manufacturer Agreement");

(b) The applicable Manufacturer has agreed to accept Claims for purposes of Rebates;

(c) Emblem has distributed or made available electronically a Formulary to Members or others as may be required by a Manufacturer;

(d) Emblem has satisfied the conditions for Rebates as set forth in the Manufacturer Agreement and conveyed by PBM to Emblem in writing; and

(e) A Manufacturer has paid Rebates on the particular Covered Product utilized by a Member.

Emblem acknowledges that whether and to what extent Manufacturers are willing to provide Rebates to PBM, its designee or GPO on behalf of Emblem including Plan Sponsor, will depend upon Formulary status and the Benefit Plan design, as well as PBM receiving reasonable information, as agreed upon by Emblem and PBM, regarding each Claim submitted to Manufacturers for Rebates. It is understood by Emblem that PBM ability to earn Rebates on behalf of Emblem including Plan Sponsor, ultimately resides separately with each Manufacturer with which PBM, its designee or GPO has entered into a Manufacturer Agreement and that PBM does not and cannot guarantee that Rebates will accrue for any Covered Products utilized by Members.

3.1.2 Rebate Payment. Co-Administrators shall ensure that PBM pays, and PBM will pay to Emblem one hundred percent (100%) of the Rebate amount Emblem receives within the six (6) months after the end of the calendar quarter in which the Claim is adjudicated and will supply Emblem with supporting reports containing sufficient detail and information, as agreed to by the PBM and Emblem or required to comply with Applicable Law and this Exhibit B. Emblem shall pay Plan Sponsor one hundred percent (100%) of the Rebate amount which Emblem is entitled to on behalf of the Plan Sponsor under Emblem's agreement with PBM no later than one hundred fifty (150) days after the end of the calendar quarter in which the Claim is adjudicated. Co-Administrators shall ensure that PBM provides, at Plan Sponsor's request, any and all supporting documentation with sufficient detail and information for Plan Sponsor to audit the amounts paid to PBM and paid by PBM to Emblem.

3.2 **Claims Processing and Eligibility Services**

3.2.1 Benefit Plan Information Services. Co-Administrators shall ensure that PBM implements, and PBM shall accurately implement and enter Benefit Plan(s) (tailored to the applicable ACA Coverage, Diabetic Mandate Coverage and Optional Rider Coverage, and associated Member groups under the Benefit Plan) and Pharmacy Network information into the Claims Adjudication system as soon as practicable after receiving such information from Emblem and agrees that it will enter such data no later than five (5) business days after receiving the data from Emblem, such that all testing phases shall be completed within such timeframe such that a Claim will process accurately within such five (5) business day timeframe. If benefit build includes networks, it will be completed within thirty (30) calendar days. Co-Administrators shall ensure that PBM loads, and PBM shall load the eligibility file within twenty-four (24) hours of receipt from Emblem and shall provide confirmation upon completion. Co-Administrators shall ensure that PBM exercises, and PBM will exercise reasonable care in updating all information provided to it by Emblem regarding Emblem and the Members.

3.2.2 Adjudication and Payment of Electronic Prescription Drug Claims from Network Participants. Co-Administrators shall ensure that PBM adjudicates and pays, and PBM will adjudicate and pay Claims, to include actual payment to Network Participants, for Covered Products electronically submitted by Network Participants through the Claims Adjudication system, according to the Benefit Plan, including Member eligibility, and reflecting other information submitted by Emblem in accordance with Applicable Law and the Agreement, but within thirty (30) days from the date of service. Co-Administrators shall ensure that PBM uses, and PBM shall use the Claims Adjudication system JUDI. Co-Administrators shall ensure that PBM facilitates, and PBM will facilitate payment of eligible Claims and provide to the submitting entity electronic notification of declined or ineligible Claims. Such Adjudication will include eligibility and coverage determination in accordance with the Benefit Plan including calculation of allowable charges and applicable Member Cost Sharing Amounts, and communication of payment disposition to Network Participants and any other actions in this Exhibit B.

3.2.3 Adjudication and Payment of Paper Claims from Members. Co-Administrators shall ensure that PBM adjudicates and pays, and PBM will adjudicate and pay Paper Claims received from a Member in accordance with the Benefit Plan. Co-Administrators shall ensure that PBM adjudicates and pays, and PBM will adjudicate and pay, to include actual payment issued to Members, as applicable, Paper Claims received from a Member. Paper Claims must be adjudicated and paid within the timeframes set forth by Applicable Law, but, in any event, within forty-five (45) days of the date of service. Co-Administrators shall ensure that PBM is responsible for, and PBM will be responsible for all interest, penalties and fines associated with late claims payment.

3.2.4 Subrogation Claims. Co-Administrators shall ensure that PBM adjudicates and processes, and PBM will adjudicate and process Subrogation Claims on behalf of

Plan Sponsor. If a state or federal government agency submits the Subrogation Claims on-line using the on-line Claims Adjudication System, the provisions contained herein shall apply.

3.2.5 Processing Subrogation Claims. Emblem agrees that any Subrogation Claims that are submitted to PBM for payment that predate the Service Start Date of the Agreement shall be processed in accordance with this Exhibit B and Subrogation Claims that are received after the termination or expiration of this Exhibit B, but filled prior to the termination or expiration, shall be processed consistent with Claims run-off provisions as set forth in the Agreement.

3.2.6 NDC File. Co-Administrators shall ensure that PBM maintains, and PBM will maintain a National Drug Code ("NDC") File ("NDC File") for Covered Products and required elements for each NDC. Co-Administrators shall ensure that PBM updates, and PBM will update the NDC File no less frequently than monthly with information provided by a nationally recognized third-party drug database and definitions related thereto with the equivalent nomenclature from the alternative pricing source. Co-Administrators shall ensure that PBM does not use, and PBM shall not use more than one (1) pricing source unless otherwise required by Applicable Law shall use the same pricing source for invoicing Plan Sponsor and for paying Network Participants and Members, and shall provide Plan Sponsor with prior written notice before changing pricing sources.

3.2.7 Sampling/Testing. Co-Administrators shall ensure that PBM conducts, and PBM will conduct appropriate testing according to formal documented testing procedures before releasing any new, changed or corrected Benefit Plan information or Formulary setup for the Benefit Plan in PBM Claims Adjudication system production environment. This testing shall not relieve PBM of its obligations to implement any changes to Benefit Plan and Pharmacy Network information into the Claims Adjudication system.

3.3 Formulary

3.3.1 Formulary. Co-Administrators shall ensure that PBM provides, and PBM will provide Emblem with the Formulary, in accordance with the Benefit Plan and the Agreement, including reflecting the Benefit Plan's applicable ACA Coverage, Diabetic Mandate Coverage and Optional Rider Coverage, and associated Member groups, and will update the Formulary in a regular, timely, knowledgeable and professional manner.

3.3.2 Formulary Standards and Activities. Co-Administrators shall ensure that PBM provides, and PBM will provide Formulary services in accordance with National Committee for Quality Assurance and URAC standards using the PBM P&T Committee or Emblem's P&T Committee. These activities will include, but are not limited to, the following:

(a) Coordination of P&T Committee meetings at least quarterly to include developing the agenda, distributing materials and coordination of meetings;

(b) Quarterly therapeutic class reviews resulting in a complete review of all drug categories on a yearly basis;

(c) Drug monographs as needed for evaluating the Formulary status of individual drugs; and

(d) Formulary publications including electronic web-based products (formulary printing will be subject to additional fees).

3.4 **Clinical Services.** Co-Administrators shall ensure that PBM provides, and PBM will provide Clinical Services, including but not limited to Utilization Management ("UM") Program Services, as described more fully in the Clinical Management Core Services attached as Schedule B-1, and the Pharmacy Services described attached as Schedule B-3 and B-4 ("Clinical Services"), which will be performed in compliance with URAC and NCQA standards, and all Applicable Laws and the Agreement. In the event additional Clinical Services are requested in addition to those set forth in Schedule B-3 and B-4, such services may be subject to additional Fees as agreed upon by the Parties.

3.5 **Transparency.** PBM has committed to a consultative business arrangement in which trust and transparency are fundamental. Co-Administrators shall ensure that PBM provides, and PBM agrees to provide consultation and development of benefit management programs in a responsible manner which focuses on transparency in cost and ability to deliver financial results to Plan Sponsor and openly provides detail regarding any value maintained by PBM.

3.6 **Overpayment and Recovery Services.**

3.6.1 Overpayments. Co-Administrators shall ensure that PBM recovers Overpayments identified by Plan Sponsor, Co-Administrators or PBM pursuant to any of the audit provisions set forth herein by employing appropriate outreach to Network Participants to demand reimbursement. If an Overpayment is the result of the errors or omissions of either Co-Administrator or PBM, an amount equal to the overpaid amount will be fully credited to Plan Sponsor on a dollar-for-dollar basis without offset for Co-Administrators' or PBM's expenses and regardless of the outcome of Plan Sponsor's recovery process.

3.6.2 Recovery Process. Plan Sponsor delegates to Co-Administrators the discretion and authority to develop and use standards and procedures for any non-class action Overpayment recovery opportunity, including but not limited to, whether or not to seek recovery, what steps to take if Co-Administrators decide to seek recovery, whether to initiate litigation or arbitration, the scope of such litigation or arbitration, which legal theories to pursue in such litigation or arbitration, and all decisions relating to such litigation or arbitration, including but not limited to, whether to compromise or settle any litigation or arbitration, and the circumstances under

which a Claim may be compromised or settled for less than the full amount of the potential recovery. In all instances where Co-Administrators pursue recovery through litigation or arbitration, Plan Sponsor, on behalf of itself and on behalf of its Plan(s), will be deemed to have granted Co-Administrators an assignment of all ownership, title and legal rights and interests in and to any and all Claims that are the subject matter of the litigation or arbitration, subject to Co-Administrators' obligation to allocate recovered Overpayment amounts to Plan Sponsor in accordance with this Exhibit B.

Plan Sponsor acknowledges that use of Co-Administrators' standards and procedures may not result in full or partial recovery for any particular Claim. Co-Administrators will not pursue any recovery if it is not permitted by Law, or if recovery would be impractical, as determined in Co-Administrator's discretion. While Co-Administrators may initiate litigation or arbitration to facilitate a recovery, Co-Administrators have no obligation to do so; however, Plan Sponsor may request Co-Administrators to undertake or abandon litigation or arbitration with respect to any particular Claim(s), which Co-Administrators shall not unreasonably deny. If Co-Administrators initiate litigation or arbitration, Plan Sponsor will use reasonable efforts to cooperate with Co-Administrators in the litigation or arbitration and in the event Plan Sponsor requests that Co-Administrators undertake such legal action, Plan Sponsor shall pay reasonable attorneys' fees actually incurred by Co-Administrators, provided, however, that no attorneys' fees will be reimbursed (a) if the Overpayment is the result of the negligence of PBM or either Co-Administrator or any of their respective Affiliates or Subcontractors; or (b) for recoveries obtained through a class action where Co-Administrators do not file an opt-out case on behalf of Plan Sponsor.

If the Agreement terminates, in whole or in part, Co-Administrators shall continue recovery activities for any Claims paid when the Agreement was in effect pursuant to the terms of this Section 3.6 and successful recoveries will be credited to Plan Sponsor.

4. NETWORK PARTICIPANT INTERFACE AND PAYMENTS

4.1 **Claims Submission.** Network Participants will be required to submit Claims for Covered Products to PBM in accordance with the procedures detailed in the National Council of Prescription Drug Programs ("NCPDP") Online Claims Submission Telecommunication Standard.

4.2 **Claims Quality.** Co-Administrators shall ensure that PBM performs, and PBM will perform online edits of the information contained in the Claims based upon the provisions and guidelines of the Benefit Plan. Missing, illegible or erroneous information will cause such Claims to be rejected and the Network Participant will be notified online according to the NCPDP standards for communicating such rejections. All rejected Claims must be resubmitted in their entirety.

4.3 **Payment Methodology/Network Participant Reimbursement Calculation.** Co-Administrators shall ensure that PBM pays, and PBM will pay Claims consistent with the

Agreement, including, but not limited to this Exhibit B and the Benefit Plan. Reimbursement to the Network Participant will be based upon the agreed-upon pricing contained in the Network Contract with the Network Participant on the date the Covered Product transaction is processed, within time frames established by Emblem and PBM and in accordance with the Agreement and all Applicable Laws, including prompt payment laws.

4.4 **Payment to Network Participants.** Co-Administrators shall ensure that PBM initiates, and PBM will initiate payment to each Network Participant to which remuneration is owed, in accordance with Applicable Law, the Agreement and the applicable Network Contract. Co-Administrators shall ensure that PBM provides, and PBM will also provide a Claims reconciliation report to each Network Participant that has submitted Claims. If a Claim is reversed after PBM has made payment, Co-Administrators shall ensure that PBM uses, and PBM will use commercially reasonable efforts to recover the payment on the reversed Claim.

5. CERTAIN AUDIT PROVISIONS

5.1 **Records Retention**. Co-Administrators shall ensure that PBM maintains, and PBM will maintain records of the Pharmacy Services provided, including information provided to it by Network Participants, in connection with Claims Adjudication, Claims payment or prescription fulfillment for at least ten (10) years after the dispensing date, processing date, reprocessing date, or such longer time period as may be required by Applicable Law or the Agreement. Such records will be maintained in a format and media mutually agreed to by the Parties in accordance with industry standards and Applicable Law, and available for audit by any Auditing Party in accordance with the Agreement.

5.2 **Financial Statements**. Co-Administrators shall ensure that PBM prepares, and PBM will prepare and maintain financial statements in accordance with GAAP and will provide its most recent annual financial statements to Emblem prior to execution of this Exhibit B and upon request by Emblem at any time and from time to time, including for review by Plan Sponsor. In addition, the Auditing Parties, may conduct an annual audit (onsite or remote, subject to the Auditing Parties' discretion) consistent with the terms of Schedule B-5, consisting of an audit of financial records, performance with respect to the terms of the Exhibit B and compliance with Applicable Laws. To the extent that deficiencies are identified by Plan Sponsor, and notwithstanding any other provision of the Agreement, additional audits or reaudits of certain areas or functions may be conducted.

5.3 **Financial Records; Audits**. Co-Administrators shall ensure that PBM prepares, and PBM will prepare and maintain all financial records that are necessary or appropriate to comply with the requirements of this Exhibit B and to clearly support all invoices and payments received. Co-Administrators shall ensure that PBM provides, and PBM will provide copies of all records to Emblem and Plan Sponsor pursuant to this Section and the Audit Protocol set forth in Schedule B-5. In the event Emblem or Plan Sponsor reasonably suspects PBM of fraud, waste and abuse, this shall not be limited to the annual audit; the Auditing Parties, may audit at any time with regard to suspected fraud, waste and abuse activities. In the

event an audit results in an audit finding that any payments have been made to PBM in excess of the actual amounts owing, the finding will be presented to PBM who shall have ten (10) days to respond to Plan Sponsor with regard to the finding. Once agreed upon (or once the ten (10) days has passed without an adequate response (a request for an extension shall not be considered a response)), Co-Administrators shall ensure that PBM reprocesses, and PBM will reprocess the claims and make corresponding adjustments to Emblem through credits to a future invoice within sixty (60) days, which Emblem shall provide to Plan Sponsor, in accordance with the Agreement. In the event that PBM fails to make such payments, Emblem may withhold from any future amounts payable to PBM the amounts determined to be owing as a result of the audit until paid in full and may take any other action permitted under this Exhibit B. Co-Administrators shall ensure that PBM provides, and PBM shall provide a corrective action plan to Emblem to prevent any such issues, to the extent systemic or from re-occurring.

5.4 **Access to Other Records; Performance Audit**. In addition to the requirements above, Co-Administrators shall ensure that PBM prepares and maintains, and PBM will accurately and completely prepare and maintain all data, information, and records that relate to, reflect, evidence, or support the performance of the services performed by PBM and its Subcontractors consistent under this Exhibit B, the Agreement and with Applicable Law. Co-Administrators shall ensure that PBM provides, and PBM will provide all records, documents, otherwise, and data related to the Pharmacy Services provided under this Exhibit B for the time period of the audit as defined by Emblem or Plan Sponsor; this will include all functions as set forth in Exhibit B, and may include audit reports for Network Participants and Network Contracts to ensure that no changes have been made that would have required approval by NYS DOH or under other Applicable Law. The Plan Sponsor is granted audit rights with respect to Emblem under the Agreement, including this Exhibit B, and Co-Administrators shall ensure that PBM makes available, and PBM shall make its personnel and books and records available to the Auditing Parties on the same basis as Emblem makes its personnel and books and records available to Plan Sponsor, and in conformity with this Exhibit B, including Schedule B-5. Plan Sponsor and Emblem shall each notify the other of all audit requests made to PBM. Emblem shall coordinate and support all audits of PBM by Plan Sponsor.

5.5 **Performance Audits**. At times reasonably agreed upon by the Parties during the Term, any of the Auditing Parties will have the right, with sufficient written notice, to enter the premises of PBM and to conduct a performance audit in order to ensure compliance with the requirements of this Exhibit B and with all legal and other obligations by PBM and any of its Subcontractors in the performance of this Exhibit B and the Agreement. Co-Administrators shall ensure that PBM accommodates and provides, and PBM and its respective officers, employees, agents, and representatives will accommodate and provide all reasonable facilities for and assistance to the Auditing Parties and will fully cooperate and assist the Auditing Parties in obtaining all documents, records, and data requested by Plan Sponsor and in completing the performance audit. Plan Sponsor may elect to conduct the audit remotely. Co-Administrators shall ensure that PBM accommodates and provides,

and PBM shall provide all data, documents and records in the timeframe set forth in the audit notice.

5.6 **Audit Results**. In the event that as a result of any audit, as described herein or pursuant to Emblem's agreement with PBM, Emblem, Plan Sponsor, or any Auditing Party determines that PBM has failed to satisfy any requirement under this Exhibit B (financial, performance, regulatory, or otherwise), Plan Sponsor or any Auditing Party will prepare and submit to Emblem and PBM a written report with respect to any such finding. Co-Administrators shall ensure that PBM responds, and PBM will respond in writing to the findings set forth in the audit report within thirty (30) days after receipt of the report, unless a shorter response time is specified in the report or is otherwise specified by Emblem, providing a copy to Plan Sponsor, which response will include a corrective action plan ("CAP") and schedule to promptly address and resolve any deficiencies, concerns, and/or recommendations in the audit report. If such response is not acceptable to Plan Sponsor, Plan Sponsor will have the right to terminate this Exhibit B upon notice to the Co-Administrators. If such response is acceptable to Plan Sponsor, Co-Administrators shall ensure that PBM executes and monitors, and PBM will execute and monitor the approved CAP and schedule and will continue to be subject to additional audits as provided in this Section and the Agreement.

5.7 **Audits of Third Party Agreements**. The Auditing Parties shall be permitted to audit agreements between PBM or its Subcontractors or designees as outlined below. The Parties agree that the terms and conditions set forth below shall not apply in the event Plan Sponsor is required by Applicable Law or a regulatory authority to conduct a more detailed or robust audit or to produce records beyond what is described below, or, as otherwise set forth in the Agreement, or, in the event of Plan Sponsor's reasonable suspicion of fraud, waste and abuse.

5.7.1 With respect to Network Contracts held by PBM's designee: Emblem and Plan Sponsor, respectively, shall, at a minimum, have the right to audit the number of PBM or designee agreements necessary to enable the audit of up to fifty percent (50%) of Plan Sponsor's total Claims revenue for two (2) calendar quarters during the twenty-four (24) month period immediately preceding the audit.

5.7.2 Audits by Regulatory Authorities. Emblem shall, within three (3) business days of receipt, provide Plan Sponsor and PBM with written notice of any pending, or any requests for, audits by any governmental or regulatory authority related to the Benefit Plan or the Agreement of which Emblem becomes aware, and Emblem and PBM shall provide all audit support and access to documents and personnel necessary to satisfy such audit request, subject to specific direction by Plan Sponsor.

6. TERMINATION

6.1 **Complete or Partial Termination of this Exhibit B**.

The Pharmacy Services can be terminated upon Plan Sponsor's exercise of any partial or complete termination rights available to Plan Sponsor pursuant to Section 10.2 of the Agreement, including, without limitation, Plan Sponsor's right to terminate this Exhibit B at any time without cause pursuant to Article 10 of **Appendix A**. Any such termination of Pharmacy Services by Plan Sponsor without cause shall be subject to the Insourcing Request process set forth under Section 6.10 of the Agreement, except if such termination is in connection with Plan Sponsor's termination of the Agreement.

6.2 **Certain Obligations upon Termination of this Exhibit B**.

6.2.1. Obligations Upon Termination. In addition to and without limiting the termination-related provisions set forth elsewhere in the Agreement, including, without limitation, Section 6.10 and 10.3 of the Agreement, the additional provisions of this Section 6.2 shall apply to the Pharmacy Services.

6.2.2. Upon notice of termination of the Agreement and/or this Exhibit B, or upon notice by Emblem to Plan Sponsor of its intention to change an existing PBM to a successor PBM, the Parties will mutually develop and execute a run-off plan providing for Plan Sponsor notification to Members of the timing of any Transition to a successor pharmacy benefit manager at least one hundred eighty (180) days prior to the effective date of such termination, as well as any other termination services in a manner and timeframe as reasonably agreed to by Emblem, PBM and Plan Sponsor. The run-off plan shall include, without limitation, a process for coordinating ORTFs for Plan Sponsor Members upon notification to PBM sixty-five (65) days prior to Plan Sponsor transition date; this shall be subject to applicable fees in Schedule B-2.

6.2.3 Data Return and Destruction. Upon termination of this Exhibit B, or upon Transition of a current PBM to a successor PBM, the terminating PBM will, within ninety (90) days, or such other time mutually agreed upon, securely return to Emblem, or, at Plan Sponsor's direction to Plan Sponsor or its designee, all Plan Sponsor Data in PBM's possession. Upon termination of this Exhibit B, or upon termination of an PBM, the PBM may, in compliance with the Agreement including, without limitation, the HIPAA Business Associate Agreement between Plan Sponsor and Emblem under the Agreement retain copies of the minimum necessary amount of Plan Sponsor's Data as may be required for PBM to comply with Applicable Laws. At such time when such PBM is no longer required to retain such Plan Sponsor Data under Applicable Laws and the Agreement, it will dispose of such Plan Sponsor Data in a secure manner that makes it unreadable or indecipherable by any means, including in compliance with other applicable terms of the Agreement, including, without limitation, the HIPAA Business Associate Agreement between Plan Sponsor and Emblem under the Agreement. Co-Administrators shall ensure that PBM extends, and PBM will extend the protections of this Exhibit B to Plan Sponsor Data for so long as PBM retains Plan Sponsor Data.

7. MISCELLANEOUS

7.1 **Insurance**. In addition to and without limiting the insurance related provisions set forth elsewhere in the Agreement, Co-Administrators shall ensure that PBM maintains, and PBM shall be required to maintain policies of insurance coverage. Emblem shall ensure PBM has delivered a certificate of insurance evidencing such coverage and any applicable endorsements or additional insured designations prior to the Effective Date and that PBM will deliver updated certificates of insurance from time to time during the Term.

7.2 **Conflicts**. The Parties acknowledge and agree that this Exhibit B sets forth the Parties understanding with regard to the delivery of Pharmacy Services. In the event that any language in this Exhibit B conflicts with language in the Agreement, solely with regard to the delivery of Pharmacy Services, this Exhibit B shall control.

List of Attachments/Exhibits

Schedule B-1 – Discount and Dispensing Fees
Schedule B-2 – Minimum Rebate Guarantees and Other Fees
Schedule B-3 –Pharmacy Services Grid
Schedule B-4 – Clinical Management Core Services
Schedule B-5 – Pharmacy Related Audits of PBM (excluding medical drugs)
Schedule B-6 – Performance Guarantees
Schedule B-7 – Specialty Product List

Schedule B- 1

(redacted)

Schedule B-2 (redacted)

Schedule B-3
Pharmacy Services Grid –Division of Operations

Services List	PBM	Emblem
Clinical Programs		
Concurrent Drug Utilization Review (cDUR)	X	
cDUR Messaging	X	
Retrospective Drug Utilization Review (rDUR)	X	
Medication Therapy Management Program	X	
Communications		
ID Cards		X
Welcome Booklet		X
Pharmacy Termination Letters	X	
EOB Creation and Mailing	X	
Drug Recall Notifications	X	
Formulary Marketing Materials	X	
Negative Formulary Change Letters	X	
Customer Services		
Inbound Member Call Center (24/7)	X	
Inbound Member Call Center (afterhours, holidays, weekends)	X	
Inbound Provider Call Center	X	
Inbound Pharmacy Call Center/ Pharmacy Help Desk	X	
DMR (Direct member reimbursement/paper claims)	X	
Grievances/Complaints		X
Digital		
Mobile App	X	
Member Portal	X	
Open Enrollment (OE) Portal	X	
Public Portal (with Find Pharmacy)	X	
Rebate Administration		
Pharmacy Drug Rebate Administration	X	
Formulary Management		
Formulary Management (i.e. Changes / Additions / Deletions, etc.)	X	
P&T Committee	X	
Negative Formulary Change Process	X	

Services List	PBM	Emblem
Custom Formulary Management		X
Operations		
Member/Provider/Pharmacy Lock-In Program		X
Medicaid Claim Subrogation	X	
Networks		
Retail Standard Pharmacy Network	X	
Retail Custom Network Management		X
Mail Standard Pharmacy Network	X	
Mail Custom Network Management		
Specialty Pharmacy Network	X	
Specialty Custom Network Management		
Custom Network Exclusions		X
Pharmacy Audit - Standard FWA	X	X
Utilization Review/Clinical Operations		
Prior Authorization (PA) - Full Delegation	X	
DUR (concurrent and retrospective)	X	
Intake/Data Entry	X	
UM Criteria	X	
PA letters (member/prescriber)	X	
PA outbound calls (prescriber)	X	
ePA - auto decisioning	X	
Date Entry/Intake	X	
Decisioning	X	
Decision tree management	X	
Appeals Level 1		X
Appeals Level 2		X
Independent Review Organization (IRO) services - access panel of IROs for external reviews		X
EHR/ Formulary Check (SureScripts)	X	
Self Service PA Tool - PAT	X	

Schedule B-4
Clinical Management Core Services

The following pharmacy clinical programs shall be provided as Pharmacy Services (excluding medical pharmacy) as a Clinical Management Core Service. Specifically, Clinical Management Core Services (or "Core Services") shall include the following programs: Utilization Management ("UM") and UM Programs as defined below; Drug Utilization Review Programs ("DUR") including Retrospective and Concurrent DUR; PBM Drug Alerts; and PBM Drug Information and Pipeline Publications. In the event Plan Sponsor elects in writing to receive additional services that exceed the scope of services set forth herein, the Emblem and PBM shall mutually agree to new service terms and present to Plan Sponsor, who shall mutually agree in writing on corresponding fee adjustments, if any.

Utilization Management (General)
I.A. Utilization Management (UM) Services:

PBM fulfillment of the Pharmacy Services on behalf of Plan Sponsor as set forth in Exhibit B-3, the Pharmacy Services Grid. These services include the following:

1) Provision of all clinical criteria supporting UM programs as described below and within Schedule B-3. This includes, but is not limited to, all new development and ongoing maintenance of clinical criteria.

2) Development and maintenance of a UM-specific work plan, program description and annual assessment and evaluation, and plan-specific policies and procedures necessary to be an NCQA/URAC delegate and to support any applicable state and federal compliance requirements as outlined in the Delegation Exhibit.

I.B UM Programs:
PBM Utilization Management program includes protocols for the following UM programs and are Core Services:

- Step Therapy
- Quantity Limits
- Prior Authorizations
- Formulary Exceptions
- Experimental and investigational drugs

I.C. UM Programs Support:
Co-Administrators shall ensure that PBM performs, and PBM shall perform the following Core Services to support the UM Program:

1. Implementation and ongoing support of UM programs; including but not limited to:
    a. electronic marketing materials
    b. physician fax forms,
    c. Member and physician education,
    d. notification letter templates,

e. benefit testing and set-up,
f. savings assessment and group-level reports

Clinical Reviews that are included in Section B-2 as Ancillary Services are not included in the Core Services.

Drug Utilization Review Programs
Co-Administrators shall ensure that PBM addresses, and PBM addresses drug therapy opportunities through retrospective and concurrent drug utilization programs.

II.A. Retrospective DUR

PBM evidence-based retrospective drug utilization review protocols (e.g. GuidedHealth®), shall be used by Emblem to contact Plan Sponsor's Members and/or physicians on important messages about drug therapy. Emblem shall use selected programs, as agreed upon in writing by Plan Sponsor, that focus on drug overutilization, underutilization, safety and drug cost management. After each program's messaging campaign, Emblem receives activity and outcomes reports.

II.B. Concurrent DUR

Automated system edits identify various drug-drug interactions, dosage, drug/age, and drug/gender messages to pharmacists at the time of service.

Concurrent DUR edits include, but are not limited to, the following conflicts:

1. Therapeutic duplication
2. Age/sex-related contraindications
3. Overutilization and underutilization
4. Drug-drug interactions
5. Incorrect drug dosage or duration of drug therapy
6. Drug-allergy contraindications
    a. Pharmacies contracted in the network are required to have a drug-allergy review system
7. Additive Toxicity of acetaminophen-containing drug products
8. Opioid abuse/misuse

III. PBM Drug Alert – Safety Drug Withdrawal Notification
Class I Drug Recalls and Withdrawals

Co-Administrators shall ensure that PBM identifies, and PBM identifies impacted Members and physicians when Key Drugs (defined below) are removed from the market. Key Drugs are those FDA Class II recalls or voluntary drug withdrawals for safety reason and Class I recalls. This process is done only at the Emblem level and is administered in compliance with NCQA standards. PBM can notify Members and physicians per Emblem's request on behalf of Plan Sponsor.

IV. PBM Drug Information and Pipeline Publications

PBM Drug Insights:

Co-Administrators shall ensure that PBM sends, and PBM shall send its providers via e-mail electronic newsletters and drug alerts providing up-to-date drug related information. The Pipeline Updates for both Specialty Products and non-Specialty Products are sent on a monthly basis and report on recent approvals, investigational drugs, and recent and anticipated generic launches. Drug Alerts, regarding recent safety issues, and generic drug announcements are sent on an as needed basis.

Co-Administrators shall ensure that PBM provides, and PBM shall provide the following UM Program Services:

2.1 Implementation and maintenance of a written Utilization Management (UM) Program ("Program") description, which outlines the Program structure and accountability under the direction of PBM Chief Medical or Chief Clinical Officer.

2.1.1 The UM Program description includes the scope of the Program and processes and information sources used by PBM to make determinations of initial approvals for quantity exceptions, and/or step therapy, Prior Authorizations and formulary exceptions for Emblem.

2.1.2 The UM Program is evaluated in a comprehensive written annual evaluation and assessment and approved at least annually by PBM Internal Clinical Quality and Outcomes Committee, with approval by PBM Chief Medical or Chief Clinical Officer.

2.1.3 The UM program description is updated at least annually or more frequently as necessary to address legal, contractual or business changes by PBM.

2.2 Co-Administrators shall ensure that PBM develops, and PBM shall develop and use written criteria for the Program based on sound clinical evidence and specify procedures for applying those criteria to the Program in an appropriate manner as reviewed by the PBM UM P&T Committee and approved by Emblem.

2.2.1 The criteria for applying and determining quantity exceptions, step therapy evaluations and formulary exceptions are clearly documented and include procedures for applying criteria based on the needs of individual Members, the characteristics of the local delivery system and the requirements of Applicable Laws. Co-Administrators shall ensure that PBM makes, and PBM shall make such criteria available to Emblem at all times via a web-based portal. Emblem, with the written agreement of Plan Sponsor, shall have option to elect to use a custom or alternative clinical criteria and Co-Administrators shall ensure that PBM provides, and PBM shall provide Emblem with a corresponding analysis regarding any loss of Rebate value.

2.2.2 Co-Administrators shall ensure that PBM involves, and PBM shall involve appropriate, actively practicing health professionals which shall include physicians, and pharmacists in the development or adoption of criteria and in the development and review of procedures for applying the criteria, as required by Applicable Laws or NCQA.

2.2.3 Co-Administrators shall ensure that PBM reviews, and PBM shall review the criteria for its Program annually, and more frequently as required by the introduction of new drugs to the market, and update the criteria and the procedures for applying them, as necessary.

2.2.4 Co-Administrators shall ensure that PBM provides, and PBM shall, in writing, provide instructions to practitioners on how to obtain the clinical criteria and ensure that the criteria are made available to practitioners upon request. Where required by Applicable Law or contract, PBM shall ensure that the clinical criteria are accessible to both practitioners and members without the need for login credentials or any other access restrictions.

2.2.5 PBM UM P&T Committee shall consist of the number of members determined by PBM as reflected in the UM P&T Committee charter. Members may be physicians or pharmacists. The Committee membership must be comprised of actively practicing physicians/pharmacists. An exception to this requirement is that the Chairperson does not need to be an actively practicing physician. Practitioners must spend at least fifty percent (50%) of their time in direct patient care, or be academicians with a clinical focus. The identity of the Committee Members will remain confidential, and no Committee Members shall disclose, other than as necessary within their own organizations or as otherwise required by law, their or any other Committee Members' membership in the Committee. Employer groups may not participate in PBM P&T Committee but may make recommendations through Emblem.

2.3 Co-Administrators shall ensure that PBM uses, and PBM shall use only qualified licensed health professionals as required by Applicable Law, including but not limited to, Article 49 of the New York Insurance Law and Public Health Law, to assess the clinical information used to support UM decisions.

2.3.1 Appropriately licensed health professionals shall supervise all of the review decisions for the Program.

2.3.2 An appropriate pharmacist and/or physician shall review any recommendation for denial of coverage for care. Co-Administrators shall ensure that PBM uses, and PBM shall use a registered clinical pharmacist to review any recommendations for denial that are based upon pre-determined, explicit, objective criteria and forwards said request to a physician reviewer for all denial determinations.

2.3.3 Co-Administrators shall ensure that PBM maintains, and PBM will maintain written procedures that are in compliance with Applicable Law, including but not limited to applicable State and federal laws for using pharmacy technicians and

registered clinical pharmacists in making recommendations for initial determinations of approval of Prior Authorization requests. To the extent that determinations are required to be communicated verbally (by state or federal law), communication shall be made by a New York State licensed Utilization Review agent.

2.3.4 Co-Administrators shall ensure that PBM provides, and PBM shall provide, and shall cause its subcontractors to provide, to Emblem a copy of the entity's New York State Utilization Review Agent license within ten (10) calendar days of receipt of the new or renewed license.

2.3.5 Co-Administrators shall ensure that PBM maintains, and PBM will maintain written procedures for using registered clinical pharmacists and for initial denial determinations.

2.3.6. For any Pharmacy Services involving UM, pre-service approvals and denials, concurrent care approvals and denials, post service approvals and denials, Prior Authorization and other applicable Pharmacy Services, Co-Administrators shall ensure that PBM utilizes, and PBM shall utilize its NCQA (and UR licensed) accredited business associate, Medical Review Institute of America (MRIoA), for physician review of denial determinations, as required by Emblem, NCQA, and Laws.

2.4 Co-Administrators shall ensure that PBM follows, and PBM shall follow the Emblem's required standards for UM decision-making for the Program as reviewed and approved by Emblem.

2.5 When making a clinical determination or an exception decision, Co-Administrators shall ensure that PBM obtains, and PBM will obtain relevant clinical information of the Member's health condition and diagnoses and consult with the treating physician, as appropriate.

2.6 Co-Administrators shall ensure that PBM maintains, and PBM shall maintain a written description setting forth all the information that is collected to support UM decision making for the Program.

2.7 Co-Administrators shall ensure that PBM performs, and Annually PBM shall perform Interrater Reliability (IRR) performance evaluations to measure the consistency in utilization management determination decisions.

2.8 Co-Administrators shall ensure that PBM provides, and PBM shall provide Emblem staff access to UM decisions made by PBM when there are appeals, and legal procedures involving the Pharmacy Services. Emblem shall perform all appeals, both level I and level II, in accordance with the Agreement.

2.9 Co-Administrators shall ensure that PBM provides, and PBM shall provide representation, as appropriate and if requested, on Emblem committees and work groups related to Pharmacy Services.

2.10 Co-Administrators shall ensure that PBM is available, and PBM shall be available to Emblem Members and Members' physicians seeking assistance with information about the

UM Program including the forms and procedures for Prior Authorization, pre-service, concurrent care, and post service approvals and denials, and exceptions and the authorization of benefits.

2.10.1 Co-Administrators shall ensure that PBM provides, and PBM shall provide the following communication services for healthcare professionals and Members:

2.10.1.a availability of staff at least eight (8) hours a day during normal business days for inbound calls regarding UM issues;

2.10.1.b ability of staff to receive inbound communication after normal business hours regarding UM issues;

2.10.1.c outbound communication from staff regarding inquiries about UM during normal business hours, unless otherwise agreed upon;

2.10.1.d staff identifies themselves by name, title and organization name when initiating or returning calls regarding UM issues;

2.10.1.e a toll-free number or staff that accept collect calls regarding UM issues;

2.10.1.f access to staff for callers with questions about the UM process.

2.11 Co-Administrators shall ensure that PBM provides, and PBM shall provide pharmaceutical safety notification to dispensing pharmacists, physicians and Members, as appropriate, regarding point of dispensing drug-drug interactions, and to physicians and Members all FDA recalls as well as voluntary drug recalls as described below.

2.11.1 Physicians, and Members are notified of voluntary drug recalls when the product is removed from the market for safety reasons.

2.11.2 Pharmacists and Members are notified of point of dispensing drug-drug interactions.

3. Co-Administrators shall ensure that PBM develops, maintains, documents and complies, and **PBM shall develop, maintain, document and comply with the following procedures for pharmaceutical management ("Drug Formulary Management"):**

3.1 Co-Administrators shall ensure that PBM promotes, and PBM ensures that its procedures for Drug Formulary Management promote the clinically appropriate use of pharmaceuticals.

3.2 Co-Administrators shall ensure that PBM supports, and PBM supports the clinical development by Emblem and/or Plan Sponsor of Drug Formulary Management procedures for medications. The Plan Sponsor formulary clinical drug reviews are based on sound clinical evidence from appropriate external organizations analyzed and summarized by PBM.

3.2.1 The Drug Formulary Management procedures shall be clearly documented and PBM shall have a defined process for applying the procedures.

3.2.2 Co-Administrators shall ensure that PBM reviews, and PBM shall clinically review its Drug Formulary Management procedures at least annually and regularly updates

the procedures as necessary and as new pharmaceutical information becomes available.

3.2.3 Co-Administrators shall ensure that PBM involves, and PBM shall involve appropriate, actively practicing health professionals, including pharmacists, in development and periodic updating, of the Drug Formulary Management procedures.

3.2.4 At least annually and when it makes changes, Co-Administrators shall ensure that PBM makes available, and PBM shall make available copies of its Drug Formulary Management procedures to Emblem, which shall be made available to Plan Sponsor.

3.2.5 Emblem and PBM annually reviews and maintains the Plan Benefit list of pharmaceuticals, including restrictions and preferences. Co-Administrators shall ensure that PBM has, and PBM shall have policies that address how to use the pharmaceuticals; an explanation of any limits or quotas; an explanation of how prescribing practitioners must provide information to support a benefit exceptions process; and the process for generic substitution, therapeutic interchange, Prior Authorization, step therapy, and formulary exception protocols.

3.2.6 Emblem, in compliance with the Agreement, shall be responsible for the implemented pharmaceutical management procedures implemented in compliance with this Exhibit B.

3.3 Co-Administrators shall provide, working with PBM,

3.3.1 Quarterly formulary committee review with Plan Sponsor and union group leader of formulary recommendations.

3.3.2 Timely response to requests from the formulary review committee for financial outcomes (change to rebate capture, rebate minimums, or changes seen in drug cost due to utilization mix change or channel management change, for requests to deviate from the formulary recommendations (e.g. not approve a formulary position, change to the clinical criteria required, etc.);

3.3.3 Process to capture the decision in benefit plan documentation for changes from the Formulary as provided and recommended by Co-Administrators and PBM; and

3.3.4 Any formulary recommendation provided by the formulary review committee to Plan Sponsor (including with regard to new to market products) shall only be implemented after notice to Plan Sponsor unless Plan Sponsor provides objection to such addition within twenty (20) Business Days after such notice.

Schedule B-5

Pharmacy Related Audits of PBM (excluding medical drugs)

In addition to and without limiting the audit related provisions set forth elsewhere in the Agreement, the following provisions and the terms and conditions of Schedule B-5, shall apply to audits regarding the provision of the Pharmacy Services:

General Audit Rights. In addition to the specific "Auditing Party" audit rights set forth in the PBM agreement to which Plan Sponsor shall benefit indirectly through Emblem as set forth of this Schedule B-5, Plan Sponsor shall have, and Co-Administrators shall ensure that Plan Sponsor has direct audit rights of PBM as described in this Schedule B-5. Throughout the Term, Plan Sponsor or the Auditing Party may audit PBM annually, at its own expense, with regard to all relevant Plan Sponsor-specific information as reasonably necessary to determine whether PBM is fulfilling the terms of this Exhibit B. Plan Sponsor may audit all aspects of PBM's services and operations including, but not be limited to administrative fees, all pricing terms (including Participating Pharmacy remittance advices), Claims Adjudication, financial guarantee terms, and all transparent and pass through components of Rebates, Manufacturer Agreements, policy and procedures, Service Levels and clinical programs, and reconciliations including all subsidy payments, transparency, pricing benchmarks (e.g., Pricing Source).

1. Audits of PBM by Plan Sponsor, shall be for the current year and the preceding year, unless a longer time period is mutually agreed upon between PBM, Plan Sponsor and Emblem.

2. The Parties agree to collaborate in good faith to develop a reasonable approach to the audit that meets the needs of Plan Sponsor (as determined by Plan Sponsor) and outlines the procedure for conducting the audit.

3. The description of claims to be audited must be provided to PBM a minimum of ten (10) business days prior to the audit.

4. Only the information necessary for Plan Sponsor to conduct a fair and valid audit will be disclosed. Any unnecessary information will be redacted before it is provided to Plan Sponsor or its Auditing Parties. PBM, Plan Sponsor and Emblem shall make the determination of what information is necessary for purposes of the audit.

5. If access to the pharmacy Network Contracts or manufacturer agreements is requested, PBM will provide access so long as PBM is legally or contractually able to do so *and* only the relevant page(s) or exhibits (that is not the entire contract) are provided for Plan Sponsor or its Auditing Parties' review.

6. Unless otherwise contractually specified or unless the audit reveals fraud, waste and abuse or a violation of applicable law by PBM, Plan Sponsor will be responsible for bearing its own costs and expenses related to the audit. PBM further reserves the right

in its sole discretion to charge Plan Sponsor an additional commercially reasonable administrative fee for costs and expenses incurred by PBM in the event that the scope materially exceeds those limits included in this Exhibit B and in the audit notification.

7. Plan Sponsor or its Auditing Parties cannot keep or make copies of any documents provided by PBM to Plan Sponsor or its Auditing Parties without PBM express written consent to do so and, if applicable, as outlined in an executed non-disclosure agreement.

8. Co-Administrators shall ensure that PBM provides, and PBM will provide Plan Sponsor or its Auditing Parties with screenshots of the claim adjudication. Plan Sponsor and its Auditing Parties will not have access to the live claims adjudication system without prior executive approval by PBM.

9. Plan Sponsor and its Auditing Parties must follow PBM visitor security policy if they are on-site.

10. Except as may otherwise be required by Applicable Law, reporting of the audit results will be restricted to Plan Sponsor and its Auditing Parties for internal use only.

11. Plan Sponsor and its Auditing Parties will provide PBM with a draft and final copy of any audit reports.

12. PBM will not be obligated to reimburse Plan Sponsor and/or Emblem or UMR for alleged errors based upon the use by the auditor of extrapolation methodologies for the purpose of inferring errors in a population of claim payments based upon the error rate in a sample drawn from that population.

13. Information concerning Plan Sponsor and Emblem, which is the subject of the auditor's final report, shall not be reaudited at any time.

14. If more than two (2) years have elapsed since PBM's processing of Plan Sponsor's pharmacy claims, those claims shall not be subject to audit without the express written permission of PBM.

15. In connection with PBM commercial agreements with PBM's third-party rebate contractor [(e.g. Express Scripts, Inc. ("ESI") and Ascent Health Services LLC ("Ascent")], PBM shall secured the ability for Plan Sponsor and the Emblem to audit certain manufacturer agreements held by PBM third-party rebate contractor (e.g. ESI and Ascent) in connection with their provision to PBM of some manufacturer contracting services.

16. In order for PBM to (as necessary) facilitate desired audits of their third-party rebate contractor, PBM, Plan Sponsor will need to adhere to the following audit protocols for audits.

17. The audit must be conducted onsite at PBM third-party rebate contractor, as applicable, by a third-party auditor that (i) has a separate, stand-alone audit division; (ii) carries commercially reasonable insurance coverage for professional malpractice; and (iii) executes a mutually acceptable confidentiality agreement with PBM third-party rebate contractor.

18. For manufacturer agreement audits:

    a. Plan Sponsor may review manufacturer agreements as reasonably necessary to audit the calculation of rebates or other manufacturer revenue payment received by Plan Sponsor and Emblem. Rebate audits will be based on the reconciliation data provided by PBM, with third-party rebate contractor data input. The reconciliation data will be available 210 days after the end of a calendar quarter.

    b. Plan Sponsor may review the number of manufacturer agreements necessary to enable Plan Sponsor to audit fifty percent (50%) of the total rebate amounts attributable to Plan Sponsor and Emblem for two (2) calendar quarters per year during the twenty-four (24) month period immediately preceding the audit.

    c. Plan Sponsor (or its auditor(s)) may take and retain notes to the extent necessary to document any identified errors, but may not copy (through handwritten notes or otherwise) or retain any manufacturer agreements (in part or in whole) or related documents provided or made available by third-party rebate contractor in connection with the audit.

19. Additional administrative protocols as communicated by PBM's client audit management team to Plan Sponsor audit team will help conduct audits.

20. **Recoveries resulting from Performance Failure**

    Without limiting any terms or conditions of this Schedule B-5, in the event of a failure resulting from a Pharmacy Related Audit of PBM, for which Co-Administrator receives financial value (if such should be the case), and such value can be directly attributed to Plan Sponsor, such amounts shall be allocated accordingly to Plan Sponsor. Should recoveries be realized they shall be provided in compliance with Section 3.6 subject to the following:

    a. To the extent that there are any claim corrections (e.g. claims reversal/resubmission), which alter claim costs such that no actual payment, i.e. direct payment in the form of a check, offset, etc. is provided to Co-Administrator by PBM, this shall not be included in any value provided to Plan Sponsor and no money shall be provided to Plan Sponsor, even if Plan Sponsor claims are included in the correction as this shall be part of routine Claims Adjudication.

b. To the extent there is a financial settlement related to the audit of PBM, pursuant to which funds are provided to Co-Administrator in a global form, whether in a reduced form or otherwise, the percentage portion of such settlement directly attributed to Plan Sponsor's membership shall be paid to the Plan Sponsor based on the allocation of the Plan Sponsors claims or data that were included in the identified audit finding. Any amounts provided to Plan Sponsor shall be a pro rata portion solely based on the actual amount received by Co-Administrator opposed to the total amount of the finding or any other amounts that any Party may believe is due.

c. Any amounts distributed to Plan Sponsor shall be only after receipt of the financial value from PBM to Co-Administrator, without any additional risk placed on the Co-Administrator.

Schedule B-6

Service Level Agreements ("SLAs")

Co-Administrators will be responsible for ensuring fulfillment of the SLAs outlined in this Schedule B-6 with respect to the Pharmacy Services.

1. INTRODUCTION

(a) Where a Service Level includes multiple conditions or components, satisfaction of each condition or component is necessary to meet the corresponding Service Level.

(b) Notwithstanding the SLAs, the Pharmacy Services will be rendered in accordance with the standard of care set forth in the Agreement, as applicable and appropriate to Pharmacy Services, and shall be conducted in accordance with the applicable established best practices of industry-leading providers of similar services.

2. DEFINITIONS

For purposes of this Exhibit B-6, the below-listed capitalized terms will have the meanings set forth below:

(a) ***"Contract Year"*** means each twelve (12) calendar month period beginning on the Service Start Date and each annual anniversary thereof.

(b) ***"Measurement Period"*** means the period during which PBM and Co-Administrators are to measure their performance against the Service Levels, which shall be specified otherwise in the applicable Service Level Table.

(c) ***"Reporting Period"*** means the period during which Co-Administrators are to report on the performance of Co-Administrators or PBM against the Service Levels, which shall be specified in the applicable Service Level Table. For clarity Reporting Period would not be less frequent than Measurement Period.

(d) ***"Performance Failure"*** means a failure of PBM or Co-Administrators, as applicable, to meet a Service Level.

(e) ***"Performance Indicator"*** means each metric set forth with respect to which PBM or Co-Administrator, as applicable, performance is to be monitored and reported and the frequency of measurement.

(f) ***"Service Level"*** means, for purposes of this Schedule B-6, the contractual standard of performance PBM or Co-Administrators, as applicable, are required to meet in relation to each Performance Indicator.

(g) ***"Service Level Performance Report"*** means the monthly performance report to be shared with Plan Sponsor (or, as applicable, made available to Plan Sponsor via the Service Level Reporting Dashboard) showing the

performance of PBM and Co-Administrators, as applicable, relative to each Performance Indicator during the applicable Reporting Period.

3. SERVICE LEVEL METHODOLOGY

3.1 Measurement Tools

(a) Co-Administrators will, and will ensure PBM will, measure performance with respect to each Performance Indicator using such means as are mutually agreed upon by the Parties in this Schedule B-6. Performance measurement and monitoring will permit reporting at a level of detail sufficient to verify compliance with the Service Levels and will be subject to audit by Plan Sponsor. Co-Administrators will, or will ensure that PBM will, as applicable: (i) implement the necessary measurement and monitoring tools and procedures required to create the Service Level Performance Report for all Performance Indicators; and (ii) maintain operational and administrative responsibility for all functions required to measure and report performance against the Performance Indicators.

3.2 Performance Methodology

(a) Except as otherwise stated in the Service Level Tables, Emblem and PBM will measure performance against all Performance Indicators on a twenty-four (24) hour a day, seven (7) days per week, three hundred sixty-five (365) days per year (24x7x365) basis.

(b) Except as otherwise specified in a Service Level Table, (i) references to hours regarding Service Levels will be to actual hours during a calendar day and not to business hours; (ii) all references to time will be to U.S. Eastern Time; (iii) all references to days, months and quarters will be to calendar days (i.e., not limited to business days), calendar months and calendar quarters; and (iv) metrics apply to all lines of business related to the Pharmacy Services, unless otherwise set forth in a Service Level Table.

3.3 Performance Reporting

(a) PBM and Co-Administrators will provide an account leader to work with performance guarantee analysts to provide monthly reporting regarding Service Levels. Co-Administrators shall either: (i) ensure that PBM provides the Service Level Performance Reporting Dashboard ("Reporting Dashboard") directly to Plan Sponsor; or (ii) provide Plan Sponsor a comprehensive Service Level Performance Report, including all supporting evidence necessary to support the Service Level Performance Report findings.

(b) All Service Level metrics shall be expressed to a minimum of two (2)

decimal points (e.g., 99.00% or 99.99%). PBM and Co-Administrators, as applicable, shall round up or down to the minimum decimal precision (e.g., if the actual Service Level achieved equals 98.50%, it shall not be rounded up to 99.00%). Conversely if the actual Service Level achieved equals 98.509%, it shall be rounded to 98.51%).

(c) Co-Administrators will, and will ensure that PBM will, promptly provide detailed supporting information for any Service Level Performance Report in a machine-readable form suitable for use on a personal computer.

(d) PBM and Co-Administrators, as applicable, shall have thirty (30) days after the Service Level Performance Report is due to report any missing metrics. If not reported, those metrics shall be deemed a missed metric/target for the Reporting Period and the applicable penalty shall be paid.

3.4 Performance Failure Analysis

Without limiting any terms or conditions of the Schedule B-6, in the event of a Performance Failure, Co-Administrators will, or will ensure that PBM will, at no additional cost to Plan Sponsor:

(a) Upon Plan Sponsor's request for a formal corrective action plan (CAP), provide Emblem and Plan Sponsor with such CAP no more than twelve (12) business days after the request, or as otherwise mutually agreed upon after the request for a CAP.

(b) Minimize the impact of and remedy the cause of the Performance Failure and resume meeting the affected Service Levels.

(c) Implement and notify Plan Sponsor (and Emblem, as applicable) of measures taken by PBM or Emblem, as applicable) to prevent recurrences of the Performance Failure and provide weekly updates until all identified action items have taken place and any root causes have been remediated. Any such communications shall be shared by Emblem with Plan Sponsor.

(d) Make written recommendations for improvements in procedures and, if requested by Plan Sponsor (or Emblem, as applicable), provide a detailed service improvement plan setting forth discrete steps and action items (including completion dates) to avoid future Performance Failures, and track progress against these completion dates.

(e) Provide Plan Sponsor (and Emblem, as applicable) with additional information, as reasonably requested, to identify service trends and identify opportunities for the continuous improvement of the Pharmacy Services.

3.5 Recoveries resulting from Performance Failure

Without limiting any terms or conditions of this Schedule B-6, in the event of a Performance Failure, Co-Administrators shall attribute any financial value associated with penalties from PBM to Co-Administrators received, which can be directly attributed to Plan Sponsor, to Plan Sponsor. The Parties agree there are no fees at risk within this Exhibit B and that any value attributable to recoveries associated with Service Level performance failure are the result of the fees at risk in the agreement between Co-Administrators and the PBM. Should recoveries be realized, they shall be provided in compliance with Section 3.6 and in accordance with the following:

(a) When a specific Service Level set forth in the PBM agreement results in a failure and such failure results in money being owed and paid to Co-Administrators, the value attributable to the data associated with the Plan Sponsor shall be paid to Plan Sponsor based on the percentage of Plan Sponsor impacted to appropriately allocate the amount received from the PBM to the Co-Administrators. Co-Administrator shall provide all information reasonably necessary for Plan Sponsor to audit the amount Co-Administrators determine is owed and payable to Plan Sponsor, and the Parties shall agree in good faith on the final amount owed and payable to Plan Sponsor. For purpose of clarity, if there is a specific Service Level failure for the Plan Sponsor alone which does not coincide with a total failure of a Service Level such that PBM does not owe Co-Administrators a penalty, then nothing shall be due to Plan Sponsor.

(b) Any Service Level money shall be distributed to Plan Sponsor only after receipt of the such amount from PBM to Co-Administrators, without additional risk placed on Co-Administrators.

SLA GRID

	SLA Name	SLA Description	Reporting Frequency	Measurement Frequency	Target
1	Benefit Configuration Accuracy (new and revised benefits)	Measures the accuracy of Configurations, and shall be calculated in accordance with the following formula: Measurement: [(Total number of Configurations sampled – Number of Inaccurate Configurations sampled) / (Total number of Configurations sampled within the same Measurement Period)] Where: "Number of Inaccurate Configurations" means the number of Configurations containing one or more errors. An error is calculated by comparing the final detailed design document submitted by Emblem, on behalf of Plan Sponsor, to PBM to the Configuration in the Production Environment. If the Production	Monthly	Quarterly	**99.5%**

	SLA Name	SLA Description	Reporting Frequency	Measurement Frequency	Target
		Environment Configuration does not match the detailed design document in one or more areas, it would be an inaccurate Configuration. A "Configuration" for the purpose of this Service Level includes benefits Configuration, reimbursement policy Configuration, and system code table maintenance.			
2	Benefit Configuration Timeliness - new/revised benefits	Standard Benefit Plan design changes will be implemented within 10 business days of Emblem/PBM receipt of all specifications unless otherwise mutually agreed upon. Complex Benefit Plan Design Changes will be implemented by a mutually agreed upon date. Complex Benefit Plan Design is defined as those Benefit Plan changes that require system enhancement or development. Measurement: Benefit Plans set up within agreed turnaround time divided by the total Benefit Plan implemented in time period.	Monthly	Monthly	**98.5%**
3	Accumulators/Benefit Accruals - Member overages	PBM shall provide a timely response (agreement/disagreement) to member overages reported by Emblem– within 5 business days and timely correction, though claims adjustments, to agreed-upon overages – within 7 business days. Measurement: Responses within the applicable timeframe divided by total requests for response during the measurement period.	Monthly	Monthly	**100.0%**
4	Accumulators/Benefit Accruals	All claims information will be accurately provided to Emblem on a real time (API) basis for deductible calculation, accruals, etc. PBM guarantees 99.5% availability for API. Measure 24 hours a day, 7 Days a week. Measurement: The actual minutes the API was available during the availability Measurement Period by the total minutes the system or application was scheduled to be available during the measurement period.	Monthly	Monthly	**99.5%**
5	Claims Timeliness - Electronic	Electronic Claims: For NYS: 100% of electronic claims paid within 30 calendar days from the date the claim was received to the date of payment. Measurement: Count of electronic claims paid in reporting period within applicable timeframes in reporting period/Count of electronic claims paid in reporting period.	Monthly	Monthly	**100.0%**
6	Claims Timeliness - Paper	Paper Claims: For NYS: 100% of paper claims paid within 44 calendar days (regulatory requirement is 45 days in total but PBM performance requirement is minus one day for front end processing) of receipt from mailroom/scanning function as measured by final release for payment unless pended for resolution by a non-supplier entity for greater than 42 days. Measurement: Count of paper claims paid in reporting period that aged beyond 44 or 29 calendar days, as	Monthly	Monthly	**100.0%**

	SLA Name	SLA Description	Reporting Frequency	Measurement Frequency	Target
		applicable, in reporting period/Count of paper claims paid in reporting period.			
7	PBM Benefit Design Errors	All errors will be corrected within 5 business days of identification of error. Errors that need systems changes/defects will be excluded from this measure and the parties will mutually agree to a timeframe depending on the nature of the issue. Measurement: The total number of errors corrected within 5 business days divided by total errors in the time period.	Monthly	Monthly	**100.0%**
8	Member Contact Center - Hours of Operation	8 am to 8 pm ET, 7 days a week. Can use alternative technology weekends and holidays. Measured through a statistically valid sampling of test calls into the Contact Center.	Monthly	Monthly	**100.0%**
9	Member Contact Center - Abandonment Rate	Percentage of calls abandoned in a queue to either a customer service representative or IVR on Emblem's dedicated toll-free line received during Hours of Operation during the current quarter (i.e., the 1st day to the last day of the quarter). Excludes calls terminated by the Member in less than 30 seconds. Measurement: Total Member calls abandoned less calls terminated by the Member in less than 30 seconds divided by the total Member calls offered.	Monthly	Quarterly	**<2%**
10	Member Contact Center - Service Level -	Emblem guarantees that 80% of Member calls will be answered 30 seconds or less. This guarantee is predicated on the installation of a toll-free number unique to Emblem. Measured by dividing: (i) the number of Member calls answered in 30 seconds or less by (ii) the total number of Member calls handled for the same Measurement Period. Includes only calls received during Hours of Operation.	Monthly	Quarterly	**80%**
11	Member Contact Center - Blockage Rate	Blockage is defined as a caller receiving a busy signal. This guarantee is predicated on the installation of a toll-free number unique to Plan Sponsor. Includes only calls received during Member contact center Hours of Operation. Measurement: Total member blocked calls divided by total member calls offered	Monthly	Quarterly	**<1%**

	SLA Name	SLA Description	Reporting Frequency	Measurement Frequency	Target
12	Pharmacy Contact Center ASA	Emblem guarantees that Pharmacy calls will be answered within an average of in 100 seconds or less. Pharmacy Contact Center Speed of Answer measures the amount of time it takes from the point that a call is placed in queue until a CSR or IVR answers the call. Measured as the sum of all Pharmacy calls answered time divided by total Pharmacy calls handled in the time period. Includes only calls received during Hours of Operation.	Monthly	Quarterly	**100 seconds**
13	Pharmacy Contact Center - Call Abandonment Rate	Percentage of Pharmacy calls abandoned in a queue to a Customer Service Representative or the IVR on Emblem's dedicated toll-free line during the current quarter, the 1st day to the last day of the quarter. Excludes calls terminated by the provider in less than 30 seconds. Includes only calls received during Hours of Operation. Measurement: Total Pharmacy calls abandoned less calls terminated by the Pharmacy in less than 30 seconds divided by the total Pharmacy calls offered.	Monthly	Quarterly	**5%**
14	Specialty Delivery - Timeliness	The Pharmacy Match Specialty Delivery Guarantee is measured at the Pharmacy Match network level This Service Level shall be calculated in accordance with the following formula: (Total number of prescriptions shipped minus total number of deliveries)/ (Total number of prescriptions shipped for the same Measurement Period), expressed as a percentage. Report overall results. Performance will be monitored; any trends noted will be included in the Service Level Report.	Quarterly	Quarterly	**98.0%**
15	Member Grievances	Emblem shall handle all Member grievances. Emblem shall investigate all grievances and ensure a full resolution including letter sent to the Member - to be completed within 30 calendar days from date of receipt of the grievance. If there are additional questions about the original complaint from the Member within 90 days, this will be considered "not fully resolved" and the guarantee will not be met. Calculated based on total grievances completed with letter sent / total grievances received in a Measurement Period.	Monthly	Monthly	**98.0%**
16	Portal Accessibility	Member portal will be available and accessible 99% of the time. Measurement: The actual minutes the Member portal was available during the Measurement Period divided by the total minutes the Member portal was scheduled to be available during the Measurement Period.	Monthly	Monthly	**99.0%**

	SLA Name	SLA Description	Reporting Frequency	Measurement Frequency	Target
17	Inquiry Response Timeliness to respond to written member inquiries - Urgent and Non-Urgent	At least 95% of written inquiries will be responded to within five (5) business days and 100% of written inquiries will be responded to within ten (10) business days. Based on Plan Sponsor's Member inquiries. Measurement: Total written inquiries responded to within 5 business days divided by the total written inquiries responded to in the Measurement Period; and total written inquiries responded to within 10 business days divided by the total written inquiries responded to in the Measurement Period.	Monthly	Quarterly	**95% in 5 business days; 100% in 10 business days**
18	Rebate Payment	Rebate payments will be paid to Plan Sponsor within 150 days after the end of each quarter during the calendar year.	Quarterly	Quarterly	**100.0%**
19	Rebate Reconciliation	Annual rebate reconciliation for 100% pass through shall occur no later than one hundred eighty (180) days after the Contract Year end in aggregate by Emblem's line of business.	Annual	Annual	**100.0%**
20	Quarterly Rebate Reporting	PBM guarantees that the data required by Emblem to support Rebates (submissions by PBM to Manufacturers) will be provided to Emblem within 120 days after the end of each calendar quarter.	Quarterly	Quarterly	**100.0%**
21	Prior Authorization Turnaround time – urgent request	98% of all urgent Prior Authorization determinations must be made within state and regulatory timeline guidance (e.g. NY Article 49~~)~~. Measured as urgent Prior Authorizations determined within applicable timeframe divided by total urgent Prior Authorizations in Measurement Period.	Monthly	Quarterly	**98.0%**
22	Prior Authorization Turnaround time - standard request	98% of all standard Prior Authorization determinations must be made within state and regulatory timeline guidance (e.g. NY Article 49). Measured as standard Prior Authorizations determined within applicable timeframe divided by total standard Prior Authorizations in Measurement Period.	Monthly	Quarterly	**98.0%**
23	Clinical Review Accuracy	Clinical Review accuracy shall be 95% or greater per contract year. Measurement: The total number of accurate reviews divided by total reviews sampled via PBM formal Quality Assurance process. Samples are evaluated against PBM formal QA process which shall include a determination of accuracy based on the end-to-end evaluation of the case handling.	Quarterly	Annually	**95%**

Schedule B-7

SPECIALTY PRODUCT LIST

EXHIBIT C

Security

This Security Exhibit (this "Exhibit") is incorporated into and made part of the Administrative Services Agreement (the "Agreement") between UMR, Inc., on behalf of itself and its Affiliates ("UMR") and EmblemHealthPlan, Inc. (each individually a Co-Administrator and together the "Co-Administrators"), and the City of New York acting through the Mayor's Office of Labor Relations pursuant to New York City Administrative Code § 12.126(d) ("Plan Sponsor"). These requirements are applicable if and to the extent that Co-Administrators create, have access to, or receive from or on behalf of Plan Sponsor any Customer Information (as defined below). Capitalized terms not specifically defined herein shall have the meanings ascribed to such terms in the Agreement.

The Parties hereby agree as follows:

Section 1: Definitions

The following terms shall have the meanings as set forth below:

Customer Information: Any Plan Sponsor information provided, collected, access, maintained or created by Co-Administrators in the course of providing products or Services under the Agreement that includes or is comprised of any of the following:

(1) Protected Health Information, as defined in each Business Associate Agreement.

(2) Non-public personal information (i.e., any information that would be termed "non-public personal information" under the Federal Gramm-Leach-Bliley Act, any related state statutes, and any related federal or state regulations);

(3) Other personal information (i.e., other personally identifiable information about individuals, or information that can be used to identify individuals, the disclosure and/or use of which is restricted by applicable Law, including social security numbers), including information that constitutes "Identifying Information" subject to § 23-1201 – 1205 of the Administrative Code of the City of New York; and

(4) Plan Sponsor Confidential Information.

Healthcare Industry Security Standards: The standards and framework of HITRUST Common Security Framework.

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EmblemHealth | UnitedHealthcare

Exhibit D: Estimated Annualized Cost

Plan Year	Program Administration	Discretionary Credits Available to CNY
2026	$153,537,265.08	$38,000,000.00
2027	$158,280,283.80	$27,000,000.00
2028	$163,238,894.28	$22,000,000.00
2029	$168,125,640.84	$12,000,000.00
2030	$173,120,183.28	$12,000,000.00

[redacted]

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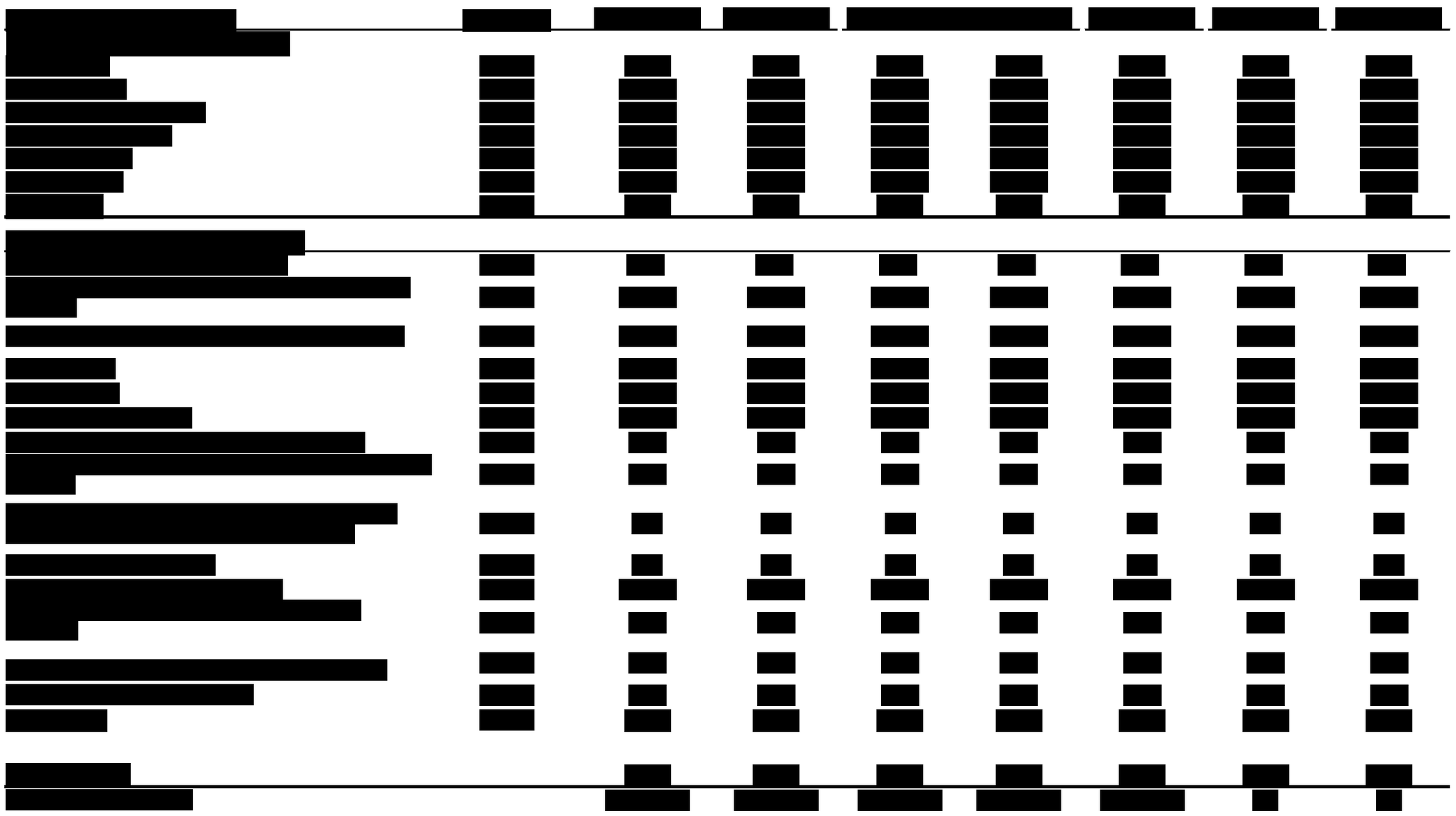

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[redacted]	[redacted]	
[redacted]	Yes	
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EmblemHealth | UnitedHealthcare

EXHIBIT E

City of New York 2026 - 2030 Plan Years Guarantee Summary

Metric	Combined Emblem & UMR Amounts at Risk
Implementation Performance Guarantees (Year 1 Only)	
Initial ID Cards Issuance	$6,500,000
Procedures and systems in place to begin processing medical claims	$6,500,000
Operational Performance Guarantees (Annual)	
Financial Accuracy	$1,500,000
Claim Procedural Accuracy	$1,500,000
Claim Payment Accuracy	$1,500,000
Turnaround Time	$1,500,000
Average Speed to Answer Telephone Calls	$1,150,000
Abandonment Rate	$1,150,000
Customer Satisfaction Surveys (City of New York and MLC)	$500,000
Account Management Satisfaction (Annual)	
Account Management	$2,500,000
Member Service Satisfaction	$1,000,000
Customer Delight Guarantee (Year 1 Only)	$10,000,000
Trend Guarantee (Year 1 Only)	60.0%
Trend Guarantee (Years 2 & 3 Only)	50.0%
Trend Guarantee (Years 4 & 5 Only)	30.0%

EmblemHealth & UMR Implementation Guarantees		
New York City		
Effective Date	Contract Execution Date	
Definition	**ID cards generated by UMR will be mailed**	
If all Customer Contingencies met	Provide notice of award and benefits in the form of SPDs or plan documents	
	Final, approved account structure and installation document(s) reflecting all benefit decisions and selected COEs; provide all final information requested for set up in collaboration with Emblem and UMR	
	Final, approved ID card proof	
	Provide full complete and accurate eligibility production files that are currently the responsibility of Plan Sponsor	
	Approve census - UMR will provide census to Plan Sponsor by 11/19/25 for review and approval will allow for next step to generate and release ID card by 12/8	
Payment Period	One time	
Fees at Risk	Amount of first plan year's medical fees at risk for this metric	**$ 6,500,000**
Definition	**Procedures and systems in place to begin processing medical claims**	
	If accumulator files and other information from prior administrator are required, the final date to begin processing claims	
If all Customer Contingencies met	Provide notice of award and benefits in the form of SPDs or plan documents	
	Provide information regarding all vendor connections, including contacts, file feed requirements, etc. (In progress with Emblem i.e. Prime, Wellspark, EAP etc.)	
	Final, approved account structure and installation document(s) reflecting all benefit decisions and selected COEs; provide all final information requested for set up in collaboration with Emblem	
	Provide full complete and accurate eligibility production files that are currently the responsibility of Plan Sponsor	
	Provide test file of all accumulators and other information to be transferred (assistance from the City of New York to engage prior carrier for lifetime maximums and coordination of benefits)	
	Provide complete production file of all accumulators and other information to be transferred (assistance from the City of New York to engage prior carrier for lifetime maximums and coordination of benefits)	
	Custodial banking:	
	Provide bank account set up information	
Payment Period	One time	
Fees at Risk	Amount of first plan year's medical fees at risk for this metric	**$ 6,500,000**

Proposed Medical Claims Performance Guarantee

Customer Name : City of New York
Plan Effective Date : 1/1/2026

I. Financial Accuracy

UMR agrees that Claim payments, on an aggregated dollar basis, shall be ninety-nine percent (99%) accurate to the plan design. If however, the financial accuracy falls below the agreed upon level, UMR will give a credit as stated on the table below.

Financial Accuracy will be calculated by dividing the total audited dollars paid correctly by the total audited dollars processed. This will be measured on customer specific results.

[redacted]

II. Claim Procedural Accuracy

UMR agrees that the Claim Procedural Accuracy will be maintained at a level of ninety-five percent (95%). If the Claim Procedural Accuracy falls below the agreed upon level, UMR will give a credit as stated on the table below.

The Claim Procedural Accuracy percentage will be calculated by dividing the number of services not containing procedural errors in the audit period by the number of services audited during the same period. This will be measured on customer specific results.

[redacted]

III. Claim Payment Accuracy

UMR agrees that Claim Payment Accuracy will be maintained at a level of ninety-eight percent (98%). If, however, the Claim Payment Accuracy falls below the agreed upon level, UMR will give a credit as stated on the table below.

Claims Payment Accuracy will be calculated by dividing the total number of services not containing payment errors in the audit period by the total number of services audited in that same period. This will be measured on customer specific results.

[redacted]

IV. Turnaround Time

UMR agrees that ninety percent (90%) of all clean Claims will be processed within 10 business days from the date that UMR receives all information necessary to adjudicate the Claim. In the event that UMR's turnaround time falls below the agreed upon level, UMR will give a credit as stated on the table below.

Claims will be considered "processed" when UMR has released the Claim for payment, denial or request for additional information. This will be measured on customer specific results.

[redacted]

V. Customer Service

Emblem and UMR guarantee the following levels of customer service will be maintained.
These areas are all measured based on customer specific results.

1. Average speed-to-answer telephone calls

Emblem (member calls) and UMR (provider calls) agree that on average, calls will be answered in thirty (30) seconds or less. If calls are answered in more than thirty (30) seconds, we will give a credit as stated on the table below.

[redacted]

2. Abandonment Rate

Emblem (member calls) and UMR (provider calls) agree that on average, three percent (3%) or less of calls may be abandoned. If more than the agreed upon level of calls are abandoned, we will give a credit as stated on the table below.

[redacted]

[redacted]

3. Customer Satisfaction Surveys (City of New York)

UMR agrees that on average, ninety percent (90%) or more of survey respondents will be “very satisfied, somewhat satisfied or satisfied” on a standard Customer Service Questionnaire. If less than the agreed upon level of satisfaction percentage is achieved, UMR will give a credit as stated on the table below.

[redacted]

4. Customer Satisfaction Surveys (MLC)

UMR agrees that on average, ninety percent (90%) or more of survey respondents will be “very satisfied, somewhat satisfied or satisfied” on a standard Customer Service Questionnaire. If less than the agreed upon level of satisfaction percentage is achieved, UMR will give a credit as stated on the table below.

[redacted]

Annual Aggregate Penalty: [redacted]

Performance Guarantee Conditions:

- Performance Guarantees are for medical and behavioral claims administration.
- Performance Guarantees are measured annually.

- In the event of a pandemic, Emblem and UMR reserve the right to revisit this guarantee subject to mutual agreement.

Proposed Account Management Performance Guarantee

Customer Name : City of New York

Account Management

Emblem and UMR agree the account management scorecard will be an average of 3 or higher. Every quarter we will send the scorecard to you via email. You will have three weeks to respond. If we don't hear back from you, the rating defaults to an automatic average of 4 (4=always meets expectations). If however, the average score falls below the agreed upon level, Co-Administrators will give a credit as stated on the table below.

The guarantee is calculated by the average of all eight measurable needs on the attached account management service scorecard:

[redacted]

Member Services Satisfaction Surveys

Emblem agrees that on average, ninety percent (90%) or more of survey respondents will be "very satisfied, somewhat satisfied or satisfied" on a standard Member Service Questionnaire. If less than the agreed upon level of satisfaction percentage is achieved, Emblem will give a credit as stated on the table below.

[redacted]

Annual Aggregate Penalty: [redacted]

Guarantee Conditions:

• Performance Guarantees are measured annually.
• In the event of a pandemic, Emblem and UMR reserve the right to revisit this guarantee, subject to mutual agreement of the Parties.

Account Management Scorecard

Customer Name: City of New York
Evaluation Period:
Date Completed:
By:

Using the rating guide below, and the definitions provided, please rate our performance for each measurable need for the period indicated above.

Rating Methodology:

5 - Exceeds Expectations
4 - Always Meets Expectations
3 - Usually Meets Expectations
2 - Sometimes (once in a while) Meets Expectations
1 - Consistently Does Not Meet Expectations

Measurable Need	Rating	Definitions
1. Accessibility		Able to contact within 24 hours.
2. Responsiveness to issues/questions		48 hour return call after issue identification
3. Timely notification of problems		Notification of problems as they are identified.
4. Coordination of issue resolution		Updates provided weekly (or agreed upon timeframe) on outstanding issues
5. Communication of plan's results		End of the month following reporting period
6. Attendance at scheduled meetings		Attendance at scheduled meetings
7. Delivery of Standard Data Reporting		15 business days following reporting period
8. Development of comprehensive action plans to resolve issues		Action items & activities outlined within 1 week of issue identification.

Comments:

The Billed Administrative Service Fees payable by Plan Sponsor under this Agreement will be adjusted through a credit to your Service Fees in accordance with the performance guarantees set forth below. This guarantees applies to medical benefits and are effective for the period on the Effective Date to December 31, 2026.

In the event the City or MLC fails to provide a quarterly survey response, such non-returned response will default to a score of "5". A minimum of 299,433 subscribers enrolled in the NYC Employee PPO Plan is required for the above guarantee(s) to remain in effect. We reserve the right to adjust the dollars at risk should actual subscriber enrollment decrease by 10% or greater. The PEPM dollar value of this guarantee is $2.78. If subscriber enrollment decreases by more than 10%, the amount at risk will be recalculated by annualizing the actual subscriber enrollment using the $2.78 PEPM value.□

Customer Delight - Applies to First Year Only - City of New York		
Definition	Customer must be 'delighted' as our customer.	
Measurement	Minimum score on a 5 point scale	Score 3
• Criteria	Quarterly survey that is completed by representative(s) the City of New York during year one. The quarterly results will be averaged for the final annual score.	
• Level	Customer specific	
• Period	Quarterly	
Payment Period	Annually	
Fees at Risk	**Dollars at Risk** for this metric	$5,000,000
Payment Amount	Of the Dollars at Risk for this metric, percentage at risk for each gradient	N/A
Gradients	Not applicable	

Introduction

[redacted]

Trend Guarantee Development

[redacted]

Required Claim Data

[redacted]

Claim Adjustments

[redacted]

[redacted]

Our Commitment:
Guarantee

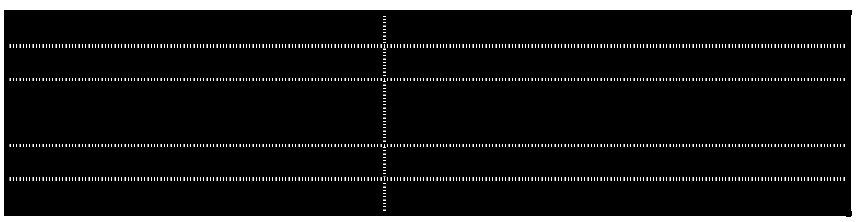
[redacted]

Basis of our Guarantee:

[redacted]

[redacted]

[redacted]



[redacted]

Introduction

[redacted]

Trend Guarantee Development

[redacted]

Required Claim Data

[redacted]

Claim Adjustments

[redacted]

[redacted]

[redacted]

Our Commitment:
Guarantee

[redacted]

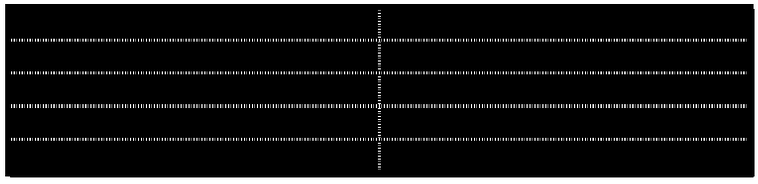
Basis of our Guarantee:

[redacted]

[redacted]

Timeline Illustration for setting of Year 2 Target:

[redacted]



[redacted]

[redacted]

Introduction

[redacted]

Trend Guarantee Development

[redacted]

Required Claim Data

[redacted]

Claim Adjustments

[redacted]

[redacted]

[redacted]

Our Commitment:
Guarantee

[redacted]

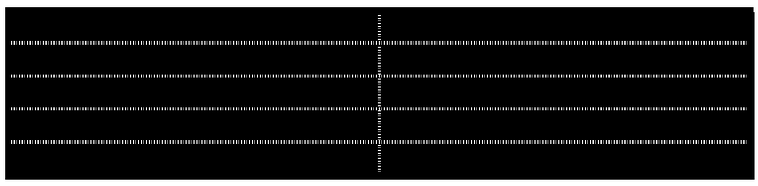
Basis of our Guarantee:

[redacted]

[redacted]

Timeline Illustration for setting of Year 3 Target:

[redacted]



[redacted]

[redacted]

Introduction

[redacted]

Trend Guarantee Development

[redacted]

Required Claim Data

[redacted]

Claim Adjustments

[redacted]

[redacted]

[redacted]

Our Commitment:
Guarantee

[redacted]

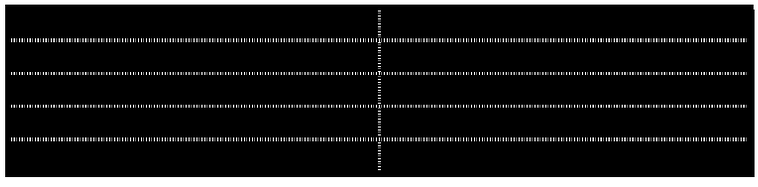
Basis of our Guarantee:

[redacted]

[redacted]

Timeline Illustration for setting of Year 4 Target:

[redacted]



[redacted]

[redacted]

EXHIBIT F

NYCE PPO Review Committee Reporting Requirements

1. The "NYCE PPO Review Committee" shall be composed of representatives and designated consultants from the City and representatives from the New York City Municipal Labor Committee (the "MLC") and its designated consultants. Members of the NYCE PPO Review Committee from the MLC and its designated consultants must sign a confidentiality agreement with Co-Administrators, and Co-Administrators will not provide "protected health information" or "personal information" to the MLC or MLC members of the NYCE PPO Review Committee. Co-Administrators agree to meet with the NYCE PPO Review Committee monthly to discuss any issues related to the administration of the Plan and to present and discuss with the NYCE PPO Review Committee the reports listed in this **Exhibit F**.

Co-Administrators shall provide timely reporting to the NYCE PPO Review Committee in accordance with the requirements set forth in this **Exhibit F**, or as may be modified by mutual agreement of the Parties. The Co-Administrators shall also timely provide ad hoc reports to the NYCE PPO Review Committee as agreed upon by mutual agreement of the MLC, the City, and the Co-Administrators. The reports shall be submitted in mutually agreed upon formats. All reports made available pursuant to this **Exhibit F** shall be the property of the City and are considered Plan Sponsor Confidential Information.

2. Co-Administrators shall provide the following reports to the City and the MLC on a monthly basis:
   - Network utilization reports by market (i.e., Downstate Counties vs. outside) set forth as a percent of claims paid in network vs. out of network, including the identification of out of network providers and level of utilization for each out of network providers
   - NYCE PPO provider recruitment status report for providers nominated by Participants, the City, the Unions and/or the MLC
   - NYCE PPO prior authorization approvals/denials reporting, both in the aggregate and by procedure (where there is a minimum threshold of services to assure confidentiality)
   - Monthly performance standard outcomes
   - Member Services utilization reports (e.g., web traffic, number of calls)
   - Monthly standard utilization cost reports for both medical and pharmacy Claims
   - Appeals and grievances reports. **These reports will be submitted on a monthly, quarterly and annual basis.**

3. Co-Administrators shall provide the following reports to the City and the MLC on a quarterly basis:
   - Performance standard report, indicating Co-Administrators' performance for all performance standard measurements and whether standards were met. Reports must provide monthly performance data as well as quarterly aggregates.
   - Quarterly reporting on the NYCE PPO plan cost, utilization, and clinical performance. Reporting shall also include relevant legislative updates. This report should be produced 60 days after the end of the reporting quarter with a one-month lag. Co-Administrators shall make themselves available upon reasonable notice to discuss these reports with the City and/or the MLC.

4. Co-Administrators shall provide the following reports to the City and the MLC on an annual basis:
    - NYCE PPO member satisfaction survey, which will include: (i) overall Member satisfaction on NYCE PPO plan benefits and services; network access; member services; and claims and care management.
    - NYCE PPO network and out of network utilization and network growth.
    - Annual NYCE PPO utilization reporting.
      Annual standard pharmacy utilization

In the event the NYCE PPO Review Committee, based on the reporting provided, raises concerns regarding Co-Administrators' Services that the City, MLC, and Co-administrators are unable to resolve to the satisfaction of the Committee, the Committee may request that the Parties retain a mediator (selected by mutual agreement of the Parties) to assist in resolution of the issue. This process is not intended to apply to any alleged breach of the Agreement and is wholly separate and unrelated to any dispute resolution process available to the City under the Agreement.

EXHIBIT G

EmblemHealth | UnitedHealthcare

**SAMPLE MONTHLY INVOICE

Client Name	City of New York	**Account Number**	TBD
Plan Name	NYC Employees PPO Plan	**Invoice Date**	TBD
Group Address		**Invoice Number**	TBD
Street	TBD	**Coverage Period**	TBD
City	TBD	**Due Date**	TBD
State	TBD		
Zip	TBD		

Dear NYC Employees PPO Plan,
Attached is the Administrative Service bill for the month of TBD in conjunction with the contract between Co-administrators and the Plan Sponsor. The billing reflects an administrative service fee for Per Employee Per Month.

	PEPM	**Participants**	**Total Amount**
EmblemHealth Medical Administrative Fee	TBD	TBD	TBD
UMR, Inc. Medical Administrative Fee	TBD	TBD	TBD
PCORI Fees	TBD	TBD	TBD
UMR Discretionary Credit	TBD	TBD	TBD
Total Amount Due	**TBD**	**TBD**	**TBD**

Please remit electronic payment to:
EmblemHealth
ABA # TBD Account # TBD
Include Group Name and/or number on the reference line

If you have any questions please contact your EmblemHealth & UnitedHealthcare account teams.

EmblemHealth | UnitedHealthcare

***SAMPLE MONTHLY INVOICE**

Client Name	City of New York	**Invoice Date**	TBD
Plan Name	NYC Employees PPO Plan	**Invoice Nbr**	NYC011426
Group Address		**Due Date**	TBD
Street	TBD		
City	TBD		
State	TBD		
Zip	TBD		

	Total Amount
Issued fee for service payments	TBD
Total Amount Due	**TBD**

Please send funds to:

Bank Name:	Citibank
Bank City, State	New Castle, DE
Routing Nbr	031100209
Account Nbr	xxxxxx1234

***Billed on the 10th of every month, aurthorized for payment by the last day of each calendar month.*

If you have any questions please contact UMR-UMRFunding@umr.com

CheckNumber	CheckDate	Transaction Type	Transaction amount	Account Source Code	Payee Name	Payee Address
0000069912	20260114	Draft	7,559.27	CZ999	UMR VALUE BASED CONTRACTING	ATTN FINANCIAL SPECIAL SERVICES WAU 6150 PO BOX 860785 MINNEAPOLIS MN 55486-0785
0000069913	20260114	Draft	219,616.99	CZ999	UMR CRS FEES	ATTN FINANCIAL SPECIAL SERVICES WAU 6150 PO BOX 860785 MINNEAPOLIS MN 55486-0785
0000070030	20260114	Draft	56,224.32	CZ999	UMR NY HCRA	ATTN FINANCIAL SPECIAL SERVICES WAU 6150 PO BOX 860785 MINNEAPOLIS MN 55486-0785
			283,400.58			

EmblemHealth

***SAMPLE QUARTERLY INVOICE**

Client Name	City of New York	**Plan Year**	TBD
Plan Name	NYC Employees PPO Plan	**Quarter #**	TBD
Group Address			
Street	TBD		
City	TBD		
State	TBD		
Zip	TBD		

	Total Amount
Pharmacy Rebate Total Amount Due	**TBD**

***Rebates are issued within 150 days following the end of each calendar quarter.*

PLAN NAME	CARRIER	ACCOUNT	GROUP	TOTAL INVOICE VALUE
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

CLIENT_NAME	CARRIER_ID	ACCOUNT_ID	GROUP_ID	CURRENT_INVOICE_ELIGIBLE_CLAIMS	BRAND_NAME	NDC_11	AGGREGATE_NET_INVOICI	CURRENT_NET_PAYMENT
CNY COMMERCIA	NY1020	EHPI	TBD - Diabetic and ACA - Base Benefit O	X,XXX	<NAME>	XXXXX-XXXX-XX	$TBD	$TBD

EmblemHealth | UnitedHealthcare

***SAMPLE DAILY INVOICE**

Client Name	City of New York	**Invoice Date**	TBD
Plan Name	NYC Employees PPO Plan	**Invoice Nbr**	NYC011426
Group Address		**Due Date**	TBD
Street	TBD		
City	TBD		
State	TBD		
Zip	TBD		

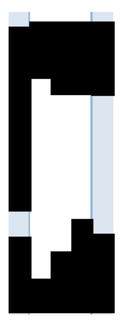
	Total Amount
Issued claim payments	TBD
Claim refunds	TBD
Total Amount Due	**TBD**

Please send funds to:

Bank Name:	Citibank
Bank City, State	New Castle, DE
Routing Nbr	031100209
Account Nbr	xxxxxx1234

***Funding authorization due by noon ET of the business day following the day on which the invoice is issued.*

If you have any questions please contact UMR-UMRFunding@umr.com



[redacted]

EXHIBIT H

Claims Data Fields

**Data dictionary available*

Account Structure
Group Number
Group Name
Policy Number(s)
Class Code(s)
Location Code(s)
Benefit Plan(s)
Member Network
Provider Network

Employee
Employee ID
Patient Sequence Number
Employee Last Name
Employee First Name
Employee ID Card
Assigned Employee Number
Employee SSN
Employee Zip Code

Patient
Patient/Claimant Last Name
Patient/Claimant First Name
Patient/Claimant Gender
Patient/Claimant Date of Birth
Patient Relationship

Claim Service
Patient Account Number
Claim Control Number (CCN)
Beginning Date of Service
Ending Date of Service
Paid Date of Claim
Bill Type Code
Procedure Code
Procedure Code Modifier*
Hospital Bill Type
Revenue Code*
Diagnosis 1
Diagnosis 1 Qualifier*
Diagnosis 2
Diagnosis 2 Qualifier*
Diagnosis 3
Diagnosis 3 Qualifier*
Hospital Billed Procedure Code 1
Hospital Billed Procedure Code 2
Hospital Billed Procedure Code 3
Hospital Billed Procedure Code 4
Hospital Admit Date
Hospital Discharge Date
Admission Source Code
Place of Service Code*
CMS Place of Service Code
Emergency Indicator
Type of Service*
Occurrences, number of procedures
Discharge Status Code
NDC (National Drug Code)
DRG Code
Adjustment Code*
Reversal Code*
Payee Code*
Check Number
Release Code*
AFV Indicator*
Type of Disability Code*
Managed Care Tier
Network Provider Indicator
Network Benefit Indicator
Other Insurance Type Code*
Alternate Benefit Calculation Applied*
Number of Units / Days Billed

Provider
Provider Tax ID Number
Servicing NPI number
Servicing Provider Name
Servicing Provider State
Servicing Provider Zip Code
Type of Provider*
Servicing Provider Specialty Code*
Provider Designation*
Internal Provider Number
Billing Provider NPI
Billing Facility Name
Billing Address
Billing Address 2
Billing City Name
Billing Facility State
Billing Facility Zip Code

Financial
Billed Amount
Allowed Amount
Payment Amount
Deductible Amount
Copay Amount
Coinsurance Amount
Other Insurance COB Amount
Amount Paid by Other Insurance
HRA Payment Amount

Admission Type

HRA Deductible Amount

Prescription Drug Coverages

Unique patient ID (consistent across medical and Rx)
Drug Name
NDC-11
Drug Strength
Quantity
Days of Therapy
Date – Serviced
Ingredient Cost
Dispensing Fee
Sales Tax
Member Cost
Copay
Plan Cost
Prescriber NPI
Pharmacy Name
Pharmacy NPI
Pharmacy Claim ID
Claim Drug Qualifier
Claim Status
Specialty Drug Indicator
Route of Administration
Prior Authorization Indicator
Prior Authorization Number
Pharmacy U and C Amount
Pharmacy Network Indicator
Pharmacy Class Code
Over the Counter Indicator
Therapeutic class
Mail/Retail Code
AWP
Acute / Maintenance Indicator
Adjustment Type
COB Indicator
Compound Indicator
Cost Basis Code
DAW
Date - Invoice
Drug Label
Formulary Indicator
GPI
AHFS Therapeutic Class Description
Gross Cost

New/Refill Indicator
Person Number

Basis of Cost Determination

EXHIBIT I

Network Adequacy Standards

The below-listed Network Adequacy Standards are designed with the different service areas in mind. Section 1 establishes the Network Adequacy Standards that are Emblem's responsibility for the Downstate Counties, and Section 2 establishes UMR's responsibility for all areas nationally excluding the Downstate Counties in addition to the maintenance of the behavioral health network nationally (including the Downstate Counties).

1. Emblem Network Adequacy Standards

- Emblem will maintain in-network utilization in the Downstate Counties as follows:
  - At least [redacted] of total eligible professional provider charges will be in-network.
  - At least [redacted] of total eligible facility charges will be in-network
  - Reconciliation of medical INN utilization will exclude any large Claims in excess of [redacted].
  - The in-network utilization commitment excludes behavioral health and pharmacy Claims.
- Emblem will maintain at least [redacted] unique non-behavioral health Network Providers within the Downstate Counties. If at any point the number of non-behavioral health Network Providers drops below the [redacted] unique non-behavioral health Network Provider threshold, Emblem will use commercially reasonable efforts to recruit additional Network Providers to raise the provider count above the [redacted] unique non-behavioral health Network Provider threshold. In no event will Emblem's provider count fall below [redacted] of the [redacted] unique non-behavioral health Network Provider threshold.

2. UMR Network Adequacy Standards

- UMR will maintain medical national facility and professional in-network utilization as follows:
  - At least [redacted] of the total eligible charges (excluding Downstate Counties) will be in network.
  - Reconciliation of medical in-network utilization will exclude any large Claims in excess of [redacted]
  - UMR's medical in-network utilization commitment excludes Behavioral Health and Pharmacy claims.
- UMR will maintain behavioral health utilization as follows:
  - At least [redacted] of total eligible facility charges will be in-network
  - At least [redacted] of total eligible professional provider charges will be in-network
  - Reconciliation of behavioral health in-network INN utilization will exclude any large Claims in excess of [redacted].
- UMR will maintain at least [redacted] unique behavioral health Network Providers within New York State.

EXHIBIT J

Implementation Timeline

#	Date	Schedule	Customer Contingencies
1	[redacted]		Confirmation of final benefits.
2	[redacted]	Pre-enrollment site and provider directory complete and ready to be published.	
3	[redacted]	Member and provider announcements mailed	Deliverable dependent on contract ratification
4	[redacted]	Emblem Call Center fully staffed and operational to accept and answer member and provider calls about the new program	
5	[redacted]	Benefit plan coded, tested, and in production. System ready for end-to-end testing.	
6	[redacted]	City of New York annual Open Enrollment period	
7	[redacted]	Digital solutions (portals and applications) operationally ready	
8	[redacted]	Verification of all network connections tested and in production	
9	[redacted]	Provide test file of all accumulators and other information to be transferred.	Assistance from Plan Sponsor to engage prior carrier for lifetime maximums and coordination of benefits
10	[redacted]	Eligibility file loaded, tested, signed off and in production for the purpose of ID Card production	Census approved by Plan Sponsor
11	[redacted]	Member calls operationally ready for Emblem team to begin using UMR platform for member administrative services starting Plan Effective Date	
12	[redacted]	UMR begins to take Provider calls	
13	[redacted]	Banking setup finalized, tested, and operationally ready. Not inclusive of EFT vendor setup.	
14	[redacted]	Clinical Advocacy Relationship to Empower ("CARE") operationally ready	Assistance from Plan Sponsor to engage prior carrier for open prior authorization cases for dates of service 1/1/2026 and beyond. Plan Sponsor will also assist in providing open case management data from prior carrier.
15	[redacted]		Additional eligibility file to be provided by Plan Sponsor for Open Enrollment transactions
16	[redacted]	ID cards ready and mailed	
17	[redacted]	Plan effective; Go live date	
18	[redacted]	Provide complete production file of all accumulators and other information to be transferred	Assistance from Plan Sponsor to engage prior carrier for lifetime maximums and coordination of benefits

Implementation Weekly Status Updates

Co-Administrators will conduct weekly status meetings throughout the Implementation Period and go-live Service Start Date to deliver comprehensive updates on the Implementation Plan and Customer Contingencies and emerging issues (including, but not limited to the below), as well as to ensure stakeholder alignment. Weekly status meetings shall address

Program Status Overview	Workstream Dashboard	Get to Green Plan
• Current progress updates • Key performance indicators and metrics • Challenges and risks identified • Upcoming goals and objectives	• Overview of individual workstreams • Status updates for each workstream • Key deliverables and deadlines • Resource allocation and utilization	• Action items to address current issues • Strategies to mitigate risks • Timeline for achieving green status • Responsible teams and stakeholders